Version 7.21

Birthing Your Baby

Your Dar a Luz resource for pregnant parents.

Please bring this binder to each visit.

Midwife on-call number 24/7
(505) 944-5488

Backup Numbers *(for use if you're unable to reach a midwife at the above number after 15 minutes):*
#1 (505) 273-5583
#2 (505) 273-5584

Client Health Information Portal is accessible at www.daraluzbirthcenter.org

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Dar a Luz Care

This section will give you some important information about the birth center! This includes our history and who we are, starting your care at the birth center, what to expect, how and when to reach us, your rights and responsibilities, and the safety of birth center care.

Welcome to Dar a Luz Birth & Health Center!

We are so pleased that you have chosen to receive your prenatal and birthing care from us! We are Albuquerque's only freestanding birthing center, and New Mexico's first licensed and nationally-accredited birth center staffed with certified nurse-midwives (CNMs).

Over the next few months, whether you are just beginning your pregnancy or whether you are transferring your care to us with only a few weeks to go, this educational binder will be an important resource for you, your partner, and your family. There will be many things that we discuss at your prenatal visits. This book is designed to supplement those visits, as well as add to other resources that you are using. We encourage you to read every section of this book and keep a list of questions**. Please bring this binder and your questions to every visit.**

At Dar a Luz, we believe that pregnancy and birth are normal life events. Most pregnant people will have very normal and comfortable pregnancies with few issues, if any. Some will have slight deviations from normal but will still be able to receive our care. There will also be some who have an issue in their pregnancy that will require them to transfer their care to a hospital-based practice. One of the purposes of this educational binder is to help you understand what is normal, what isn't normal, and when to be in contact with Dar a Luz about any of it. If there is something going on in your pregnancy that is not addressed, please don't hesitate to call us. Our relationship is a partnership -- we will work together to facilitate the healthiest possible outcome for you and your baby. Our commitment to our clients and families is that all will be treated with dignity, respect, compassion, and empathy.

Congratulations on your pregnancy, and thank you for sharing it with Dar a Luz!

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A Message from Abigail: How our Midwife Practice Works

Dar a Luz is a group practice. At this time, we have seven midwives who share five full-time positions. Five of our midwives are considered full-time clinical, and cover just a few more clinic and call shifts. One midwife is part-time and does mostly clinic and occasional call. Abigail is the Executive Director of the birth center, and does mostly administrative duties, and has about one clinic and two weekends working directly with clients every six weeks. This is a decent-sized practice, and it can be hard to get to know all of the midwives, especially if you are starting your care with us later in your pregnancy. It is recommended that you **see as many of the midwives as you can** during your prenatal care, but you may opt to see only certain midwives, too. We try our best to see everyone in the practice, but you can imagine how hard it is for us to know who we haven't seen when there are upwards of 150 pregnant people in our care at any given time! So, it is up to you to try and see all the midwives during the prenatal period, if that is important to you.

Because we are a group practice, this also means that we share on-call responsibilities. There are always two midwives on call: the first-call midwife (she is the one who is generally covering the 24-hour call phone and attends labors and births in that time period), and a backup-call midwife who is just that: backup for the first-call midwife. She is usually covering other clinical duties, but will attend labor/birth if there is more than one client in labor, or if the first-call midwife needs assistance. Midwives rotate every 12-24 hours on call. When you go into labor, the midwife on first call will generally be the midwife who will be your labor support and birth attendant. On occasion, it will be the second call midwife, because the first call midwife is too busy -- usually with another birth. Please understand you may not choose who your labor midwife is going to be, even if she is on second call. Our schedule is complicated and rotates in very specific ways to protect midwives in clinic, and also for our midwives' personal time.

It is also important to understand that because there are seven different midwives, there are seven different styles and seven different personalities! We pride ourselves on being a diverse group with very different backgrounds and lifestyles -- this makes us a stronger practice. But because we are all different, you may find that you have some favorites. This would be true in any group practice. We ask you to be as open and accepting of all the different personalities in our practice as we are of you, our clients. If you prefer, you don't need to see every midwife in your clinic visits, but you may not ask to not have a particular midwife at your birth. If you feel that you absolutely cannot have a certain midwife at your birth, then you will need to transfer your care. Please also know that we are a solution-focused practice, and we want to support you! If you feel you have been mistreated, please contact Shelley, our Director of Operations, immediately.

In addition, please also understand that the midwife clinic schedule is a complicated and fluid schedule. No appointments are set in stone. Ever. There are many reasons we might need to change your appointment: for example, if a midwife is sick, has bereavement leave, has been in an accident, etc., and we have no one to cover her clinic on short notice; if we have a parent/baby who need to be scheduled for a time-sensitive visit (and remember, we will adjust the schedule for you too!); if we have had many births the night before and we have had to utilize a midwife who was supposed to be in clinic the next day; or something like an emergency that needs full midwife or staff attendance. In a small practice like ours, things can change quickly and we need our clients to be open and fluid along with us. And trust me, it is as inconvenient for us to move things around as it is for you!

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Lastly, we really need you to give us a **working MOBILE telephone number** (we send appointment reminders by text; we do NOT call). We make all calls and send all texts from the main Dar a Luz phone line **(505) 924-BABY** (2229). You can text us there too! We also need to be able to reach you to discuss urgent lab results and to schedule times for your home visit, so it is very helpful for you to make sure your phone is charged and where you can hear it. Always give us an alternate phone number that you can be reached at in case your phone is not working. Please also give us a **good EMAIL address** for you that is not an address that you don't check often or is for junk. We send important information via email as well. We also ask that you check your voice mail. **If you see that you have missed a call from (505) 924-2229, please check your message and respond quickly**. Thank you!

Please know that every single staff member at Dar a Luz cares about every parent, every baby and every family that comes through our doors and chooses us to care for them. If something doesn't feel right, we need to know so that we can remedy the situation and do better. We always strive to do better and to be better. Every employee in this practice wants the absolute best outcome for every parent and baby and we all highly value integrity, decency and respect and believe everyone deserves that -- not just in their health care, but in their life.

Respectfully,

AEaves, CNM

Abigail Lanin Eaves, CNM
Executive Director
Certified Nurse-Midwife

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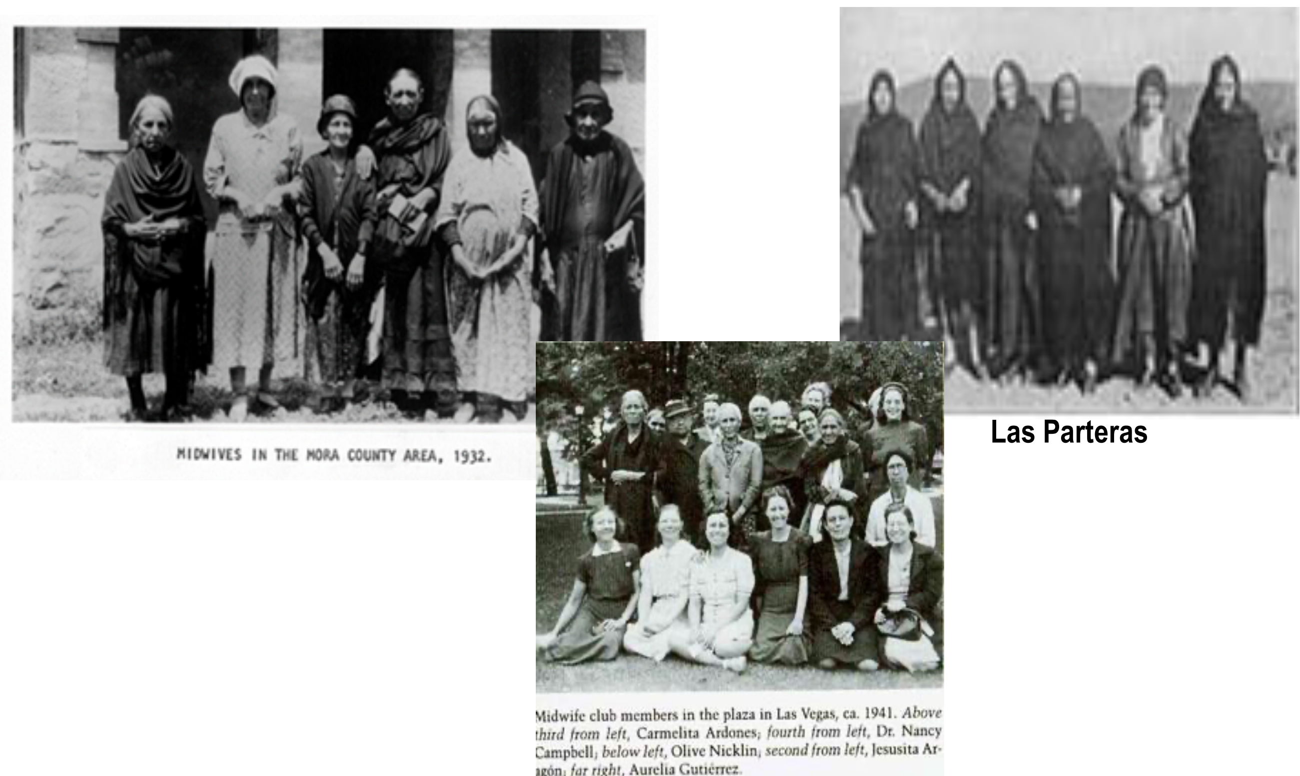
History of Midwives in New Mexico

One hundred years ago, *curandera-parteras* (traditional Hispanic midwives) were the primary maternity caregivers in northern New Mexico. In the early 20th century, there were more than 800 *curandera-parteras* practicing throughout the state. Most of them were working in rural, isolated Hispanic villages in northern New Mexico. Because of limited available physicians, poor road conditions, cultural preference, and poverty, the services of the *curandera-parteras* were vital to the families of New Mexico. In the 1930s, the New Mexico Department of Health began a valuable relationship with the *curandera-parteras* through the Midwife Consultant Program to address the infant mortality rate that was twice the national average. The high rates were primarily due to lack of education for maternity providers, malnutrition, and poor sanitation in a mostly rural state.

The Catholic Maternity Institute (CMI) in Santa Fe opened in 1944, and serves as the prime example of the private sector response to New Mexico's soaring maternal and infant mortality rates. CMI was opened by two missionary nuns, Sister M. Helen and Sister M. Theophane, who were graduate nurse-midwives from the Lobenstine Midwifery School in New York City. CMI provided weekly prenatal clinics and birth center or home deliveries to poor families in the area and remained open until 1969. "La Casita" at CMI was the first birth center in the United States, and its presence opened the door for families to exercise this option. Under the leadership of the CMI midwives, the American College of Nurse-Midwives (the national professional organization for nurse midwives) was incorporated in New Mexico in 1955. Midwifery has been a part of New Mexican cultural heritage for many generations and is very active today.

The University of New Mexico is one of the five best-certified nurse midwifery education programs in the United States. Today, midwives in New Mexico attend 38.2% of all vaginal births (hospital, birth center and at home) in New Mexico, while the national average is only about 10%.



MIDWIVES IN THE MORA COUNTY AREA, 1932.

Las Parteras

Midwife club members in the plaza in Las Vegas, ca. 1941. *Above third from left*, Carmelita Ardones; *fourth from left*, Dr. Nancy Campbell; *below left*, Olive Nicklin; *second from left*, Jesusita Aragón; *far right*, Aurelia Gutiérrez.

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About Dar a Luz Birth & Health Center

The birth center is not a new concept. There are over 250 birth centers in the United States and many more opening every year. The first birth center in Albuquerque was the Southwest Maternity Center, where over 1,000 babies were born between the late 1970s and mid-1980s. It has now been over 30 years since the closing of Southwest Maternity Center, and Dar a Luz is the only freestanding nurse-midwife operated birthing center to open in Albuquerque. The freestanding birth center in Taos which was open for over 25 years, is now closed.

Abigail Lanin Eaves, CNM, a graduate of the nurse-midwifery program at UNM, learned of birth centers in her first semester of graduate school in 2000. She was immediately impressed with the birth center concept and was committed to opening one in Albuquerque, where she was born and raised. Albuquerque has been a very supportive environment for home birth for many years, and Abigail felt that a birthing center was the perfect intermediate environment between the home and the hospital. Midwifery is also no stranger to Albuquerque – more than half of the babies born here in Bernalillo County are born into the hands of midwives! So, it seemed natural to have a birthing center staffed with midwives.

Full Circle Midwifery Birth & Health Center (FCM) was founded in April 2007 by Abigail and Alisa Henning, both certified-nurse midwives (CNM). FCM was incorporated in the State of New Mexico on August 9, 2007 as a domestic non-profit corporation. At the time, there were three directors on the board. We applied for our tax-exempt status in December 2007, and were granted our 501(c)(3) in March 2008. By that time, we had recruited several more board members and were dedicated to raising money and awareness in order to open the center.

In late 2008, we started a capital campaign in an effort to raise $100,000. At the same time, the economy took a down-turn and our fundraising efforts were hugely diminished. We raised about $20,000 over an 8-month period. We also started writing grants in hopes of getting start-up funds, but because of the economy, most of the foundations stopped awarding start-up funding. We received our first grant from the McCune Charitable Foundation in 2009. We continued to work on board development and finding the right spot for the center.

By mid-2009, we had not made any progress on finding a site that worked for the center. At this time, Alisa Henning resigned from the board and took a midwifery position out of state. Abigail became interim president of the board, in addition to her role as Executive Director, and continued to work on opening the center.

After many more months of development and strategic planning and touring many buildings, we found this wonderful former day spa property in the North Valley that we now call home. We renovated the building between December 2010 and March 2011. We had numerous volunteers who helped with painting, cleaning, planting, watering, moving mulch and many other things to get ready for our opening day: March 24, 2011! Abigail Lanin Eaves, CNM and Melanie Yanke, CNM (now retired from Dar a Luz) were the only midwives to serve our families for the first two years that we were open. They worked tirelessly to build the foundation for what Dar a Luz is today. FCM was renamed in early-March 2011 to Dar a Luz Birth & Health Center. Dar a luz is a South American term literally translating to “to come into light” or “to bring to light;” it figuratively translates as “to give birth.”

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Dar a Luz Birth & Health Center is a member of the American Association of Birth Centers, and became accredited by the Commission for Accreditation of Birth Centers in August of 2011. We continue to maintain this standard of excellence. Meeting the standards of accreditation indicates to clients, states, health and liability insurance agencies, consulting providers, and hospitals that a birth center has met a high standard of evidence-based and widely recognized benchmarks for prenatal care, neonatal care, business operations, and safety. Continuing accreditation demonstrates to consumers and other entities that best practices are being met and maintained by a birth center.

Dar a Luz became the **first freestanding birth center to be licensed by the New Mexico Department of Health** on January 20, 2017. We all worked very hard for over six years to get the law passed to require licensure for birth centers in the state, and then we helped to write the regulations for freestanding birth centers in NM. This is an important milestone for our state, and for birth centers to increase access to family centered care!

Building

The center is located on an acre of property in the North Valley, at 7708 4th Street NW. We have convenient parking. There is a private garden for family and staff. The building is approximately 3,000 square feet, and includes two birthing suites, two visiting rooms (we purposely don't call them exam rooms), a lab, education and meeting spaces, a lending library, office space, a retail area, a snack area, and a back office with room for lactation visits, laundry facilities and office space.

Safety Rules

Although this feels like a home and has gated gardens, we ask that each family be responsible for supervision of their children at all times in the center, around the pond and in the gardens. If you bring your children to the birth center during labor, we ask that you have one adult (other than the parents) to watch your children and ensure their safety.

Birth Center Services

- Nurse-midwifery and nursing services are available at all times. A CNM carries a mobile phone to assure that a nurse-midwife is available 24 hours a day, 7 days a week, including all holidays. Nurses must also be available by phone for the CNM to contact them when needed.
- Obstetrical and gynecologic consultation is available if the client chooses, or in the event of obstetrical or medical complications requiring hospitalization or physician involvement in care.
- Breastfeeding resources and assistance are available at all times through the nurse-midwives, registered nurses or IBCLC lactation consultants. We typically offer a weekly breastfeeding support group at the center.
- Referral to outside services, such as diagnostic ultrasound or radiology services, family or individual counseling services, WIC, Medicaid and specialist physician services shall be made as appropriate.

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Requirements for Continuation of Care

Classes

- **All families who have not taken the Interventions & Hospital Transfers class previously are required to take the class** to prepare them for the possibility of a transfer to the hospital.
- All **first-time parents** must take **a 5-week series of childbirth classes** (the Dar a Luz class or Blissborn).
    - These classes are a key part of the comprehensive care given at the birth center to prepare families for a natural birth in a birth center setting.
    - Exceptions may be made for late transfers (35+ weeks) who can show that they have taken classes elsewhere. In those cases, we expect you to take whatever classes are still available, including the Condensed birth class or part of a five-week series.
- All **first-time parents** must take **Breastfeeding, Newborn, and Carseat classes**.
    - These classes are a key part of the comprehensive care given at the birth center to prepare families for a natural birth in a birth center setting.
- All parents who **have had a baby before,** but **have not had a baby at the birth center** are required to take **the Condensed childbirth class,** and are strongly encouraged to take all of the other classes.

Labs and ultrasounds

- **All clients will be tested for certain routine prenatal labs,** including routine prenatal labs and/or testing to rule out gestational diabetes and group B strep (GBS).
- **All clients will be required to get at least one ultrasound** to determine the location of the placenta and to rule out any major issues that would require additional care after birth.

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A Note About Diversity and Inclusiveness...

Specifically in terms of how people identify, many of our pregnant clients are cis-gendered people who identify as mothers in heterosexual relationships with the baby's father... and this is not the case for all of our clients. We also serve a diverse clientele for whom the traditional concepts of women's healthcare do not apply. The English language is slow to catch up to the complexities within each human's experience. For simplicity, in addition to "mother," when addressing a group our staff often uses the term "pregnant people," the pronouns they/them, the title "parent," and the word "partner" to include diverse situations.

Some of our clients' situations may include the reality that:

- it is vitally important to many of the families who choose Dar a Luz that partners/co-parents feel supported, advocated for, and included as equals in their babies' births.
- not all birthing parents have a partner, either by choice or by circumstance, and that any emphasis on partners can feel painful and alienating in group situation.
- one or more of the parents identify with different pronouns than they were assigned at birth. This includes she/her/hers, he/him/his, and they/them/theirs and more; some parents object to binary gender identity assigned at birth for their babies as well. Some of our clients also don't identify as mothers or fathers, and prefer another identifier, such as "parent."
- some of us identify strongly with the word "mother" and the concept of women's health and hold the female identity as sacred. Female humanity as a concept has been hard-won; sharing language can be hard for those who still feel disenfranchised, and we recognize this, too.
- some of our clients' relationships involve parents who aren't romantic partners, or partners who aren't parents, parents of the same gender, non-binary parents, transgender parents, and more.
- regardless of reproductive anatomy, people need both accurate and inclusive language regarding their biology. We are committed to using your pronouns and parent identifiers.
- we have a community that includes varied socioeconomics, faiths, skin colors, cultures, ethnicities, belief systems, sexualities, genders, pronouns, jobs, relationship statuses, mental health diagnoses, past histories, current situations, health statuses, abilities, and so much more.
- attempting to use fully inclusive language in classes, groups, and written words can make the language awkward and slow, and that it is nearly impossible to do it perfectly– but it's worth working toward. Our staff is dedicated to doing our best to help everyone feel included!

Dar a Luz embraces and welcomes diversity

We are dedicated to always improving and to working with each client, we ask that you:

1. Inform us if yours is a diverse situation and what your language is around that situation, including:
    a. Letting us know about your unique situation(s) and how that affects your choices and care.
    b. Letting us know your pronoun(s) and parental identifier(s) if you choose to, and these will be highlighted in your chart.
    c. Letting us know what would help you feel more included and comfortable.
2. Give us grace as we work toward using more inclusive language and finding solutions to these language issues. We welcome suggestions and love to be educated!
3. Gently remind us if we mess up or forget – it is often easier to do well with individuals than groups. We have a very busy practice, and we also care about each of you and your preferences.

When you reach out to anyone at Dar a Luz in this manner, you can expect respect and inquisitiveness about your preferences. By holding each other gently, and kindly teaching each other about how we prefer to be treated and addressed, we can find solutions to any challenges together.

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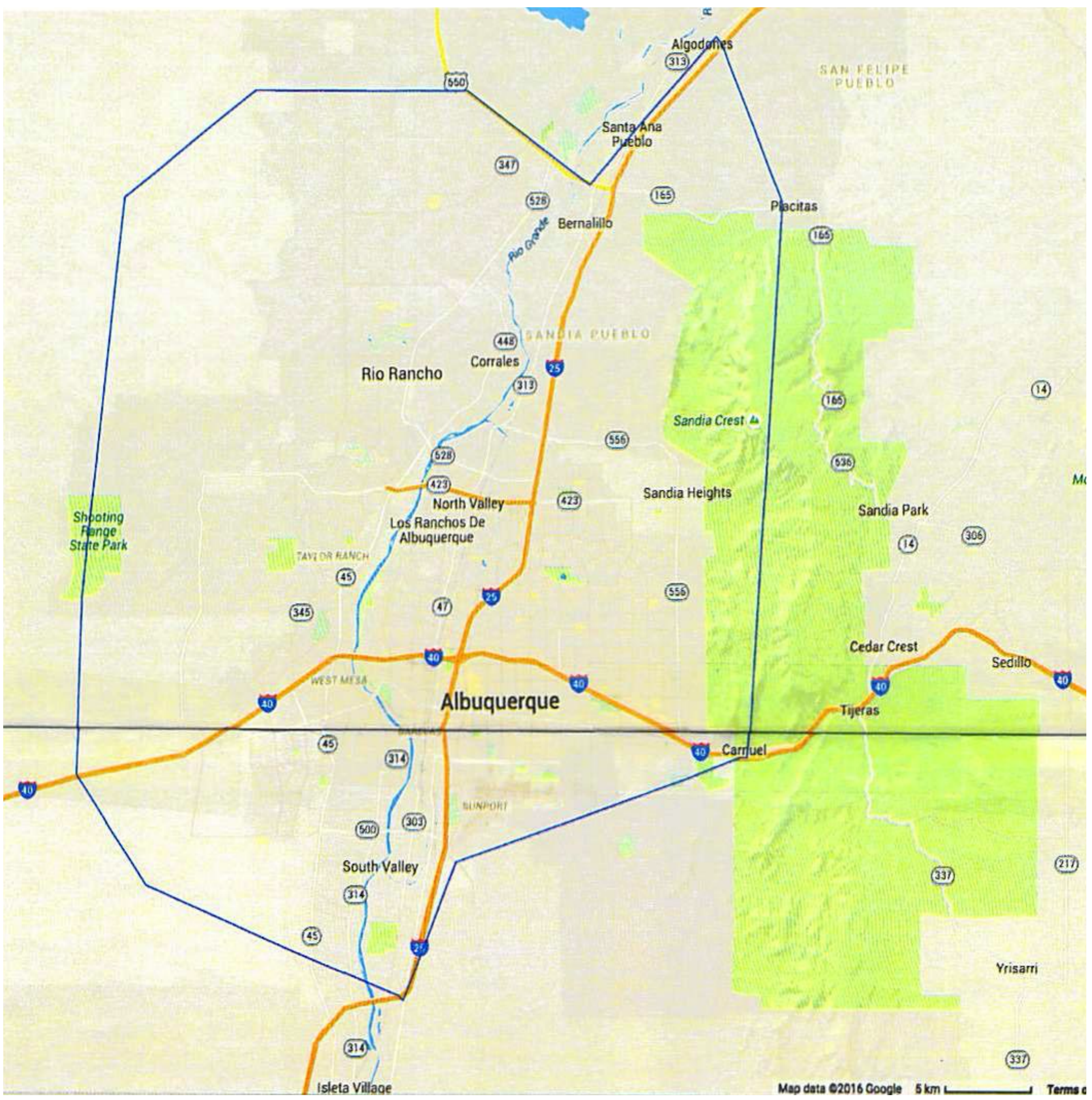
Home Visit Policy & Map

Home visits between 24-36 hours after birth may be available to clients who live or can stay **within 30 minutes of the birth center (see map below)**. These visits may need to be scheduled at the birth center instead, at the discretion of the on-call midwives or for other safety concerns (like COVID 19). Note: We **do not include** in our home visit area **Mariposa in far east Rio Rancho, or Kirtland Air Force Base** (due to the additional time required to get through security). Please check with the midwives to see if you qualify for a home visit, or if you will need to come to the birth center instead. If you birth in the hospital, one of the on-call midwives will do her best to come see you before your discharge, or she may need to have a phone visit with you.



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Contact Information

For emergencies: Call 911

Phone	**(505) 924-BABY (2229)**
Fax	**(505) 554-3673**
Midwife on-call number	**(505) 944-5488**
Backup on-call numbers	**(505) 273-5583, (505) 273-5584** *(ONLY if no call-back within 15 minutes)*

Office Hours	**9:00 am - 5:00 pm Monday through Thursday** for appointments**.** **9:00 am - 1:00 pm on Friday** for appointments**.** *You may also be scheduled as needed on weekends and after hours.*

Labor Calls

Call the midwife on-call number **(505) 944-5488**. Please leave a message and it will be returned within 15 minutes.

Use the backup numbers **(505) 273-5583 and (505) 273-5584** only if you haven't received a call-back within 15 minutes.

Urgent Clinical Issues

Call the midwife on-call number **(505) 944-5488**. Calls will be addressed the same day.

Non-Urgent Clinical Issues

Call the office at **(505) 924-2229** during business hours and talk to a nurse (**extension #5**). If the nurse cannot answer your question, she will talk to the midwife in clinic. Calls will be returned in 24-48 hours.

Email addresses

For non-urgent issues only:

Office:

Tracy Cooper, Receptionist — Tracy@daraluzbirthcenter.org
Erica Deerinwater, Certified Biller and Coder — Erica@daraluzbirthcenter.org

Leadership:

Abigail Lanin Eaves, CNM, Executive Director, Midwife — Abigail@daraluzbirthcenter.org
Shelley Black, Director of Operations — Shelley@daraluzbirthcenter.org
Alisa Henning, CNM, Clinical Director, Midwife — Alisa@daraluzbirthcenter.org

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Midwives:

Abigail Lanin Eaves, CNM, Executive Director, Midwife	Abigail@daraluzbirthcenter.org
Alisa Henning, CNM, Clinical Director, Midwife	Alisa@daraluzbirthcenter.org
Susan Moore Daniels, CNM, Midwife	Susan@daraluzbirthcenter.org
Yelena Baras, CNM, Midwife	Yelena@daraluzbirthcenter.org
Lauren Zielinski, CNM, Midwife	Laurenz@daraluzbirthcenter.org
Corrianne Parada, CNM, Midwife	Corrianne@daraluzbirthcenter.org
Meagan Morse, CNM, WHNP, Midwife	Meagan@daraluzbirthcenter.org

Nurses:

Jenna Montano, RN, Birth Assistant (BA)	Jenna@daraluzbirthcenter.org
Savannah Holloway, RN, BA	Savannah@daraluzbirthcenter.org
Claire Merritt, RN, BA, Condensed Class Instructor	Claire@daraluzbirthcenter.org
Stephanie Sanchez, RN, BA, IBCLC (Lactation Counselor)	Stephanie@daraluzbirthcenter.org
Olivia Herrera, RN, IBCLC	Olivia@daraluzbirthcenter.org

Lactation:

Robin Hayter, IBCLC	Robin@daraluzbirthcenter.org
Stephanie Sanchez, RN, BA, IBCLC	Stephanie@daraluzbirthcenter.org

Educators:

Amity McElroy, Dar a Luz Class Instructor/Class Educator	Amity@daraluzbirthcenter.org
Laura Wood, Blissborn Class Educator/Class Coordinator	Laura@daraluzbirthcenter.org
Nancy Anthony, Certified Car Safety Instructor	Nancy@daraluzbirthcenter.org

Social Networks

Find us on Facebook (Dar a Luz Birth & Health Center), Instagram, and Twitter.

Client Grievances

All complaints about any aspect of Dar a Luz Birth & Health Center services should be brought to the Executive Director, **Abigail Lanin Eaves**. She will personally respond within five business days.

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Birth Center Staff

See the Dar a Luz website for current bios and pictures of all our staff.

What is a Certified Nurse Midwife (CNM)?

CNMs are Registered Nurses who have earned a Master's Degree with two additional years of training in midwifery. We provide prenatal, birth, postpartum, and breastfeeding care; we also care for newborns for the first 28 days of life. CNMs are licensed to practice independently and can prescribe medications. "Midwife" means "with women," and this is what midwives are known for: being there throughout pregnancy and birth. If there are problems, we work closely with consultant doctors. CNMs can also provide care for your annual pelvic health and contraceptive needs, including birth control, pap smears, and some primary care issues. We do not manage chronic diseases or prescribe medical marijuana cards.

Registered Nurse (RN) Birth Assistants & Lactation Consultants

A Registered Nurse has two to four years of college education, and is trained to give individualized care and education to patients in many areas. Our nurses are experienced in labor, birth, postpartum, and newborn care. We also have IBCLC lactation consultants on staff who are available to help with breastfeeding and newborn feeding issues.

At the birth center, the registered nurse assists with many duties, including lab draws, lactation consultations, quality assurance checks, statistics reporting, support groups, and childbirth education classes. They will also be called in to assist the midwife when the baby is born, and will take care of the family until they go home.

Administrative Staff and Educators

Dar a Luz has an amazing group of support staff to help you navigate this time, as well as highly-qualified Educators to guide your learning. Everyone on staff is dedicated to helping you achieve your goals for your pregnancy, labor, birth, and postpartum period.

Students

Dar a Luz supports promotion of midwifery by offering high school students an internship during their senior year to learn about birth center care. We precept nursing and midwifery students for their clinical rotation in women's health care. Some pre-med students or resident doctors may have a clinical rotation at the center to get exposure to our unique model of care. During pregnancy, you may be asked if a student can be part of your care. This is a great way to get extra attention while helping educate students. If you do not want students to attend to you, please let the staff know.

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Consultants

The midwives at Dar a Luz consult and collaborate with many other providers throughout the Albuquerque area and surrounding communities. We primarily collaborate with family practice physicians at University of New Mexico. We do have colleagues for consultation at Presbyterian and Lovelace if needed. We also collaborate with perinatologists, specialty physicians, chiropractors, mental health providers, acupuncturists and physical and occupational therapists. We will help guide our clients to the best providers for complimentary therapies as well as additional medical care outside of our scope of practice. None of our consultants are on staff and do not care for our clients at the center.

Dr. Larry Leeman, Lead Physician Consultant

"I am trained in family medicine and obstetrics with a primary focus on working with pregnancy and newborns. I work primarily at the University of New Mexico where I am a professor of Family Medicine, and OB/GYN and co-medical director of the new Mother Baby Unit. In my private practice at UNM, I especially enjoy working with those who desire natural childbirth. I also work at UNM with complicated pregnancies, including twins, diabetes, prior Cesarean deliveries, and preterm labor or in need of Cesarean delivery. I care for newborn babies, as well, in my practice.

“I graduated from medical school at the University of California, San Francisco, and completed a family medicine residency at UNM prior to moving to the Zuni reservation. At Zuni, I practiced full scope rural family medicine and became the director of obstetrics. The Zuni women delivered in a birth center setting where over 90 percent did not request pain medicines in labor and where the Cesarean rate was only seven percent despite a high incidence of pregnancy complications due to diabetes and hypertension. The experience of working in the birth center setting at Zuni helped me to see that everyone doesn't require a hospital for childbirth. After leaving Zuni, I received a fellowship training in obstetrics — operative and high risk — at the University of Rochester and returned to the University of New Mexico in 1998. In addition to teaching maternal and child health to resident physicians in family medicine, OB/GYN and pediatrics, I also do research in the areas of pregnancy outcomes, rural prenatal care and contraception. My spouse, Rebecca, is a nurse-midwife, and we were lucky enough to have three sons. Our recreation includes international travel, scuba diving, and gardening."

Community Collaboration

Dar a Luz also works with Dr. Leeman’s colleagues at UNMH. We also have warm relationships with all CNM/MD collaborative practices in the city, as well as all local hospitals.

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Client Health Information Portal

Dar a Luz Birth & Health Center is pleased to offer you access to your Client Portal. The Client Portal allows you to view your health records including lab results, educational materials, request corrections and appointments, send messages to the birth center staff and complete medical history forms online.

For urgent questions regarding your information, or if you have any problems logging into the portal, please contact Tracy during business hours directly at (505) 924-2229, extension "0." She is available at this number by phone or text, or you may email her at tracy@daraluzbirthcenter.org

We appreciate you accessing the portal because it is the most secure way for you to view and receive your protected health information.

How do I log in to the Client Portal?

Please find your username and temporary password in the information sheet provided to you by email. We recommend you change your password to keep your information secure. In your favorite web browser, visit us at the web address listed below. Enter your Username and Password. When you log into the portal, click on the tab with YOUR NAME to access your information.

Login at www.daraluzbirthcenter.phiportal.com

Username: ______________________________ Password: ____________________

How do I change my client portal account password or information?

Click the downward arrow next to your account name and select User Settings. Within User Settings, correct any information on the left and click the Update Profile button. To change your password, type your current password on the right, then create and confirm your new password. Click the Change Password button to apply the new password to your account. Please keep a record of this password. If it is ever lost, our office will need to reset the password.

If you forget your password, you will have to call the office and we will reset it and email the reset password to the email address on file. Then you will need to go through the same process to change your password. This is really simple and should only take about a minute to do.

Using the Client Portal

Accessibility Note: To increase or decrease the size of the text on the Patient Portal, scroll to the bottom of any page and click "Increase text."

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Navigation: Most of the Client Portal's features can be navigated within the top navigation bar, including Help. You have four core options in Client Portal (Summary, Messages, Client and Help).

- **Summary:** Each time you log in to the Client Portal, you may wish to view recent updates to your account. The Summary button in the navigation bar will display your recent messages and upcoming appointments for all clients to which your account has access.
  - Shows your unread messages and upcoming appointments
- **Client:** This button contains patient-specific features, such as demographics and health records.
  - **Demographics:** Request a correction to your demographic information for your address or phone number.
  - **Health Record:** View and download your "Summary of Care Record" which includes information related to demographics, smoking status, problem list, procedures, medications, immunizations, allergies, vital signs, lab results and instructions. You will also find medical history and consent forms in this section to be filled out before your next appointment.
  - **Educational Resources:** View specific educational resources in this section like the electronic version of Birthing Your Baby and other topics sent to you during your care.
  - **Appointments:** View your recent and future appointments and request an appointment
  - **Access Log:** View when your account has been accessed and by whom.
- **Messages:** The Messages button displays all messages on your account. Whenever a new Message is available, this button will display a notification badge.
  - **Messages:** Send and receive secure messages from the receptionist (Tracy Cooper), nurses (Stephanie, Jenna, Savannah, Claire, and Olivia) and your midwives (Abigail, Melanie, Susan, Yelena, Alisa, Lauren, and Corrianne).
  - **ATTENTION: Do not send emergency messages through the portal!** Please use the midwife on-call phone for emergencies: (505) 944-5488. Messages sent through the portal are not checked by staff on weekends, holidays or when staff are on vacation, so if you have not received a timely response, please call the office during regular business hours at (505) 924-2229.
- **Help:** The help section includes the FAQs on how to use the different functions.

The whole point of woman-centered birth is
the knowledge that a woman
is the birth power source.
She may need, and deserve, help, but in essence,
she always had, currently has, and will have the power.

~ Heather McCue

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Client Rights

Dar a Luz Birth & Health Center has adopted "The Rights of Childbearing Women" published by Childbirth Connection (2006) as a guideline to ensure that all childbearing women and birthing people have access to information and care that is based on the best scientific evidence now available, and that they understand and have opportunities to exercise their right to make health care decisions.

Download source www.childbirthconnection.org

1. Every woman has the right to **health care before, during and after pregnancy and childbirth.**
2. Every woman and infant has the right to **receive care that is consistent with current scientific evidence** about benefits and risks.* Practices that have been found to be safe and beneficial should be used when indicated. Harmful, ineffective or unnecessary practices should be avoided. Unproven interventions should be used only in the context of research to evaluate their effects.
3. Every woman has the right to **choose a midwife or a physician** as her maternity care provider. Both caregivers skilled in normal childbearing and caregivers skilled in complications are needed to ensure quality care for all.
4. Every woman has the right to **choose her birth setting from the full range of safe options** available in her community, on the basis of complete, objective information about benefits, risks and costs of these options.*
5. Every woman has the right to receive all or most of her maternity care from a single care-giver or a small group of caregivers with whom she can establish a relationship. Every woman has the right to **leave her maternity caregiver and select another** if she becomes dissatisfied with her care.* (Only the second sentence is a legal right.)
6. Every woman has the right to **information about the professional identity and qualifications** of those involved with her care, and to know when those involved are trainees.*
7. Every woman has the right to **communicate with caregivers and receive all care in privacy**, which may involve excluding nonessential personnel. She also has the right to have all personal information treated according to standards of confidentiality.*
8. Every woman has the right to **receive maternity care that identifies and addresses social and behavioral factors** that affect her health and that of her baby.** She should receive information to help her take the best care of herself and her baby and have access to social services and behavioral change programs that could contribute to their health.
9. Every woman has the right to **full and clear information about benefits, risks and costs of the procedures, drugs, tests and treatments** offered to her, and of all other reasonable options, including no intervention.* She should receive this information about all interventions that are likely to be offered during labor and birth well before the onset of labor.
10. Every woman has the right to **accept or refuse procedures, drugs, tests and treatments**, and to have her choices honored. She has the right to change her mind.* (Please note that this established legal right has been challenged in a number of recent cases.)
11. Every woman has the right to **be informed if her caregivers wish to enroll her or her infant in a research study**. She should receive full information about all known and possible benefits and risks of participation; and she has the right to decide whether to participate, free from coercion and without negative consequences.*
12. Every woman has the right to **unrestricted access to all available records** about her pregnancy, labor, birth, postpartum course and infant; to obtain a full copy of these records; and to receive help in understanding them, if necessary.*
13. Every woman has the right to **receive maternity care that is appropriate to her cultural and religious background**, and to receive information in a language in which she can communicate.*

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14. Every woman has the right to **have family members and friends of her choice present** during all aspects of her maternity care.**
15. Every woman has the right to **receive continuous social, emotional and physical support** during labor and birth from a caregiver who has been trained in labor support.**
16. Every woman has the right to **receive full advance information about risks and benefits** of all reasonably available methods for relieving pain during labor and birth, including methods that do not require the use of drugs. She has the right to choose which methods will be used and to change her mind at any time.*
17. Every woman has the right to **freedom of movement during labor**, unencumbered by tubes, wires or other apparatus. She also has the right to give birth in the position of her choice.*
18. Every woman has the right to **virtually uninterrupted contact with her newborn** from the moment of birth, as long as she and her baby are healthy and do not need care that requires separation.**
19. Every woman has the right to **receive complete information about the benefits of breastfeeding** well in advance of labor, to refuse supplemental bottles and other actions that interfere with breastfeeding, and to have access to skilled lactation support for as long as she chooses to breastfeed.**
20. Every woman has the right to **decide collaboratively with caregivers** when she and her baby will leave the birth site for home, based on their conditions and circumstances.**

* At this time in the United States, childbearing women are legally entitled to these rights.
* * The legal system would probably uphold these rights**

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Notice of Privacy Practices

Last updated 2021

Your information. Your rights. Our responsibilities. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization and bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone, mobile phone, email) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. **If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.**

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes
- We never sell your information

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Uses and Disclosures

We typically use or share your health information in the following ways.

To treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

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To run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

To bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

To help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

To do research

We can use or share your information for health research but we would have you sign a consent for this.

To comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws.

To respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

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To work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

To address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

To respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of this Notice April 15, 2017, Privacy Officer Shelley Black

Insurance Coverage Complaints

You can file a complaint about your insurance company if you don't agree with the way they are handling your claims. The New Mexico Superintendent of Insurance has a Managed Health Care department that processes all complaints involving HMO and PPO plans licensed to conduct business within New Mexico. The Managed Health Care Bureau may be reached at (855) 427-5674. File an insurance complaint here: www.hirrconsumer.osi.state.nm.us/consumer-assistance/forms/managed-healthcare.html

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Client Responsibilities

Dar a Luz Birth & Health Center sees our relationship with our clients as a partnership. We are committed to working together to facilitate the healthiest possible outcome for you and your baby.

We also expect that you actively participate in your care and assume the following responsibilities:

1. You are expected to **provide complete and accurate information**, including your full name, address, home and/or cell phone number, date of birth, Social Security number, insurance carrier and employer, when it is required.
2. You are expected to **provide complete and accurate information about your health and medical history**, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health.
3. You are expected to **provide complete and accurate information about your health insurance coverage**.
4. You are expected to **keep your financial commitment** which includes paying your bills in a timely manner.
5. You are expected to **ask questions when you do not understand information or instructions**. If you believe you can't follow through with your treatment plan, you are responsible for telling your midwife. You are responsible for outcomes if you do not follow the care, treatment and services plan.
6. You are **responsible for any valuables** that you bring to the birth center.
7. You are **responsible for supervision of your children** at all times while at the birth center.
8. You are expected to **treat the property of the birth center with respect** as if it were your own home.
9. You are expected to **treat all staff, other clients, and visitors with courtesy and respect**.
10. You are required to abide by all birth center rules and safety regulations.
11. You are expected be mindful of noise levels, privacy and number of visitors and the nonsmoking policy on the premises.
12. You have the **responsibility to keep appointments**. If you cannot keep your appointment, please call the birth center at least 24 hours prior to your scheduled appointment if possible. If you are going to be late, please notify the office. If you are 15 minutes late, your appointment will be rescheduled.

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Advance Directive for Health Care

An **advance directive** is a way to tell other people what medical care you would want, if you were not able to speak for yourself. The best way to make sure that your wishes about your medical care are followed is to talk to your family, friends, and health care providers before you get very sick or cannot speak for yourself. Then you write down what medical care you would want, before anything happens, in case you are not able to speak for yourself. The **advance directive** can be used by your spokesperson, to tell others your wishes regarding your medical care.

Durable Power of Attorney

A durable Power of Attorney for **health care decisions** is a document that gives a person of your choosing the authority to make the choices listed in your **advance directive** for you if you are unable to make them yourself.

It's hard to imagine these things when we are well – the idea of not being able to wake up or being very sick are not easy things to talk about. Here are some questions that you might talk about with your family and friends. They may help you think about what you would want to write down about your medical care.

- Is it important for me to make my own choices?
- Is it OK for someone else to make choices for me if I am very sick, unable to talk and/or wake up?
- Is there medical treatment I would like to have to keep me alive?
- Is there medical treatment I would NOT like to have to keep me alive?
- What are my beliefs about death and dying?
- What medical care would I want if I were never able to wake up or not ever going to get better?

You can find forms online for New Mexico Advance Directives, or seek legal advice on how to do either process. You must sign and date the form. You are not required to have your document witnessed or notarized, but it may help to do this in case your advance directive is ever challenged. You can change it at any time.

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Safety of Birth Center Care

People often wonder if a birth center is safe for their pregnancy and birth. Many studies have shown that birth centers are **as safe as or safer than hospitals** for those who are carefully selected and "low-risk." When clients were cared for by Certified Nurse Midwives (CNMs) in a freestanding birth center with transfers to collaborative CNM/physician practices, they used significantly less resources, had fewer interventions, had fewer operative deliveries, and had higher breastfeeding rates with equally good neonatal outcomes when compared to a matched group who were cared for by physicians in the hospital. Those cared for at birth centers consistently have higher maternal satisfaction rates.

The most recent study (available online free of charge) showing these outcomes is:

> Outcomes of Care in Birth Centers: Demonstration of a Durable Model. By S. Stapleton, C. Osborne, & J. Illuzzi. *Journal of Midwifery & Women's Health, Volume 58, No. 1. January/February 2013.*

The cesarean section rate in the United States is nearly 33% of births. This is twice the 15% maximum rate recommended by the World Health Organization. Birth centers are consistently at or below a 10% cesarean section rate.

Early and regular prenatal care and continuity of care through birth and postpartum are vital to the healthiest outcome for you and your baby. This allows for prevention or early recognition of problems that may require a consultation or transfer.

(For more information, also see the section **"Hydrotherapy and Waterbirth"**)

To be pregnant has been for me each time the supreme joy...
I was doing the greatest thing in the world
without having to DO anything--

All I had to do was be.

~ Gloria Vanderbilt

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What to Expect From Birth Center Care

You can expect:
- individualized care from the midwives.
- to participate in your care and discuss your choices.
- more time in your appointments to have your questions answered.
- appointments every 6-8 weeks until 28 weeks, every 2-4 weeks until 36 weeks, then weekly until birth.
- more support and education including childbirth, breastfeeding and newborn classes.
- a familiar, safe atmosphere for care with the medical technology there if you need it.
- a family-centered approach to pregnancy, birth, postpartum and newborn care.
- more choices on how to birth your baby.
- introduction to a large birth center community of families and support

Who Can Receive Care at the Birth Center?

The good news is almost everyone can! However, there are some current problems or history of documented problems that **ARE NOT considered "low-risk" AND CANNOT be cared for at the birth center** (a glossary of medical terms is included at the end of the book):

- Over 45 years of age
- More than one previous cesarean section
- Eclampsia
- Uterine rupture
- Previous Rh sensitization
- Gestation of more than 32 weeks with no prenatal care
- Heart disease, chronic hypertension, severe heart murmur
- Symptomatic congenital heart defects
- Deep vein thrombosis (DVT) requiring anticoagulant therapy
- Pulmonary embolus
- Asthma not well controlled
- Diabetes on medication
- Hyperthyroidism or uncontrolled hypothyroidism
- Systemic Lupus Erythematosis (SLE)
- HIV positive
- Bleeding disorders
- Sickle cell anemia
- Acute medical conditions (TB, acute hepatitis, cholecystitis and pyelonephritis)
- BMI ≥40 at pre-pregnant weight
- Chronic illness out of scope of practice for CNM
- Moderate to severe renal disease
- Heavy cigarette smoker
- Severe mental health problems
- Severe recurring migraine headaches
- Seizure disorder with history of seizures in previous year and/or currently requiring medication
- Significant and/or ongoing substance/drug use including cannabis
- Clients designated by CNM as inappropriate for birth center care

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Reasons for Consultation

Occasionally problems arise that the CNM will consult about with family medicine, obstetrician, Maternal Fetal Medicine (MFM), pediatrician or other physicians. The CNM may co-manage these problems at the birth center when deemed appropriate by the consulting MD or may transfer care if not appropriate. The CNM may use her own discretion on when to consult about problems not on this list.

History of Documented Problems:

- History of thyroid surgery or current use of thyroid medication with abnormal thyroid studies
- Cone biopsy or Loop Electrosurgical Excision Procedure (LEEP) of the cervix within the last year
- Clinical evidence of structural uterine abnormalities
- Positive maternal antibody screen of antibody that is associated with fetal hemolytic disease
- History of rheumatic fever or asymptomatic mitral valve prolapse
- Previous stillbirth or neonatal loss after 24 weeks
- Two or more preterm births at less than 35 weeks
- Previous birth weight less than 2500 grams, other than preterm labor and delivery
- Previous infant with major congenital anomalies
- Infant with genetic/metabolic disorder

Problems During Pregnancy

- Anemia unresponsive to therapy or other than iron deficiency
- Abnormal glucose tolerance testing indicating gestational diabetes
- Recurrent unexplained vaginal bleeding
- Urinary Tract Infection (UTI) unresponsive to treatment
- Abnormal findings on ultrasound
- Estimated fetal weight less than 2500 grams or more than 4500 grams at term
- Suspected intrauterine growth restriction (IUGR)
- Suspected premature labor
- Hyperemesis unresponsive to IV hydration and anti-nausea medications
- Pregnancy-induced hypertension with normal labs
- Thrombophlebitis
- Pyelonephritis
- Nonvertex presentation persisting after 37 weeks
- Oligohydramnios or polyhydramnios

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During Labor, Birth or Postpartum

- Ruptured membranes greater than 24 hours without active labor
- Arrest of dilatation or descent in active phase labor
- Evidence of chorioamnionitis
- Non-reassuring fetal surveillance
- Retained placenta
- Severe psychiatric diagnosis requiring medical intervention

Newborn

- Congenital anomaly not requiring immediate acute care
- Transient tachypnea persisting longer than 4 hours without other signs of respiratory distress
- Hypoglycemia unresponsive to feeding

Reasons for Transfer

Most go through pregnancy and birth without any major problems; however, about 10-15% of pregnancies will develop conditions that need the next level of care. This could require a transfer to a midwife or doctor who practices in the hospital. **Only 1-2% of all transfers are considered an emergency**, so there is usually plenty of time to discuss the situation. Below are some of the complications that would be reasons for a transfer of care:

During Pregnancy

- Major fetal anomaly
- Suspicions of hydatiform mole, ectopic pregnancy, miscarriage requiring surgical procedure
- Fetal demise
- Pregnancy with multiple babies (i.e. twins)
- Suspected incompetent cervix
- Low-lying or placenta previa not resolved by 36 weeks
- Pregnancy Induced Hypertension (PIH), Pre-eclampsia
- Active pre-term labor at less than 37 weeks
- Intrauterine growth restriction (IUGR)
- At 37 weeks, oligohydramnios (inadequate fluid around baby) or polyhydramnios (too much fluid)
- Baby not head down position at 37 weeks and unsuccessful external version
- Greater than 42 weeks of pregnancy (post-term)
- Gestational Diabetes not controlled by diet
- Persistent anemia (hematocrit less than 28 and not responding to treatment)
- Laboratory evidence of sensitization in Rh negative woman
- Positive HIV antibody with confirmation by Western blot
- Syphilis positive
- Severe mental health problem
- At CNM discretion

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During Labor, Birth or Postpartum

- Labor at less than 37 weeks of pregnancy
- Baby not head down position in labor (Breech or Transverse)
- Worsening pregnancy-induced hypertension (PIH)
- Active genital herpes lesion at time of labor
- Non-reassuring fetal status
- Inadequate pain relief
- Cord prolapse
- Suspected placental abruption or uterine rupture
- Active infectious process or fever of unknown origin
- Need for labor augmentation
- Second stage pushing without progress in descent of fetal head
- Laceration requiring repair by a physician, 3rd and 4th degree lacerations
- Hemorrhage failing to respond to appropriate management
- Severe anemia, symptomatic and for which a transfusion is recommended
- Deep vein thrombosis or pulmonary embolism
- Any condition requiring more than 12 hours of continuous postpartum observation
- At CNM discretion

Newborn

- Apgar score of less than 7 at 5 minutes
- Unable to maintain temperature at 2 hours of age
- Severe or worsening respiratory distress
- Resuscitation requiring chest compression
- Congenital anomaly requiring immediate acute care
- Immediate jaundice
- Exaggerated tremors or any seizure activity
- Suspected maternal or fetal infection (chorioamnionitis)
- Any condition requiring more than 12 hours of continuous post-birth observation
- At CNM discretion

Birth is the sudden opening of a window,
through which you look out upon a stupendous prospect.
For what has happened?
A miracle.
You have exchanged nothing for the possibility of everything.

~ William MacNeile Dixon

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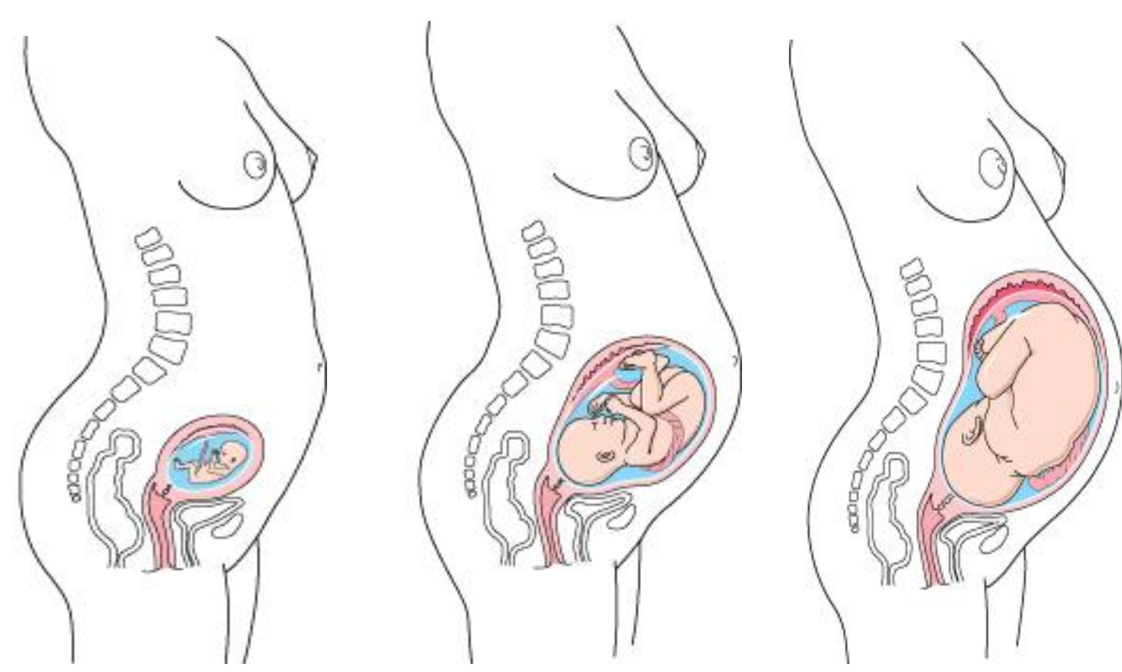
Pregnancy

This section will educate you about the changes your body and baby are going through.

Stages of Pregnancy



First Trimester (month 1-3 or weeks 1-12) | Second Trimester (month 4-6 or weeks 13-28) | Third Trimester (month 7-9 or weeks 29-42)

First Trimester (weeks 1-12)

During the first trimester your body goes through many changes. These changes start in the first few weeks of pregnancy. Changes in your hormones affect almost every part of your body. Everyone feels different in pregnancy, and each pregnancy is different. You may have some of these common changes:

- Extreme tiredness
- Tender breasts
- Nausea and vomiting (morning sickness) or heartburn
- Cravings or dislikes for certain foods
- Mood swings
- Constipation (trouble having bowel movements)
- Urinary frequency
- Headache
- Weight gain or loss

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Second Trimester (weeks 13-28)

You will begin to feel better during this time. You will have more energy and the nausea should go away. As your baby grows, your body will begin to look like you are pregnant. You will feel your baby move when you are around 20 weeks.

These are some of the common changes that you may have:

- Body aches in your back, abdomen, groin or legs
- Stretch marks on your abdomen, breasts or thighs
- Darkening of the skin around your nipples (the areola)
- A change of color on your skin that forms a line down from your belly button (linea nigra)
- Patches of darker skin on your face
- Numb and tingling hands (carpal tunnel syndrome)
- Itching on the abdomen, hands and feet (edema)
- Swelling of the ankles and hands

Third Trimester (weeks 29-42)

Your baby is growing and gaining weight fast. This is an exciting time when you are preparing for the birth of your baby. You may go to childbirth classes and have a baby shower. Think about breastfeeding. Start counting fetal movements. Your due date is based on 40 weeks since your last menstrual period and full term is between 38 to 42 weeks. It is common for labor to begin 2 weeks before or 2 weeks after your due date. You may be offered an induction (start) of labor between 41 and 42 weeks if you do not go into labor on your own. You may notice some of these new body changes:

- Feeling short of breath
- Go to the bathroom more often
- Hemorrhoids
- Heartburn
- Backache
- Swelling of the ankles and hands
- Trouble sleeping
- Feeling more tired
- Braxton-Hicks contractions (tightening of your uterus)
- More pelvic pressure
- May start leaking colostrum (first milk) from your breasts

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Fetal Growth: Conception to Birth

Fetal growth happens so fast!

View pictures at www.webmd.com/baby/slideshow-fetal-development

Conception -- about 2 weeks after last menstrual period (LMP)

- Sperm fertilizes egg and cells grow quickly
- Embryo moves to uterus and attaches to uterine wall

At 4 weeks after LMP

- Home pregnancy test is positive usually within 1 day of a missed period
- Brain and spinal cord forming, heart and blood vessels begin to form
- Arm and leg buds appear

At 8 weeks

- All major body organs are developing and heart beats
- Arms and legs grow longer
- Nearly 1 inch long (about the size of a grape)

At 12 weeks

- You can hear heartbeat at the clinic
- Nose and lips forming
- Kidneys are forming
- Eyes and eyelids are forming
- Length is 3 inches
- Weighs almost 1 ounce

At 16 weeks

- Muscle and bones forming
- Fingers and toes have fingerprints
- Starts moving hands, legs and head
- Length is 4-5 inches
- Weighs 3 ounces

At 20 weeks

- Most women/birthing people can feel movement
- Many get an ultrasound at this time to assess normal anatomy and growth
- Body is completely formed, may be able to see if it is a boy or girl
- May suck thumb, yawn, stretch, make faces
- Length is 6 inches
- Weighs 9 ounces

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At 24 weeks

- Has sleep and awake times
- Responds to sounds by moving, may have hiccups
- Hair begins to grow on head
- Lungs are formed
- Length is 12 inches
- Weighs 1 ½ pounds

At 28 weeks

- Changes position often
- Feel very active fetal movements
- Length is 13-14 inches
- Weighs 2 ½ pounds

At 32 weeks

- Strong kicks and movements
- Eyes open and close
- Begins breathing movements with lungs
- Starts storing fat, iron and calcium
- Gaining weight quickly
- Length is 15-17 inches
- Weighs 4 to 4 ½ pounds

At 36 weeks

- Feel smaller movements (less kicks and more stretches and rolls)
- Head is usually down in pelvis by now
- Brain is maturing
- Lungs are almost mature
- Length is 16 to 19 inches
- Weighs 5 to 6 ½ pounds

Weeks 37-42

- Baby is "term" and commonly born during this time
- Length is 19 to 21 inches
- Weighs 6 to 9 pounds

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Emotional Adjustments

During pregnancy, you may have extreme reactions and mood swings. Your emotional reactions and views of the world may change. Be aware that you may feel extremely sensitive. You may look inward more and at the same time want to share your experience with others.

Fears are common in pregnancy, and you might feel extremely vulnerable. Fears of death for yourself and your baby surface. Your body might seem out of your control, and is changing rapidly, which can be frightening. This makes some people feel more dependent. During pregnancy, you might be searching for new support and direction in imagining your new role, and the life changes before you. Although everyone has unique emotions, there are some feelings that are common to most people.

The first three months are a period of adjustment. Common reactions include:

- Being upset or ambivalent about being pregnant. Some have feelings of disappointment, rejection, anxiety, depression and unhappiness. This is normal for this period of pregnancy.
- Focus on yourself as you deal with any previous bad experiences with pregnancy, the effects of pregnancy on your life and career, stress over financial and housing concerns, anxiety over your ability to be a parent and acceptance of pregnancy by your partner.
- You might feel overjoyed especially if they have had a hard time becoming pregnant. You may not believe it is actually true and look for every little sign that you are pregnant. This is particularly true if you have had a previous miscarriage.
- Weight may become a focus. Some are concerned about weight loss if nausea has been a problem. Others see gaining weight as being something they can control and nutrition becomes very important. Less commonly, some may be having a difficult time coping with pregnancy and may limit their diet to prevent “showing” or letting their family know that they are pregnant.

The third through sixth months are a period of radiant health when you feel good and have few discomforts of pregnancy. This is also a time of inward reflection and has its own challenges which include:

- Reliving and evaluating all aspects of your own relationship with your own mother or another parent. This may bring up conflict and guilt or make your relationship even better. You may feel like you need to prove yourself as a parent. At the same time, you may feel a need to be cared for and demand attention and love.
- When you feel the baby move, this verifies without a question that you are responsible for another being inside of you. This triggers a certain amount of grief related to letting go of former relationships, attachments and aspects of your former role before becoming pregnant.
- Your focus shifts more toward the baby. You may find yourself wanting to share your experiences with other pregnant people. You tend to have more dreams and concerns for the baby’s well-being.

The last three months are a period of watchful waiting. Your attention will be mostly on the baby and preparing for the arrival. Going to classes, having a baby shower, choosing names and preparing the room are some of the activities during this time. This period has its own share of fears and uncertainty including:

- Feeling very protective of the baby, avoiding crowds or anyone perceived as being dangerous.
- Fears for your own life and the baby’s life. Fears of an abnormal baby.
- Fears of labor and birth (pain, loss of control, the unknown); vivid dreams reflect these fears.
- Anticipating the loss of attention after birth.
- Some depression, increased dependency from loved ones, and introversion are common.

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Common Complaints During Pregnancy

Abdominal Pain

Common causes of abdominal pain are muscles that get stretched as your uterus and baby grow. You may be told you are having round ligament pain. This happens as the uterus grows and pulls on the ligament (band of connective tissue) that is attached to the uterus. These changes cause discomfort or pain usually in the lower abdominal area but are not harmful for you or your baby.

Some ideas for relief

- Do exercises to strengthen your stomach muscles.
- Use a pregnancy belt or cradle to support the baby (ask for a prescription)
- Warm bath, warm compresses, heating pad on low setting to abdomen.
- Take regular strength Tylenol® (acetaminophen).
- Turn to your side to sit up when getting out of bed. Avoid twisting or sitting straight up.
- *Call the midwife if you have any stomach or back pain that is getting worse or will not go away with rest or Tylenol. Call the midwife if you have cramping every 10-15 minutes and are less than 37 weeks. This could be a sign of preterm labor.*

Allergies

Allergies are annoying anytime but especially in pregnancy.

Before taking any medications try these ways to reduce your symptoms:

- Limit your exposure to know allergy triggers
- Try saline nasal sprays to ease the symptoms
- Try a neti pot with saline to clear nasal secretions
- Exercise can reduce nasal inflammation
- Adhesive nasal strips can help keep nasal passages open
- Sleep with your head elevated 30-45 degrees to improve breathing

If you still need medications, these medications may be used in pregnancy:

- Chlor-Trimeton® (chlorpheniramine) 4 mg every 4 to 6 hours as needed
- Benadryl® (diphenhydramine) as directed
- Zyrtec Allergy® (cetirizine) 5-10 mg daily. Max 10mg/24 hours
- Claritin® (loratadine) 10 mg once a day
- For moderate to severe symptoms your midwife can prescribe a corticosteroid like Flonase®, Rhinocort® or Nasonex®

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Back and Pelvic Pain

More than 50% of women and pregnant people have back and/or pelvic pain in pregnancy and it usually gets worse in the third trimester. Common causes of backache are poor posture, weak stomach muscles, too much weight gain, or relaxed joints due to hormone changes.

- Good posture and exercise may decrease back and pelvic pain.
- Rest, sitting with your feet up, warm or cold packs on your back may provide some relief.
- You may take regular or extra strength Tylenol® (acetaminophen).
- Do not stand still for long periods of time.
- Wear flat shoes for comfort, not high heels.
- Do not lift things heavier than 30 pounds. Always lift correctly using your legs.
- Try pregnancy yoga, massage or chiropractic care.
- Heating pad to back on low setting.
- Some find pregnancy belts helpful. Ask for a prescription.
- *Call the midwife if you have back pain with fever over 101° F; this could be a kidney infection.*

Bleeding from the Vagina

During pregnancy the cervix has an increased blood supply and blood vessels can break easily. Some experience small amounts of bleeding (spotting) during pregnancy after vaginal exams or sexual intercourse. Other causes could be due to a vaginal infection or a bleed associated with the placenta.

- *Call the midwife if you have bright red bleeding heavier than spotting, with or without cramping.*

Shortness of Breath

Common causes of feeling short of breath include less space for the lungs as the baby grows bigger, weight gain, stress and sometimes anemia (low iron in your blood). Hormone changes while pregnant normally encourage you to breathe deeper and faster because you are breathing for you and your baby.

- For relief, put your arms over your head, sit or stand up straight and take slow, deep breaths
- While you sleep, place pillows under your head to make it easier to breathe
- If you have asthma or other breathing problems, please tell your midwife
- Do not smoke
- *Call the midwife if you hear wheezing, feel like you cannot breathe, or are coughing up blood*

Carpal Tunnel Syndrome/Numbness of the Hands

Some experience numbness in the hands during pregnancy. This is caused by swelling in the joints that puts pressure on the nerves in the wrist resulting in numbness. The numbness will go away after your pregnancy. Elevating the hands at night may be helpful. Think about how you're using your hands and how you're sleeping. Some find some relief by wearing a wrist splint. Ask your midwife about a prescription for a splint.

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Colds and Cold Symptoms

Most people experience 2-3 colds in the winter and spring season, and during pregnancy the symptoms are often more severe due to the weakened immune state in pregnancy. Colds are caused by viruses, and cold formulas only treat the symptoms and do not cure a cold.

Consider practicing these things to reduce your risk of getting sick and to help when you do get sick

- Eat a healthy diet
- Get enough sleep (7-8 hours nightly)
- Drink 10 glasses (8 oz) of water per day (2-3 liters or 80 ounces)
- Exercise regularly
- Reduce stress
- Wash your hands often
- Avoid close contact with sick family or friends

Once you have a cold, try these practices to help your symptoms

- Gargle with warm salt water for a sore throat (1 tsp salt per 8 oz water)
- Avoid dairy because it thickens mucous secretions
- Saline nasal drops for loosening nasal mucus
- Try rinsing nasal passages with a neti pot
- Sleep with head of the bed elevated
- Breathing warm, humid air to help loosen congestion/use a facial steamer or hot shower
- Try using nasal strips to open the nasal passages
- Chicken soup helps relieve inflammation and soothe congestion
- Adding honey or lemon to a warm cup of tea to help relieve a sore throat
- Using hot and cold packs to alleviate sinus pain

There are multi-symptom formulas or you may choose to treat just the symptoms you are experiencing. These over-the-counter medicines are probably safe in pregnancy especially after the first trimester. Please read the labels and take as directed.

Cough

- Dextromethorpan is a cough suppressant which keeps you from coughing as much. It can be found in Robitussin Cough Relief®, Vicks DayQuil Cough® and Delsym®
- Guaifenesin is an expectorant, which thins the mucous in your chest so you can cough it up easier. It is found in Mucinex® and Robitussin DM®
- Cough drops
- Cool mist humidifier

Stuffy nose and sinus pressure

- Pseudoephedrine and phenylephrine are decongestants which reduce nasal congestion and sinus pressure by constricting the blood vessels in the nose and decreasing swelling. They are found in Sudafed®. Do not take if you have high blood pressure.

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Sneezing, runny nose and watery eyes

- Chlorpheniramine (found in Triaminic Allergy®), diphenhydramine (found in Benadryl®) and doxylamine (found in NyQuil®) are antihistamines that reduce the immune response created by the virus. They cause drowsiness and should be taken at bedtime. They work best in first couple days of symptoms.

Sore throat

- Acetaminophen (Tylenol®) can be taken to reduce pain.
- Antihistamines can help dry up postnasal drip (see above).
- Benzocaine and menthol containing lozenges and sprays can numb and soothe the throat. Chloraseptic® Spray, Cepacol®
- Cough drops keep the saliva flowing which may reduce throat irritation.
- *If you have been sick for more than 2 weeks, call the office for an appointment to see the midwife.*

Constipation

Bowel changes including constipation and diarrhea are common in pregnancy and are most likely due to changes in dietary habits, exercise routines, and pregnancy hormones.

- For relief of constipation, eat high fiber foods (fiber cereal, prunes, fresh fruits, vegetables, whole grains).
- Drink at least 10 glasses (8 oz) of water per day. (2-3 liters or 80 ounces)
- Take a 30-minute walk every day. Exercise and movement help your bowels move better.
- Take a fiber supplement such as Metamucil®, Fiber Con®, Citrucel® or a laxative, Dulcolax®.
- You can use an over-the-counter stool softener like Colace® (docusate sodium) or glycerin suppositories.
- Probiotics can improve your intestinal flora and may decrease constipation
- Magnesium oxide 400-800 mg daily, causes looser stools.
- Milk of Magnesia (magnesium hydroxide) 400 mg/5 ml. May take 30-60 ml at bedtime. Occasional use only recommended if other methods are not helpful.
- *Call the midwife if you have bleeding from your rectum, severe cramping or more than six stools in 24 hours.*

Cravings

It's common to notice changes in your food preferences during pregnancy. It is common to have cravings for different foods throughout your pregnancy and for foods you usually like to be unappetizing. Try to limit cravings for sweets or foods that are not healthy.

By far the most common craving for pregnant women
is not to be pregnant.
~ Phyllis Diller

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Some have cravings for things like clay, dirt, ice, laundry starch or paper which is called pica. Sometimes this can be a family or cultural practice. It can happen anytime during pregnancy and small amounts are usually not harmful. Cravings for larger amounts can be a sign of anemia or malnutrition. It could become a problem, if the clay, dirt or paint has lead in it. Let your midwife know about any unusual cravings you are having.

Diarrhea

Bowel changes including constipation and diarrhea are common in pregnancy and are most likely due to changes in dietary habits, exercise routines, and pregnancy hormones. Diarrhea may also occur after eating food contaminated by bacteria or from a virus.

For stomach virus or food poisoning

The stomach flu, or gastroenteritis, can be caused by a number of different viruses that attack your gastrointestinal system. You are contagious even before symptoms begin at one to three days after exposure and up to 2 weeks after symptoms resolve. Symptoms include diarrhea, nausea and vomiting, fever, headache, and sore muscles. If you know the stomach flu is going around, additional methods of prevention include:

- Use the dishwasher instead of hand-washing dishes when possible
- Use soap and water instead of hand sanitizer
- Keep a sick family member isolated and use a different bathroom
- Wipe off shopping cart handles
- Clean countertops and surfaces with a bleach-based solution, and wash clothes with a bleach-based detergent until all members in the household recover

The stomach flu has to run its course, and can't be cured by medications but these are some things that can help:

- Let your stomach rest at least 24 hours and don’t eat anything until nausea and diarrhea stop
- When nausea lessens, try taking small sips of clear fluids (broth, water or electrolyte replacement) at regular intervals or chewing ice chips
- Avoid caffeinated drinks like coffee, strong black tea, and chocolate
- General foods to avoid are dairy, fibrous foods, and anything fatty or spicy
- Acupressure pressure point P-6 may decrease nausea
- Take Tylenol for aches and fever
- For persistent diarrhea, try Imodium® only after the first trimester of pregnancy
- When nausea and diarrhea resolve, start the BRAT diet for the next 24 hours
    - **B**ananas: Bananas are easy to digest and can replace the potassium you lose from vomiting and diarrhea
    - **R**ice: Brown rice has too much fiber, but white rice is easier on the stomach and provides energy from carbs
    - **A**pplesauce: Applesauce can provide an energy boost due to the carbs and sugars, and also contains pectin, which can help with diarrhea
    - **T**oast: Avoid whole-wheat bread, as fiber can be difficult on the digestive system. White bread is processed and easier to digest

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Dizziness and Fatigue

You'll probably feel tired in the beginning of pregnancy. This is caused by changes in hormones that make you feel sleepy. Coping with the changes of pregnancy can be stressful. When you feel dizzy it may be a sign that you are not drinking or eating enough. You also have blood pressure changes when changing positions that sometimes cause dizziness or "head rushes."

- For relief, take naps, eat foods rich in iron and protein
- Drink 10 glasses (8 oz) of water per day. (2-3 liters or 80 ounces)
- Change positions slowly. When dizzy, move slowly and lie on your left side
- Avoid getting too hot
- *Call the midwife if you faint or are dizzy for more than twenty-four hours*

Dreams

It's common to have more dreams during pregnancy. This may be due to hormonal changes, more sleep thus more time to dream and possibly remembering more dreams because of being awakened during the night by the baby moving or going to the bathroom. Dreams may be more vivid, detailed or in color. They can come any time before, during or after pregnancy.

Dreams and nightmares don't need to be taken literally. They are most likely a representation of fears and anxieties about childbirth, parenthood and the baby. Some things to remember are:

- Dreams are normal
- Share your dreams with someone you trust to help you explore the meaning
- Exploring the meaning of the dreams may help you identify fears and anxiety
- Focus on the positive aspects of the dreams; get accurate information about the negative parts

Flu/Influenza

Changes in the immune system, heart and lungs during pregnancy make some people more prone to severe illness from flu, including illness requiring hospitalization. Flu may also be harmful to the baby, especially during the early months of fetal development. Getting the flu vaccine is the best protection against the flu for the pregnant parent and baby. Even though the vaccine does not cover every possible strain of the flu that you may encounter, it will reduce your risk by half. (See **"Seasonal Flu Consent Info"** for more information on the flu vaccine.) There are everyday things you can do to protect yourself like:

- Covering coughs
- Washing hands often
- Avoiding people who are sick
- Breastfeeding helps protect infants

Flu symptoms include:

- Fever, chills
- Fatigue, Body aches
- Cough, Sore throat
- Runny or stuffy nose
- Headache
- Some may have vomiting and diarrhea

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Early treatment is important during pregnancy:

- Take Tylenol® to control your fever
- Antiviral drugs make your symptoms milder and work best when started within 48 hours after symptoms start.
- ***If you think you have the flu, call the midwife (DO NOT COME TO THE OFFICE) or go to Urgent Care.***
- **If you are experiencing severe symptoms, seek emergency medical care. These include:**
    - Difficulty breathing or shortness of breath
    - Persistent pain or pressure in the abdomen or chest
    - Persistent dizziness, confusion or inability to arouse
    - Seizures
    - Not urinating
    - Severe muscle pain
    - Severe weakness and unsteadiness
    - Fever or cough that improve but then return or worsen
    - High fever not responding to Tylenol
    - Decreased or no movement of your baby

I enjoy convalescence. It is the part that makes the illness worthwhile.

~ George Bernard Shaw

Heartburn/Indigestion/Gas

A common cause of heartburn is pressure from the fetus on the stomach, which causes food and stomach acids to come back up.

- For relief, eat 5-6 small meals per day, instead of big meals.
- Sit up for 45 minutes after eating or take a short walk.
- Do not go to sleep for 1-2 hours after eating.
- Use 2 or more pillows to prop up your head when you sleep.
- Try Papaya enzyme.
- Apple cider vinegar in water may help.
- You can take Tums® (calcium carbonate), Maalox® or Mylanta® (aluminum with magnesium hydroxide), Riopan® (magaldrate), Pepcid AC® (famotidine), Tagamet® (cimetidine) or Gas-X (simethicone).
- Avoid greasy or spicy foods, carbonated beverages, and caffeine.
- **DO NOT TAKE Alka Seltzer® or baking soda for indigestion or heartburn.**
- *If over the counter remedies do not work, talk to the midwife. Some may require prescription strength medications.*

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Headaches/Migraines

- Hormone changes, tense shoulder and neck muscles, stress, vision changes requiring new glasses, sinus congestion or not eating and drinking enough may cause headaches.
- For relief, lay down in a dark quiet room with a warm or cold pack on your head.
- A neck or shoulder massage might help.
- Avoid stress, caffeine, alcohol, second hand smoke, and smoking.
- Take regular or extra strength Tylenol® (acetaminophen) as directed up to 4 grams in 24 hours.
- You may take Advil® (ibuprofen) 400-600 mg every 6-8 hours but only in the first 28 weeks of pregnancy (1st and 2nd trimesters).
- Daily headache/migraine prevention:
  - Get 7-8 hours of rest per night
  - Eat small meals every 2-3 hours
  - Drink at least 10 glasses (8 oz) of water per day (2-3 liters or 80 ounces).
  - Take a walk in the fresh air
  - Magnesium oxide 300 mg, two times per day
  - Riboflavin (B2) 200 mg, two times per day
- For headaches/migraines in pregnancy:
  - Magnesium oxide 900 mg up to four times per day
  - Tylenol® 650-1000 mg up to four times per day
  - Benadryl® 25-50 mg up to four times per day
  - Sudafed® 30-60 mg up to four times per day
  - May add Phenergan® or Zofran® as needed for nausea and vomiting
- ***If your headache does not go away with fluids, rest, and medications; if it is the worst headache you have ever had; or if you are seeing spots or having blurred vision, call the midwife immediately.***

Hemorrhoids

Hemorrhoids are swollen veins in your rectal area. Sometimes they bleed when you have a bowel movement. Common causes are pregnancy hormones, lack of exercise, sitting/standing for long periods of time, constipation, and pressure from the growing uterus; some people are just more likely to get them.

- For relief, eat foods with lots of fiber. Avoid constipation.
- Drink 10 glasses (8 oz) of water per day (2-3 liters or 80 ounces).
- Take warm baths or use cold packs on affected areas.
- Try not to sit for a long time. Rest with hips and legs elevated.
- Try Tucks® (witch hazel), Anusol® suppositories or Preparation H® cream to help with pain and itching.
- *If you do not get any relief, talk to the midwife. Some may require prescription-strength medications.*

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Leg Cramps

- Leg cramps may be caused by a fluid or calcium imbalance in the legs. The pressure of the baby's weight on the pelvic blood vessels and nerves can make your legs cramp. The cramps are more common at night.
- Avoid standing still for long periods of time. If you must stand for your job, wear support hose and shift your weight from heel to toe.
- If you get a leg cramp, do calf stretches by straightening your leg and pulling your toes towards your head to stretch the muscle and put heat on the cramped area.
- Exercise every day. Walking and swimming are good.
- Eat foods rich in calcium and magnesium, such as milk, dark green vegetables, and whole grain cereals, corn, nuts (almonds, cashews, brazil), and brown rice.
- Drink 10 glasses (8 oz) of water per day (2-3 liters or 80 ounces).
- You may take Tylenol® (acetaminophen).
- We may encourage you to take a calcium/magnesium supplement if the cramping persists.
- ***Call if you are experiencing swelling, redness, hot spots, or pain in just one or both legs.***

Nose Bleeds

This happens more often while pregnant. It is due to an increased amount of blood in your whole body and hormone changes. If this happens, put direct and firm pressure below the bridge or bone of the nose for a few minutes until the bleeding stops.

Think of stretch marks as pregnancy service stripes.

~ Joyce Armor

Skin Changes/Rashes

Some people, especially those with darker skin and hair colors, notice an irregular brownish discoloration on their forehead, nose, cheeks or neck (cholasma) during pregnancy. You may get a darker stripe from the belly button to the pubic area (linea nigra). This is normal and due to the increased hormones of pregnancy. It will go away within a year after having the baby.

Stretch marks are common but it is not understood what causes them. Most likely they are a family trait but weight gain does not affect them. There is nothing that can prevent them. They may develop on the breast, belly or buttocks. Sometimes they can itch. They are reddish at first and fade to a silvery white in the first year after pregnancy. You can try Vitamin E, cocoa butter or Bio Oil® to help soothe them.

Dry skin, itching and rashes may be due to various factors including, dry weather, sensitive skin, allergic reactions, insect bites, infections, etc.

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Try these over-the-counter meds first:

- Avoid any known allergens
- Consider if you have made a change in any personal hygiene or laundry products recently
- Use a good lubricating lotion like Lubriderm® or Eucerin®.
- Calamine® lotion can help relieve itching.
- Aveeno® oatmeal bath (or use 2 cups dry colloidal oatmeal [or blend it into a powder] in bath).
- Try diphenhydramine (Benadryl® cream), which is an antihistamine that reduces the immune response.
- Try hydrocortisone 1% cream to help decrease hives and swelling.
- Try an antifungal cream to see if it is a fungus or yeast infection.
- *If the symptoms continue after trying these things, call the office for an appointment.*

Sleep Disorders/Insomnia

Poor sleep patterns are common in pregnancy and postpartum. (See **"Complimentary Therapies & Activities: Sleep"** for more info.) If you are consistently getting less than 7 hours of sleep a night, you may benefit from better sleep hygiene and some sleep aids. Try these safe remedies:

- Warm bath
- Warm milk before bed
- Chamomile tea or linden tea
- Unisom® (doxylamine)
- Benadryl® (diphenhydramine)
- Tylenol PM® (diphenhydramine and acetaminophen)

If your sleep does not improve, talk to your midwife about further evaluation and other treatments.

Swelling of Hands, Legs, and Feet

Swelling may be caused by pressure from the baby, hormones of pregnancy, or standing for long periods. Rarely, it is a sign of increased blood pressure.

- For relief, drink more fluids. Eat more protein. Avoid eating lots of salty foods.
- Do not wear clothes that are tight at the waist or have a tight band around the legs. Use support hose (ask for a prescription).
- Avoid standing still, sitting with your legs down or crossed for long periods. Rest with your feet up. Lie on your side. Get exercise as often as possible.
- ***If you get SUDDEN swelling in your feet and legs, hands and/or face, or you wake up and are more swollen in the morning than you were the night before, call the midwife.***

Urinary Tract Infection (UTI)

A bladder or urinary tract infection can cause you to go to the bathroom more often, and can make it sting when you do. You will need to

- *Call the midwife immediately, especially if you have painful urination, increased number of urinations, feel like you can't empty your bladder, have back pain, or have blood in your urine.*
- *If you have any of these symptoms with a fever > 101° F, call the midwife immediately.*

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- To help prevent infection, wipe from front to back when you go to the bathroom.
- Urinate after sex every time to clear out bacteria that may have been pushed into the urinary tract.
- It may not be comfortable to pee, but drinking lots of water and fully emptying your bladder more often can help clear out bacteria, to allow inflammation to lessen and the tissues to heal. Less concentrated urine stings less, too.
- Avoid caffeine and sweet foods.
- You may drink UNSWEETENED cranberry juice or grapefruit juice, or take a cranberry supplement twice a day to raise the acidity in your bladder and fight off bacteria.

Urination: Increased

You need to urinate more often due to pressure that the baby puts on your bladder. A bladder infection (or UTI) can also cause you to go to the bathroom more often.

- *If you have painful urination, increased number of urinations from normal, feel like you can't empty your bladder or have blood in your urine, call the midwife.*
- *If you have any of these symptoms with a fever > 101° F, call the midwife immediately.*
- For relief, drink more water during the day, less at night.
- Avoid caffeine and sweet foods.

Uterine Tightening

Uterine tightening or "Braxton-Hicks contractions" are common during pregnancy and begin in the first few months but are often not strong enough to be felt until the middle or later part of pregnancy. They are caused by the stretching of the uterine muscles as the baby grows inside. These tightening are sporadic and often painless but they can last a few minutes and you may notice a tightening of the abdomen. They become more frequent, stronger and more regular as you get close to your due date. They are more common in the evenings or after working all day. Sometimes they are mistaken for labor contractions.

Premature Labor Warning Signs

- **Regular belly tightening or contractions, with or without pain**
- **More than 5 contractions in 1 hour**
- **Cramping like you may have during your period**
- **Belly cramping, with or without diarrhea**
- **Low, dull back pain that is constant or may come and go**
- **Pressure in your bottom or feeling that the baby is pressing down**
- **More discharge from your vagina or bleeding from your vagina**
- **Just not feeling right**

If you have any of these warning signs:

1. Empty your bladder. Drink 3 to 5 glasses of water.
2. Lie down on your left side for 1 hour.
3. If your symptoms do not change, call the midwife on call 944-5488.

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Vaginal Discharge

An increase in milky white vaginal discharge (leukorrhea) while pregnant is normal and is caused by an increase in hormones. Vaginal discharge normally increases later in pregnancy. You might notice clumps of discharge near your due date, which can be part of the mucous plug.

- If you have an itchy, thick white and clumpy discharge, this could be a yeast infection. You can schedule an appointment with the midwife for evaluation OR try Monistat 7 or Gyne-Lotrimin 7 vaginal cream to see if your symptoms are relieved.
- *If you have an increase in discharge associated with a foul odor, different color, discomfort or itching, it may be a bacterial vaginal infection. Schedule an appointment with the midwife for evaluation.*
- *If you feel fluid leaking from your vagina and you suspect it is not urine, and it continues to leak or run down your leg, you could be leaking amniotic fluid from around the baby and you need to call the midwife as soon as you can, so we can test the fluid. If it is amniotic fluid, we'll probably work with you to help you get your labor started!*

Vomiting and Nausea

It's very common to have nausea in the first 3 months of pregnancy. Often, this stops by 12 to 14 weeks of pregnancy. Some experience nausea on and off throughout their pregnancy. The hormones of pregnancy, low blood sugar, slower moving food and changing emotions can all cause nausea.

- Try eating small meals every two hours during the day. You may try a snack during the night. Eating dry crackers or toast before you get out of bed in the morning may help too.
- Avoid drinking fluids while you are eating. Try eating cold foods instead of hot.
- Avoid foods with strong odors. Eating high protein, low fat and low spice foods may also help. Have others cook for you during this time.
- You may drink peppermint or ginger tea. Try eating candied ginger, ginger snaps, Ginger Ale.
- Avoid vitamins and iron supplements until you feel better, but keep taking folic acid (try at night).
- Avoid all alcohol, caffeine and cigarettes.
- Wrist acupressure bands may help.
- Rinse your mouth after vomiting to stop the acid from damaging your teeth. Mix 1 teaspoon of baking soda in 8 ounces of water, rinse your mouth and spit. Wait 30 minutes and brush your teeth.

For relief

- You can take Ginger 500 mg two times a day or 250 mg four times a day. Take for at least 3 days to get the most benefit.
- Take Vitamin B-6 (pyridoxine) 25 mg, three times a day.
- If it doesn't get better: Take UNISOM® (doxylamine) 12.5 mg (1/2 tablet) with Vitamin B-6 (pyridoxine) 25mg, three times per day. Buy UNISOM® Tablets NOT Capsules.
- Dramamine® (dimenhydrinate) 1-2 tabs every 4-6 hours. Maximum 8 tabs daily.
- Benadryl® (diphenhydramine) 25-50mg every 4-6 hours. Maximum 12 tabs daily.
- Emetrol liquid® (dextrose/fructose/phosphoric acid): 15-30mL every 15 minutes up to 1 hour. Max 5 doses.
- Zofran® (ondanestron) is a prescription drug that may help. Call the midwife for this.
- *Call the midwife if you cannot keep food or liquid down, have blood in vomit or cannot stop vomiting for 24 hours. Some may require prescription-strength meds to control nausea and vomiting.*

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Early Pregnancy Warning Signs

Call the birth center at (505) 924-2229 Monday thru Thursday from 9 to 5 and Friday 9 to 12, or call the midwife on call at (505) 944-5488 for any of these warning signs.

Abdominal Pain: *Call if you have any stomach or back pain that is getting worse or will not go away with rest or Tylenol®. Call the midwife if you have cramping every 10-15 minutes and are less than 34 weeks. This could be a sign of preterm labor.*

Back Aches: *Call if you have back pain with fever over 101° F, this could be a kidney infection.*

Bleeding from the Vagina: *Call if you have bleeding like a period with or without cramping.*

Feeling Short of Breath: *Call when you hear yourself wheeze, feel like you cannot breathe, or are coughing up blood.*

Diarrhea: *Diarrhea may be caused by a virus or food poisoning. Call if you have bleeding from your rectum, severe cramping or more than six (6) watery stools in 24 hours.*

Dizziness and Fatigue: *Call the midwife if you faint or are dizzy for more than twenty-four hours.*

Headaches: *If your headache does not go away with rest and medications, if it is the worst headache you have ever had, or if you are seeing spots or having blurred vision, call the midwife immediately.*

Leg Cramping: *Call if you are experiencing swelling, redness, hot spots or pain in just one or both legs.*

Chills and Fever: *If you think you have a fever, take your temperature with a digital thermometer. Call for a fever over 101°F.*

Edema or Swelling: *If you get SUDDEN swelling in your feet and legs, hands and/or face, call the midwife.*

Painful Urination: *If you have painful urination (dysuria), increased number of urinations from normal, feeling like you can't empty your bladder or blood in your urine, call the midwife. If you have any of these symptoms with a fever > 101° F, call the midwife immediately.*

Abnormal Vaginal Discharge: *If you have an increase in discharge associated with a foul odor, different color or discomfort or itching, call the midwife. If you feel fluid leaking from your vagina and you know it is not urine and it continues to leak or run down your leg, you could be leaking amniotic fluid from around the baby-call the midwife immediately.*

Vomiting that won't stop: *Call if you cannot keep food or liquid down, have blood in the vomit or cannot stop vomiting for 24 hours.*

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Medications Over-The-Counter (OTC) That May Be Used in Pregnancy

(Please see more information about each topic in **"Common Complaints During Pregnancy."**)

Allergies

- ✓ Chlor-Trimeton® (chlorpheniramine) 4 mg every 4 to 6 hours as needed.
- ✓ Benadryl® (diphenhydramine) as directed
- ✓ Zyrtec Allergy® (cetirizine) 5-10 mg daily. Max 10mg/24 hours.
- ✓ Claritin® (loratadine) 10 mg once a day.

Colds

Cough

- ✓ Dextromethorpan is a cough suppressant which keeps you from coughing as much. It can be found in Robitussin Cough Relief®, Vicks DayQuil Cough® and Delsym®.
- ✓ Guaifenesin is an expectorant which thins the mucous in your chest so you can cough it up easier. It is found in Mucinex® and Robitussin DM®.
- ✓ Cough drops

Stuffy nose and sinus pressure

- ✓ Pseudoephedrine and phenylephrine are decongestants which reduce nasal congestion and sinus pressure by constricting the blood vessels in the nose and decreasing swelling. They are found in Sudafed®. Do not take if you have high blood pressure.

Sneezing, runny nose and watery eyes

- ✓ Chlorpheniramine (found in Triaminic Allergy®), diphenhydramine (found in Benadryl®) and doxylamine (found in NyQuil®) are antihistamines that reduce the immune response created by the virus. They cause drowsiness and should be taken at bedtime. They work best in first couple days of symptoms.

Sore throat

- ✓ Acetaminophen (Tylenol®) can be taken to reduce pain.
- ✓ Antihistamines can help dry up postnasal drip (see above).
- ✓ Benzocaine and menthol containing lozenges and sprays can numb and soothe the throat. Chloraseptic® Spray, Cepacol®
- ✓ Cough drops keep the saliva flowing which may reduce throat irritation.

Constipation

- ✓ Fiber supplement such as Metamucil®, Fiber Con®, Citrucel® or a laxative, Dulcolax®.
- ✓ Stool softener, Colace® (docusate sodium) or glycerin suppositories.
- ✓ Probiotics can improve your intestinal flora and may decrease constipation
- ✓ Magnesium oxide 400-800 mg daily, causes looser stools.
- ✓ Milk of Magnesia (magnesium hydroxide) 400 mg/5 ml. May take 30-60 ml at bedtime.
- ✓ Occasional use only recommended if other methods are not helpful.

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Diarrhea

- ✓ For persistent diarrhea, try Imodium® only after the first trimester of pregnancy

Heartburn

- ✓ You can take Tums® (calcium carbonate), Maalox® or Mylanta® (aluminum with magnesium hydroxide) Riopan® (magaldrate), Pepcid AC® (famotidine), Tagamet® (cimetidine) or Gas-X (simethicone).

Headaches/Migraines

- ✓ Take regular or extra strength Tylenol® (acetaminophen) as directed up to 4 grams in 24 hours.
- ✓ You may take Advil® (ibuprofen) 400-600 mg every 6-8 hours but only in the first 28 weeks of pregnancy (1st and 2nd trimesters).
- ✓ Daily headache / migraine prevention:
    - Magnesium oxide 300 mg, two times per day
    - Riboflavin (B2) 200 mg, two times per day
- ✓ For Headaches / Migraines in Pregnancy:
    - Magnesium oxide 900 mg up to four times per day
    - Tylenol® 650-1000 mg up to four times per day
    - Benadryl® 25-50 mg up to four times per day
    - Sudafed® 30-60 mg up to four times per day

Hemorrhoids

- ✓ Try Tucks® (witch hazel), Anusol® suppositories or Preparation H® cream to help with pain and itching.

Humor may be hazardous to your illness.

~ Ellie Katz

Pain or fever

- ✓ Tylenol® (acetaminophen) 325 to 650 mg every 4 to 6 hours. Do not take more than 4000 mg in 24 hours.
- ✓ Advil® or Motrin® (ibuprofen) 400 mg every 4 hours, 600 mg every 6 hours or 800 mg every 8 hours **(Can take only up to 28 weeks - later use affects fetal heart valves).**

DO NOT TAKE Aspirin or Aleve® (naproxen) while you are pregnant.
Do not take **Advil® or Motrin®** (ibuprofen) **after 28 weeks**.

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Skin rash

- ✔ Calamine® lotion can help relieve itching.
- ✔ Aveeno® oatmeal bath
- ✔ Try diphenhydramine (Benadryl® cream) which is an antihistamine that reduces the immune response.
- ✔ Try hydrocortisone 1% cream to help decrease hives and swelling.
- ✔ Try an antifungal cream to see if it is a fungus or yeast infection.

Sleeping

- ✔ Unisom® (doxylamine)
- ✔ Benadryl® (diphenhydramine)
- ✔ Tylenol PM® (diphenhydramine and acetaminophen)

Vomiting and Nausea

- ✔ Ginger 500 mg two times a day or 250 mg four times a day. Take for at least 3 days to get the most benefit.
- ✔ Vitamin B-6 (pyridoxine) 25 mg, three times a day.
- ✔ UNISOM® (doxylamine) 12.5 mg (1/2 tablet) with Vitamin B-6 (pyridoxine) 25mg, three times per day. Buy UNISOM® Tablets NOT Capsules.
- ✔ Dramamine® (dimenhydrinate) 1-2 tabs every 4-6 hours. Maximum 8 tabs daily.
- ✔ Benadryl® (diphenhydramine) 25-50mg every 4-6 hours. Maximum 12 tabs daily.
- ✔ Emetrol liquid® (dextrose/fructose/phosphoric acid) 15-30 mL every 15 minutes up to 1 hour. Max 5 doses.

Vaginal yeast infection

- ✔ Monistat 7 or Gyne-Lotrimin 7 vaginal cream

Sickness is felt, but health not at all.

~ Traditional Proverb

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Herbs During Pregnancy

Although herbs are natural, not all herbs are safe in pregnancy. Unlike prescription drugs, natural herbs do not go through the same scrutiny and evaluation process by the FDA, so the quality and strength of an herbal preparation can vary between two batches of the same product and between products from different manufacturers. Consumers have little way of knowing if a product will do what the label claims, or how safe the product may be. Reliable information about the product may be hard to find, which makes researching these products' effectiveness more challenging.

Caution: Some medicines and herbs can be dangerous during pregnancy, especially in the first three months when the organs are forming. Always talk to the midwife about any herbs you are taking. Store medicines and herbs away from children.

AVOID These Herbs to During Pregnancy

The following herbs are considered **Likely Unsafe or Unsafe** during pregnancy:

- Saw Palmetto
- Goldenseal
- Dong Quai
- Ephedra, Ma-huang, Osha root
- Yohimbe
- Pay D' Arco
- Passion Flower
- Black Cohosh
- Blue Cohosh
- Roman Chamomile
- Pennyroyal

Herbs That May be Used in Pregnancy

The following herbs have been rated **Likely Safe or Possibly Safe** for use during pregnancy:

- ✓ Red Raspberry Leaf: Rich in iron, this herb has helped tone the uterus, increase milk production, decrease nausea, and ease labor pains and some say it can reduce complications and the use of interventions during birth. It is seen in pregnancy teas and is most commonly recommended for use after the first trimester.
- ✓ Peppermint Leaf: Helpful in relieving nausea/morning sickness and flatulence
- ✓ Ginger root: Helps relieve nausea and vomiting
- ✓ Slippery Elm Bark (when the inner bark is used orally in amounts used in foods): Used to help relieve nausea, heartburn, and vaginal irritations
- ✓ Oats & Oat Straw; Rich in calcium and magnesium; helps relieve anxiety, restlessness and irritated skin
- ✓ Elderberry: used for immune support and can be used in lozenges, tincture, glycerites or tea

For more on alternative medicines/herbs:
americanpregnancy.org/pregnancyhealth/naturalherbsvitamins.html

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Essential Oils in Pregnancy, Labor, and Breastfeeding

Essential oils are concentrated extracts of herbs in oil. As with herbs, there is limited research available and the use of essential oils during pregnancy is a controversial topic. The safety or potential harmful effects of essential oils depends on the quantity taken and the method of administration. It is probable that the essential oil metabolites cross the placenta. It is recommended to avoid use of all essential oils during the first three months of pregnancy. It would also be prudent to avoid the internal or undiluted application of essential oils throughout pregnancy.

Essential oils that appear to be safe in pregnancy include cardamom, German and Roman chamomile, frankincense, geranium, ginger, neroli, patchouli, petitgrain, rosewood, rose, sandalwood, and other nontoxic essential oils. It is extremely unlikely that a nightly bath containing a few drops of essential oils will cause any problems for the unborn child. For more information go to www.naha.org/explore-aromatherapy/safety/

AVOID These Essential Oils throughout Pregnancy, Labor, and While Breastfeeding

Essential Oil	**Latin Name**
Aniseed	*Pimpinella anisum*
Basil ct. estragole	*Ocimum basilicum*
Birch	*Betula lenta*
Camphor	*Cinnamomum camphora*
Hyssop	*Hyssopus officinalis*
Mugwort	*Artemisia vulgaris*
Parsley seed or leaf	*Petroselinum sativum*
Pennyroyal	*Mentha pulegium*
Sage	*Salvia officinalis*
Tansy	*Tanacetum vulgare*
Tarragon	*Artemisia dracunculus*
Thuja	*Thuja occidentalis*
Wintergreen	*Gaultheria procumbens*
Wormwood	*Artemisia absinthium*

Use of essential oils in labor should only be in small amounts and locally applied, not used with a diffuser. The fragrances could be irritating to your newborn's virgin lungs. Also, you want your baby to pick up your body scent for bonding, and other scents could be confusing.

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Vaccinations in Pregnancy

Rhogam® (Rh D Immune Globulin) Consent Info

Rh D Immune Globulin, better known as Rhogam, is made from human plasma and does not contain thimerosal (mercury). Although Rh immune globulin is a blood product and carries warnings about risk of transmission of viruses such as HIV and hepatitis the risk of transmission is theoretical. It is used to prevent hemolytic disease of the fetus and newborn (HDFN).

Prior to the introduction of the Rh D immune globulin injection in 1968, women and pregnant people who were Rh negative were at risk for sensitization and subsequent HDFN. This is a serious, often fatal disease caused by incompatibility between an Rh-negative mother and a Rh-positive fetus. These are the risks if prophylaxis is not used:

- 13% to 14% of Rh-negative mothers/pregnant people could become sensitized during an Rh-incompatible pregnancy
- 25% of fetuses would need immediate treatment to avoid kernicterus (a form of brain damage caused by excessive jaundice and associated symptoms)
- 25% of fetuses would develop *hydrops fetalis* and die
- Only 50% of fetuses would be mildly affected and not require treatment

Sensitization can occur when a Rh-negative mother/pregnant person is carrying a Rh-positive fetus. As many as 75% of all pregnancies experience a fetal-maternal transplacental hemorrhage (TPH) during pregnancy or birth. The amount of fetal blood in the maternal circulation is less than 0.1 ml in 60% of cases and less than 5 ml in 99% of cases. This risk of TPH increases with chorionic villus sampling, spontaneous or therapeutic abortion, ectopic pregnancy, amniocentesis, preeclampsia, external version, hemorrhage from placenta previa or abruption, cesarean section and manual removal of the placenta. When a TPH occurs, the mother/pregnant person develops antibodies to the Rh-positive fetal red blood cells (RBCs). The first Rh-incompatible pregnancy is rarely affected but in the subsequent pregnancies the mother/pregnant person mounts a secondary immune response to the fetal RBCs and large amounts of antibodies are produced. These antibodies cross the placenta and make fetal RBCs susceptible to destruction and are then destroyed by the fetal immune system, which leads to HDFN.

Clinical signs

The clinical signs of HDFN can range from very mild symptoms to death, in utero or shortly after delivery. These include:

- The fetal liver and spleen enlarge as they attempt to produce more fetal RBCs in response to hemolysis (breaking down of red blood cells). Nucleated RBCs can be observed in the fetal blood due to the release of immature erythrocytes (this gave rise to the name, *erythroblastosis fetalis*).
- In the worst cases, severe anemia leads to *hydrops fetalis*, which is characterized by severe edema that develops sometime after 18 weeks' gestation. Hydrops fetalis is caused by enlargement of the liver and spleen which leads to increased blood pressure in these organs and the fetus ultimately develops congestive heart failure and liver failure.
- After delivery, jaundice may occur due to an increase in RBCs. The infant cannot completely process the bilirubin, which was metabolized by the placenta and the mother before birth.

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- Kernicterus or bilirubin encephalopathy can occur as levels of unconjugated bilirubin increase to high levels. The bilirubin can accumulate in nerve tissues resulting in central nervous system damage and developmental problems that can include:
    - dental enamel abnormalities
    - high-frequency nerve deafness
    - athetoid cerebral palsy
    - intellectual disability
    - bleeding in the lungs
    - death

Treatment

Rh D immune globulin has been safely used for over 30 years and there are no reported adverse fetal effects. The action of Rhogam® is to suppress the mother's production of antibodies in response to receipt of the Rh-positive antigen. Passive immunity transmitted through immunization prevents the development of maternal antibody, specifically D antibodies that cause HDFN in subsequent pregnancies. When given the standard dose of 300 mcg at 28 weeks to Rh-negative mothers when the father of the baby's blood type is Rh positive or unknown and within 72 hours of delivery of a Rh-positive child, it has a success rate of greater than 99%. Women/pregnant people should also be given the mini-dose if they have early pregnancy miscarriage or heavy bleeding before antibody production begins and the mother/pregnant person becomes sensitized. When the father of the baby's blood type is confirmed by blood test to be Rh negative and there is no chance that anyone else could be the father, mother and baby are at very low risk of being affected and parents may choose to decline the Rh D immune globulin.

WE STRONGLY RECOMMEND FOLLOWING THESE GUIDELINES BECAUSE ONCE THE MOTHER HAS BECOME SENSITIZED TO THE RH FACTOR, THE PROCESS CANNOT BE REVERSED.

Rh D immune globulin is NOT administered to the newborn infant, to previously sensitized Rh-negative mothers, or to Rh negative mothers whose infant is Rh negative. It is NEVER given to Rh D positive or Du positive women. Rh D immune globulin will reduce the effectiveness of any live virus vaccine taken within 3 months of injection. Live vaccines include measles, mumps, rubella (MMR), oral polio, typhoid, chickenpox (varicella), BCG (Bacillus Calmette and Guérin), and nasal flu vaccine.

After vaccination, get emergency medical help if you have any of these signs of an allergic reaction: hives; difficulty breathing; swelling of your face, lips, tongue, or throat.

Call birth center at (505) 924-2229 or the midwife on call at (505) 944-5488 at once if you have any of these serious side effects:

- fever, chills, or shaking
- urinating less than normal/a change in color of your urine
- sudden weight gain, swelling in your hands, feet, or ankles
- back pain
- shortness of breath

Less serious side effects may include:

- muscle aches or pains
- headache; feeling tired or light-headed
- nausea, vomiting; or pain or tenderness where the injection is given

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Seasonal Flu Vaccine Consent Info

The flu shot (inactivated vaccine) given during pregnancy has been shown to protect both the mother and baby (up to 6 months old) from flu. **The nasal spray vaccine should not be given to people who are pregnant.** Flu is more likely to cause severe illness in pregnancy. Changes in the immune system, heart, and lungs during pregnancy make pregnant women more prone to severe illness from flu as well as hospitalizations and even death. A pregnant person with flu also has a greater chance for serious problems for their unborn baby, including miscarriage or preterm birth. We offer the preservative free (no thimerosal, mercury) flu vaccine for those who want it. If you get sick with flu-like symptoms call your midwife and we will prescribe an antiviral medicine that treats the flu.

Ways to prevent the flu include:

- Avoid close contact with people who are sick.
- Stay home when you are sick. Reschedule your prenatal appointments.
- Cover your mouth and nose. Consider wearing a face mask.
- Clean your hands. Wash them frequently with soap and water or alcohol-based hand rub.
- Avoid touching your eyes, nose or mouth which can spread germs.
- Practice other good health habits. Get plenty of sleep, be physically active, manage your stress,
- Drink plenty of fluids and eat nutritious food.

Influenza (the flu) is a serious illness, especially when you are pregnant.

Getting the flu can cause serious problems when you are pregnant. Even if you are generally healthy, changes in immune, heart, and lung functions during pregnancy make you more likely to get seriously ill from the flu. If you are pregnant and you get the flu, you are at higher risk of hospitalization, and even death. Severe illness in the pregnancy can also be dangerous to the fetus because it increases the chance for serious problems such as premature labor and delivery.

The flu shot is the best protection for you and your baby.

When you get your flu shot, your body start to make antibodies that help protect you against the flu. Antibodies can be passed on to your unborn baby, and help protect the baby for up to 6 months after he or she is born. This is important, because vaccines do not work in babies younger than 6 months. At this age, babies will not develop sufficient immune response, so they can't get the flu vaccine until they are 6 months old. If you breastfeed your infant, antibodies may also be passed in breast milk. It takes about two weeks to make antibodies after getting the flu vaccine.

The flu shot is safe for you, for your unborn child and during breastfeeding.

Flu shots have been given to millions of pregnant women over many years with a good safety record. There is a large body of scientific evidence that supports the safety of the flu vaccine for pregnant women and their babies. In 2010 -2011 there was a study that women who received shots both years that had an increased risk of early miscarriage 28 days following the second vaccine. This is currently under further study. You can receive the flu shot at any time, during any trimester, while you are pregnant. The inactivated (killed) vaccine is the only form that is recommended for you during pregnancy. The "flu shot" is given by injection into the muscle. The influenza viruses are always changing, so a new vaccine is made each year with the viruses most likely to cause flu that year. It is recommended to get annual vaccination.

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The side effects of the flu vaccine are mild when compared to the disease itself.

After getting your flu shot, you may experience some mild side effects. The most common side effects include soreness, tenderness, redness and/or swelling where the shot was given. Sometimes you might have headache, muscle aches, fever, and nausea or feel tired. If the side effects occur, they usually begin soon after the vaccine and last for 1-2 days.

If you have flu-like symptoms--even if you have already had a flu shot--call your provider because medicine can be prescribed that can lessen the chance of serious illness. These medicines must be started as soon as possible. Symptoms include: fever, cough, sore throat, headache, body aches, runny or stuffy nose, vomiting, or diarrhea.

Pertussis/Whooping Cough

Pertussis, also known as whooping cough, is an acute infectious disease caused by the bacterium *Bordetella pertussis*. It was the most common childhood disease in the US before the availability of the vaccine in the 1940s. Pertussis is primarily a toxin-mediated disease. The bacteria attach to the hairs in the lung cells and produce toxins that paralyze these hairs. This causes inflammation and interferes with the clearing of mucous that leads to the characteristic high-pitched whooping sound of the cough.

How is it transmitted?

Pertussis is spread easily by contact with infected mucous and breathing air after someone coughs or sneezes. It is harder to get it from contact with freshly contaminated articles of an infected person. About 80% of those who come in contact with the bacteria will become infected. The incubation period is commonly 7-10 days, with a range of 4-21 days, and rarely may be as long as 42 days. Persons are most infectious during the first stage of the disease or about 21 days.

What are the symptoms?

The disease is divided into 3 stages: the infectious, the coughing and the recovery. The infectious stage is characterized by the onset of runny nose, sneezing, low-grade fever and a mild, occasional cough, similar to the common cold. The cough gradually becomes more severe, and after 1-2 weeks the second stage begins.

The coughing stage is when most people are diagnosed with pertussis. It is characterized by bursts of numerous rapid coughs due to the difficulty expelling thick mucus from the lung tubes. At the end of these bursts is the high-pitched whoop while breathing in. Vomiting and exhaustion commonly follow the episode. These attacks occur more frequently at night with an average of 15 attacks in a 24-hour period. This stage usually lasts 1-6 weeks but may persist for up to 10 weeks. Infants less than 6 months of age may not have the strength to have a whoop but will have the episodes of coughing.

The recovery stage is gradual and the cough disappears in 2-3 weeks but often recurs in subsequent respiratory infections for many months.

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What are the possible complications?

The most common complication, and the cause of most pertussis-related deaths, is secondary bacterial pneumonia. Young infants are at the highest risk for acquiring pertussis-associated complications. Neurologic complications include seizures and diseases of the brain due to lack of oxygen from coughing or possibly from the toxin. Up to 12% of infants younger than 6 months of age had complications. Of the deaths that occur, 83% are in infants 3 months old or younger.

How is it diagnosed and treated?

The diagnosis of pertussis is based on characteristic clinical history (cough for more than 2 weeks with whoop) and a variety of lab tests. There is no one test that is 100% accurate. Culture is the best test but the bacteria is difficult to culture and it is most accurate in the first 3-4 weeks of the illness. The cultures may take up to 2 weeks for results. There are faster tests but there may be high false-positive results in some labs and if the specimen was not collected properly. There are tests that can detect if you have been exposed to pertussis but unfortunately, they do not reliably predict how much immunity one has. The best way to treat pertussis is to try to relieve the symptoms and sometimes antibiotics can be helpful.

How is pertussis prevented?

Vaccination is the key to prevention. Infants are recommended to begin the **DTaP** primary series at 2, 4 and 6 months of age with boosters at 15-18 months and 4-6 years. **Tdap** is the adult booster that is given at 11-12 years and at least once in adulthood. The **Tdap** vaccine contains tetanus toxoid, a reduced amount of diphtheria toxoid compared to DTaP and acellular pertussis (inactivated *B. pertussis* toxins instead of whole cells). Having pertussis does not produce permanent immunity and those persons should receive a Tdap booster also.

Tdap **should not be given** to persons with a history of a severe allergic reaction to a vaccine component or persons with a history of seizures or brain disorder occurring within 7 days after getting a pertussis vaccine.

It is to be used with **caution** in the following situations:

- History of Guillain-Barre syndrome within 6 weeks after a previous dose of tetanus toxoid containing vaccine and a progressive neurologic disorder (such as uncontrolled epilepsy or progressive brain disease) until the condition has stabilized.
- Persons with a history of a severe local reaction following a prior dose of a tetanus and/or diphtheria toxoid-containing vaccine should generally not receive Tdap or Td vaccination until at least 10 years have elapsed after the last Td-containing vaccine.
- Moderate or severe acute illness is a precaution to vaccination. Persons for whom vaccination is deferred because of moderate or severe acute illness should be vaccinated when their condition improves.

These conditions **are not a contraindication** to Tdap vaccination for adolescents or adults:

- An adverse reaction to DTaP in childhood (temperature of 105° F or higher, collapse or shock-like state, persistent crying or convulsions with or without fever, or excessive limb swelling).
- A stable neurologic disorder such as controlled seizures or cerebral palsy.
- Pregnancy, breastfeeding and immunosuppression.

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The safety of Tdap vaccines is well established and no serious adverse reactions have been attributed to Tdap. The most common reactions to the vaccine can include:

- Pain (66%), redness (25%), or swelling (21%) at the injection site.
- Temperature of 100.4° F or higher was reported by 1.4% of recipients.
- Headache, fatigue and gastrointestinal symptoms.

Special Considerations for Pregnancy

New Mexico has experienced pertussis rates of epidemic proportion since 2011. In 2017, New Mexico rates of pertussis (9.4 cases per 100,000 persons) have declined slightly but are still above the national average of 5.8 cases per 100,000 persons. Infants less than 12 months of age are more affected by pertussis than the rest of the population and had 55.5 cases per 100,000 persons.

Pertussis can cause serious and sometimes life-threatening complications in infants, especially within the first 6 months of life. In infants younger than 1 year of age who get pertussis, more than half must be hospitalized. The younger the infant, the more likely treatment in the hospital will be needed. Of those infants who are hospitalized with pertussis about 1 in 5 will get pneumonia and 1 in 100 will die.

On Oct. 24, 2012, the Advisory Committee on Immunization Practices (ACIP) committee recommended that all pregnant women should be given a dose of Tdap during each pregnancy. If not administered, during pregnancy, "Tdap should be administered immediately postpartum." Optimally, you should receive Tdap between 27 and 36 weeks of gestation, to maximize the maternal antibody response and passive transfer of antibodies to the infant. The work group concluded that Tdap maternal pertussis antibodies would wane greatly between subsequent pregnancies, and that a single Tdap dose during one pregnancy was not sufficient to provide adequate protection for subsequent pregnancies.

October 2017: A CDC study in Clinical Infectious Diseases found that maternal Tdap vaccination during the third trimester prevented 78% of pertussis cases among infants younger than 2 months, as well as 90% of hospitalizations among those who developed whooping cough. However, the findings showed that only 49% of pregnant women who gave birth between fall 2015 and spring 2016 received the vaccine.

Current recommendations

Every pregnant woman/birthing person **should receive a dose of the Tdap vaccine between 27-36 weeks of gestation, even if she has received the vaccine previously.** If you do not get the vaccine during pregnancy, she should receive it immediately postpartum.

Safety of Tdap for the mother/birthing person and infant

ACIP concluded that there is no elevated frequency or an unusual occurrence of adverse events among pregnant women who have received Tdap vaccine, or in their newborns. Tdap vaccine is recommended after 20 weeks' gestation because that optimizes antibody transfer and protection at birth. **The immune response to the vaccine peaks two weeks after administration.**

Both tetanus and diphtheria toxoids (Td) and tetanus toxoid (TT) vaccines have been used extensively in pregnant women worldwide since the 1960s to prevent neonatal tetanus. Td and TT vaccines administered during pregnancy have not been shown to harm either the mother/pregnant person or baby/fetus. There are currently no pertussis vaccines licensed or recommended for newborns at birth. The best way to prevent pertussis in a young infant is by vaccinating the mother during pregnancy.

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Vaccination During Pregnancy is Ideal

Transplacental transfer of maternal pertussis antibodies from mother to infant may provide protection against pertussis in early life, before beginning the primary DTaP series. There is evidence of efficient transplacental transfer of pertussis antibodies to infants. The effectiveness of maternal antibodies in preventing infant pertussis is not yet known, but pertussis antibodies can protect against some disease and the severe outcomes that come along with it. **And, if you're vaccinated with Tdap vaccine during pregnancy, you will also yourself be protected at time of delivery and will be less likely to transmit pertussis to your newborn infant.**

By getting your Tdap vaccine during pregnancy, your infant will gain pertussis antibodies during the most vulnerable time – before three months of age. However, providing this early immunity may also interfere with the infant's immune response to DTaP vaccine. The infant's immune response to DTaP may not be as strong, but the clinical implications may not be significant. The benefits of vaccinating during pregnancy and protecting a newborn outweigh the potential risk of blunting the infant's response to DTaP vaccine. Since infants are at greatest risk of severe disease and death from pertussis before 3 months of age – when their immune systems are least developed – any protection that can be provided is critical. Infants should receive their DTaP vaccines on schedule, starting at 2 months of age.

Tetanus/Diphtheria/Pertussis (Tdap) Vaccine Consent Info

Tetanus (Lockjaw)

- Tetanus is caused by bacteria that enters the body through cuts, scratches, or wounds.
- It causes painful muscle spasms, usually all over the body. It can lead to tightening of the jaw muscles so the victim cannot open their mouth or swallow.
- It kills about 1 out of 5 people who are infected.

Diphtheria

- Diphtheria is caused by bacteria which causes a thick covering in the back of the throat.
- It can lead to breathing problems, paralysis, heart failure, and even death.

Pertussis (Whooping Cough)

- Pertussis is caused by bacteria, and causes severe coughing spells, vomiting, and disturbed sleep.
- It can lead to weight loss, incontinence, rib fractures and passing out from violent coughing. Up to 2 in 100 adolescents and 5 in 100 adults with pertussis are hospitalized or have complications, including pneumonia.

Who should get vaccinated?

- Persons aged 11 through 64 years who have completed a childhood DTP/DTaP series but who have not previously received Tdap.
- Adolescents and adults (e.g., parents, siblings, grandparents including over age 65, child-care providers, and health-care personnel) who have or anticipate having close contact with an infant aged less than 12 months should receive a single dose of Tdap to protect against pertussis if they have not previously received Tdap. Ideally, these adolescents and adults should receive Tdap at least 2 weeks before beginning close contact with the infant.

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- Pregnant people who previously have not received Tdap. It should be given during the third or late second trimester (after 20 weeks' gestation). If not administered during pregnancy, Tdap should be administered immediately postpartum. Tetanus and diphtheria-toxoid containing vaccines administered during pregnancy have not been shown to be teratogenic. Infants get some protection from pertussis in early life and before beginning the primary DTaP series from maternal antibodies that are transferred across the placenta.

What are the risks from the Tdap vaccine?

Mild Problems (noticeable, but shouldn't interfere with activities)

- Pain (about 3 in 4 adolescents and 2 in 3 adults)
- Redness or swelling (about 1 in 5)
- Mild fever of at least 100.4°F (up to about 1 in 25 adolescents and 1 in 100 adults)
- Headache (about 4 in 10 adolescents and 3 in 10 adults)
- Tiredness (about 1 in 3 adolescents and 1 in 4 adults)
- Nausea, vomiting, diarrhea, stomach ache (up to 1 in 4 adolescents and 1 in 10 adults)
- Chills, body aches, sore joints, rash, swollen glands (uncommon)

Moderate Problems (May interfere with activities, but shouldn't require medical attention)

- Pain at the injection site (about 1 in 20 adolescents and 1 in 100 adults)
- Redness or swelling (up to about 1 in 16 adolescents and 1 in 25 adults)
- Fever over 102°F (about 1 in 100 adolescents and 1 in 250 adults)
- Headache (1 in 300)
- Nausea, vomiting, diarrhea, stomach ache (up to 3 in 100 adolescents and 1 in 100 adults)
- Extensive swelling of the arm where the shot was given (up to about 3 in 100).

Severe Problems (Unable to perform usual activities; require medical attention)

- Two adults had nervous system problems after getting the vaccine during clinical trials. These may or may not have been caused by the vaccine. These problems went away on their own and did not cause any permanent harm.
- Swelling, severe pain, and redness in the arm where the shot was given (rare)
- A severe allergic reaction could occur after any vaccine. They are estimated to occur less than once in a million doses.

What should I look for if there is a severe reaction?

- Any unusual condition, such as a high fever or behavior changes. Signs of a severe allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness. If this happens, call a doctor or get the person to a doctor right away.
- Tell the doctor what happened, the date and time it happened, and when the vaccine was given.
- Ask your provider to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form. Or you can file this report through the VAERS website at www.vaers.hhs.gov, or by calling (800) 822-7967. VAERS does not provide medical advice.

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Breastfeeding after Tdap Vaccination

Breastfeeding is not a contraindication for receiving Tdap vaccine. Tdap vaccine can and should be given to those who plan to breastfeed. Breastfeeding is fully compatible with Tdap vaccination and preventing pertussis in mothers can reduce the chance that the infant will get pertussis. Also, breastfeeding can pass antibodies made in response to the Tdap shot on to infants, which may reduce an infant's chances of getting sick with pertussis. This is especially important for infants younger than 6 months of age, who have no other way of receiving enough pertussis antibodies, since they are not fully protected until their third dose of DTaP vaccine at 6 months of age.

Cocooning

The strategy of protecting infants from pertussis by vaccinating those in close contact with them is known as "cocooning." ACIP has recommended cocooning with Tdap vaccine since 2005 and continues to recommend this strategy for all those with expected close contact with newborns. Cocooning enhances maternal vaccination to provide maximum protection to the infant. Close contacts including fathers, grandparents and other caregivers are recommended to get the Tdap vaccine at least two weeks before coming into contact with their infants. Full implementation of cocooning has proven to be a challenge; vaccinating during pregnancy provides the best opportunity to protect infants from pertussis.

Epidemiology and Prevention of Vaccine-Preventable Diseases, 12th Edition, May 2011. *U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.*

CDC Vaccines and Preventable Diseases. *Tdap for Pregnant Women: Information for Providers*. Updated Jan 25, 2015. *www.cdc.gov/vaccines/vpd-vac/pertussis/tdap-pregnancy-hcp.htm*. Retrieved on 6/2/16.

Routine Screenings at Each Visit

- **Urine sample**: You will need to give a urine sample at your first visit. If you are having symptoms of burning with urination, please leave a sample. Be sure to drink fluids before you come in. This test shows if you drink enough water, have a urine or bladder infection, or have other problems while pregnant.
- **Weight:** You will weigh yourself at each visit and let your midwife know your weight to see if you are gaining within the recommended amount. If you gain or lose too much, you may be referred to a nutritionist. (See **"Weight Gain Guide and Graph"** for more info.)
- **Blood pressure (B/P):** You will have your blood pressure checked at each visit. This tells us if you are at risk for high blood pressure while you are pregnant.
- **Fundal height:** The midwife will measure the height of your growing uterus. This tells us that the baby is growing adequately. Normal range is 2 centimeters, plus or minus how many weeks of pregnancy you are.
- **Fetal heart rate:** Before 10-12 weeks, it can be very difficult to hear a heartbeat but after that, we will listen at every visit.

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Tests During Pregnancy

First Visit Tests

- **Blood Type:** This test is usually done at your first visit and checks your blood type in case you need to be given blood. If you have a negative blood type, you will be offered Rhogam® or Rhophylac® [Rho (D) Immune Globulin], a shot to prevent problems while you are pregnant and in your next pregnancy.
- **CBC or Blood Count:** This test is done at your first visit and tells us if you have anemia. If you are anemic, you will get information on diet and supplements to help to raise your iron levels.
- **Genetic Prenatal and Carrier Screening:** These tests are optional and some can be done anytime in pregnancy. There are blood and ultrasound screening test you can choose that detect some but not all genetic defects.
- **Gonorrhea, Chlamydia and Syphilis:** You will be checked for infections that you can get from another person during sex. Many people do not have any signs of these infections. These infections can cause serious problems for you, your partner and your baby. If you have an infection, you and your partner need treatment.
- **Hepatitis B & C:** A blood test is done to check for this viral infection that affects your liver. You can get it through sexual contact or when exposed to infected blood or body fluids. It is more common than AIDS and can be as deadly. There is a vaccine for Hepatitis B but not for Hepatitis C.
- **HgbA1c:** The hemoglobin A1c blood test will be done at your first visit to determine your average glucose levels for the past 3 months. A random glucose will also be drawn at the first visit.
- **HIV testing:** This blood test is routinely done unless you refuse it. The test tells whether you have HIV, the virus that causes AIDS. If you test positive while pregnant, you can be given medicine to reduce the risk of your baby getting HIV.
- **Pap test or smear**: This test checks for changes in the cells of the cervix (the opening of your uterus). If your pap is abnormal, you may need another test called a colposcopy. This test looks at the cells to see if they could turn into cancer.
- **Rubella:** This is a blood test to check if you are immune to rubella (German measles). If your antibody levels are low, we will inform you about the risks and offer the MMR vaccine after you deliver your baby. Please talk to your midwife if you have had contact with anyone having rubella.
- **Vitamin B12 / Folate:** This is a blood test to check if you have a deficiency of vitamin B12 or folic acid which can cause anemia. Those who follow a vegan/vegetarian diet or have a MTHFR mutation are most at risk. Those who have a B12 deficiency that does not respond to treatment are not eligible to use Nitrous Oxide in labor.
- **Vitamin D:** We have found that almost everyone is deficient in vitamin D. We recommend that everyone supplements with Vitamin D 4000 iu daily through pregnancy and breastfeeding. You produce Vitamin D when your skin is exposed to the sun or get it through supplements and fortified foods.

26-28 Weeks Tests

- **Hematocrit and Hemoglobin:** This blood test is done around 24 to 28 weeks to check for anemia (low iron). If you are anemic, you will get information on diet and supplements to help to raise your iron levels.
- **Syphilis**: As of January 2020, the state of New Mexico requires that all clients be screened again for syphilis at 26-28 weeks of pregnancy. (See **"Syphilis"** below for more information.)

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- **Blood Type:** This test is repeated if you are Rh negative. We strongly recommend Rhogam®, a shot to prevent formation of antibodies against other blood types while you are pregnant and in your next pregnancy.
- **Glucose test:** All birth center clients must be screened for gestational diabetes between 26-28 weeks of pregnancy. Uncontrolled gestational diabetes can cause serious problems for both you and your baby. If your test is abnormal, you will be referred to a perinatologist for diabetic diet counseling and to monitor fetal growth. You may continue your care at the birth center as long as you can control the diabetes with diet and exercise and do not need medications. Testing can be done several ways:

  - Non-fasting 1-hour glucose tolerance blood test (GTT) and if abnormal (≥130), followed by a fasting 3-hour GTT
    OR
  - Fasting 2-hour GTT
    OR
  - Monitoring of blood glucose 4 times daily with diet recall for 1-2 weeks and if abnormal, followed by a fasting 3-hour GTT or referral to diet counseling.

Instructions for Glucose Testing

Instructions For 1-Hour GTT

1. Eat your normal diet. Keep hydrated.
2. Bring a protein snack to eat after your test is done.
3. When you arrive for your appointment, you will be given a 50-gram glucose drink. You have a choice of a fruit flavored glucola (contains food coloring and preservatives) furnished by the lab OR you can request a prescription in advance for a 50-gram glucose powder (without food coloring or preservatives) which can be purchased for $10 from Sam's Regent Pharmacy (located at 7120 Wyoming Blvd NE). Bring the bottle of glucose powder to your visit so that it can be diluted with water. Drink it quickly (within 5 minutes).
4. Tell the nurse what time you finished drinking the glucola so we can draw your blood an hour later.

Instructions For 2-Hour GTT

1. You will need to fast for 10 hours prior to your appointment. You can have water to drink during this time, but nothing else. Bring a protein snack to eat after your test is done.
2. When you arrive for your appointment, we will draw a fasting blood glucose level and then you will be given a 75-gram glucose drink. You have a choice of a fruit flavored glucola (contains food coloring and preservatives) furnished by the lab OR you can request a prescription in advance for a 75-gram glucose powder (without food coloring or preservatives) which can be purchased for $10 from Sam's Regent Pharmacy (located at 7120 Wyoming Blvd NE). Bring the bottle of glucose powder to your visit so that it can be diluted with water. Drink it quickly (within 5 minutes).
3. Tell the nurse what time you finished drinking the glucola so we can draw your blood at 1 and 2 hours later.

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Instructions For 3-Hour GTT

1. You will need to fast for 10 hours prior to your appointment. You can have water to drink during this time, but nothing else. Bring a protein snack to eat after your test is done.
2. When you arrive for your appointment, we will draw a fasting blood glucose level and then you will be given a 100-gram glucose drink. You have a choice of a fruit flavored glucola (contains food coloring and preservatives) furnished by the lab OR you can request a prescription in advance for a 100-gram glucose powder (without food coloring or preservatives) which can be purchased for $10 from Sam's Regent Pharmacy (7120 Wyoming Blvd NE). Bring the glucose powder to your visit so that it can be diluted with water. Drink it quickly (within 5 minutes).
3. Tell the nurse what time you finished the glucola so we can draw your blood 1 and 2 hours later.

Syphilis

Syphilis is a sexually transmitted infection that can cause serious health problems if it is not treated. You can get syphilis by direct contact with a syphilis sore during vaginal, anal, or oral sex. You can find sores on or around the penis, vagina, or anus, or in the rectum, on the lips, or in the mouth and it may not be obvious that a sex partner has syphilis.

Symptoms

Syphilis is divided into stages (primary, secondary, latent, and tertiary), with different signs and symptoms associated with each stage. A person with primary syphilis generally has a sore or sores at the original site of infection. These sores usually occur on or around the genitals, around the anus or in the rectum, or in or around the mouth. These sores are usually (but not always) firm, round, and painless and may last 3 to 6 months. Symptoms of secondary syphilis include skin rash, swollen lymph nodes, and fever. The signs and symptoms of primary and secondary syphilis can be mild, and they might not be noticed. During the latent stage, there are no signs or symptoms. Tertiary syphilis is associated with severe medical problems. A doctor can usually diagnose tertiary syphilis with the help of multiple tests. It can affect the heart, brain, and other organs of the body.

Prevention

If you are sexually active, you can do the following things to lower your chances of getting syphilis:

- Know the testing and treatment history of any sex partner(s).
- Be in a long-term mutually monogamous relationship with a partner who has been tested for syphilis and does not have syphilis;
- Use latex condoms the right way every time you have sex. Condoms prevent transmission of syphilis by preventing contact with a sore. Sometimes sores occur in areas not covered by a condom. Contact with these sores can still transmit syphilis.

Treatment

Syphilis can be cured with the right antibiotics from your health care provider. However, treatment might not undo any damage that the infection has already done. Having syphilis once does not protect you from getting it again. Even after you've been successfully treated, you can still be re-infected. Only laboratory tests can confirm whether you have syphilis. Follow-up testing by your health care provider is recommended to make sure that your treatment was successful.

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Pregnancy

Syphilis can also spread from an infected mother to her unborn child. All pregnant clients should be tested for syphilis at the first prenatal visit. Those who live in areas with high rates of syphilis should be tested again at the beginning of the third trimester, and again when your baby is born. Keep in mind that you can have syphilis and not know it because many people with syphilis do not have any symptoms. Also, syphilis symptoms may be very mild, or be similar to signs of other health problems. The only way to know for sure if you have syphilis is to get tested.

Syphilis can be treated and cured with antibiotics. If you test positive for syphilis during pregnancy, be sure to get treatment right away. You should have follow-up testing for at least one year to make sure that your treatment is working.

Congenital Syphilis (CS)

Congenital syphilis is a disease that occurs when a mother/pregnant person with syphilis passes the infection on to their baby during pregnancy. Syphilis may affect your pregnancy by causing miscarriage, stillbirth, premature birth, low birth weight or newborn death shortly after birth. When a baby is born with CS, the effects on your baby's health depend on how long you had syphilis and if — or when — you got treatment for the infection.

CS in newborns can cause:

- Deformed bones
- Severe anemia (low blood count)
- Enlarged liver and spleen
- Jaundice (yellowing of the skin or eyes)
- Brain and nerve problems, like blindness or deafness
- Meningitis
- Skin rashes

It is possible that a baby with CS won't have any symptoms at birth. Up to 40% of babies who do not get treatment for CS may be stillborn or die from the infection as a newborn. Usually, these health problems develop in the first few weeks after birth, but they can also happen years later. They may also be developmentally delayed or have seizures.

Diagnosis and Treatment

Your baby will need a blood test, a physical exam, or do other tests, such as a spinal tap or an x-ray, to determine if your baby has CS. Babies who have CS need to be treated right away — or they can develop serious health problems. Depending on the results of your baby's medical evaluation, he/she may need antibiotics in a hospital for 10 days. In some cases, only one injection of antibiotic is needed. It's also important that babies treated for CS get follow-up care to make sure that the treatment worked.

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Syphilis Screening Consent Info

Syphilis is a sexually transmitted infection that is spread by direct contact with a syphilis sore during vaginal, anal, or oral sex. You can find sores on or around the penis, vagina, or anus, or in the rectum, on the lips, or in the mouth. Syphilis is divided into stages (primary, secondary, latent, and tertiary) and there are different signs and symptoms associated with each stage that make is more difficult to diagnose. Syphilis can spread from an infected mother to her unborn child which is called congenital syphilis. Babies may not have any symptoms at birth but if not treated, they can have severe medical complications including death. Antibiotic treatment is recommended for syphilis positive mothers during pregnancy and may be needed for their babies after birth.

The most reliable way to detect syphilis is through a blood test. Labs are required to report syphilis positive tests to the New Mexico Department of Health (NMDOH) Sexually Transmitted Disease Program within 24 hours of diagnosis. The number of reported cases of primary and secondary syphilis among women and reported cases of congenital syphilis has increased every year since 2012 in the United States. The Centers for Disease Control and Prevention (CDC) reports more than 1,300 cases of congenital syphilis in 2018 in the United States resulting in severe health complications and deaths among newborns.

The CDC ranks New Mexico 6th among the nation for rates of primary and secondary syphilis in 2018, representing more than a 50% increase in the rate over 2017.

In 2018, New Mexico had the 8th highest rate of infants born with congenital syphilis in the United States, with 10 cases of congenital syphilis reported to the NMDOH, resulting in 2 deaths. From 2012 and 2017, New Mexico reported an average of 2 cases of congenital syphilis per year.

As of December 30, 2019, 23 cases of congenital syphilis among New Mexico residents have been reported to NMDOH. Congenital syphilis is preventable with screening and treatment during pregnancy of those found to have syphilis. Pregnant people have already been required to be tested for syphilis at their first prenatal examination.

The CDC recommends syphilis testing be repeated during the third trimester (28-32 weeks) and at the time of delivery in those who are at high risk for syphilis or live in areas with high rates of syphilis.

Dar a Luz complies with the January 10, 2020, New Mexico Department of Health mandatory order for additional syphilis screening.

1. Dar a Luz has always screened women/birthing people for syphilis at their initial prenatal visit. We also review records for clients who transfer into our care to make sure the screening was done at the initial prenatal visit.
2. The new syphilis screening requirement in the third trimester has been added to the gestational diabetes and anemia testing done at 26-28 weeks. This will be a requirement for care at Dar a Luz and you may not opt out.
3. Recommended screening at time of birth will be drawn at the time of an IV-start for those clients needing IV access. For all other clients, the labs may be drawn any time prior to discharge from the birth center. You may decline testing at birth if your initial and third trimester results were negative.
4. Anyone who transfers before labor, during labor or postpartum will automatically have this lab drawn on admission to the hospital.

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Group B Streptococcus (GBS) Screening Consent Info

GBS is a common bacterium in our environment and can be found in the vagina or rectum of about 25% of all healthy people. It is impossible to eradicate it from the body permanently and can return to a healthy system within hours of using antibiotics. It is a weak bacterium and only those with a susceptible immune system get colonized. This is not a sexually transmitted infection and people do not usually have any symptoms.

In 2019, the American College of Obstetricians and Gynecologists updated their recommended routine screening for GBS in all pregnant clients by taking a culture from the vaginal and rectal area to be done between 36 0/7 to 37 6/7 weeks of pregnancy. The results are usually available in one to two days. Those who test positive for GBS are said to be "colonized," and 50% of those will pass the bacteria to the baby. When birthing mothers are NOT treated with antibiotics in labor, 1-2% of those babies will develop GBS disease. In 2016, GBS disease affected about 0.22 newborns in every 1,000 live births in the United States. Preterm newborns are more affected by GBS disease than term babies with death rates of 19.2% for preterm compared to 2.1% for term babies.

Babies may experience early or late onset of GBS. Early onset is the most common. Late onset can occur within a week or a few months of delivery and meningitis is the most common symptom. Early onset symptoms include:

- Breathing problems, increased heart rate and unstable temperature occurring within hours of delivery;
- Babies tend to get sleepy and not feed well after birth;
- Gastrointestinal and kidney problems;
- Sepsis (infection of the blood), pneumonia and meningitis are the most common complications.

The recommended treatment is to give antibiotics for prevention and protection of the baby when labor begins and every 4 hours until delivery. This is usually Penicillin or Ampicillin or a different antibiotic if you are allergic to Penicillin. CDC recommends that clients with any of the following be treated during labor:

- A positive GBS culture during this pregnancy.
- A urinary tract infection as a result of GBS during your pregnancy.
- Labor or rupture of membranes before 37 weeks AND unknown GBS status.
- Rupture of membranes 18 hours or more before delivery AND unknown GBS status.
- Fever during labor AND unknown GBS status.
- A previous baby with GBS disease.

There is good research evidence to show that the recommended first-line antibiotic treatment with penicillin, ampicillin or cefazolin reach high enough levels in the amniotic fluid and fetal tissues to significantly decrease the potential for GBS disease. Penicillin works very well on GBS and does not kill a broad range of other bacteria which leaves most of the intestinal and vaginal flora intact. These antibiotics provide the best protection for the baby when they are given at least 4 hours before delivery. If you have a severe allergy to penicillin, you will be tested to see which antibiotic can be given (clindamycin or vancomycin). There is limited research data on how effective these second-line antibiotics are in reaching high enough levels in the amniotic fluid and fetal tissues but according to the CDC these antibiotics reduce the risk of GBS disease for the baby.

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There is no good research evidence to show that garlic in the vagina or Hibiclens vaginal washes are effective alternative treatment methods for GBS. GBS cultures after use of garlic in the vagina for a week have not come back negative. Although Hibiclens may decrease GBS in the vagina, is not as effective as penicillin because it only flushes the vagina and cannot cross the amniotic membranes. Antibiotics work to treat GBS in the mother and protect the baby by saturating the fetal tissues and amniotic fluid thereby giving the baby prophylaxis. Hibiclens also kills ALL bacteria in the vagina, even the good ones that the baby usually gets during birth and needs to establish healthy digestion. In addition, the Cochrane Database (where independent researchers go through thousands of randomized trails) makes this recent statement:

"Vaginal chlorhexidine (Hibiclens) resulted in a statistically significant reduction in GBS colonization of neonates, but was not associated with reductions in other outcomes. The review currently does not support the use of vaginal disinfection with chlorhexidine in labor."

The following alternative treatments are ineffective against GBS and should not be used:

- Oral or intramuscular antibiotics prior to or during labor
- Hibiclens bath or wipes
- Garlic cloves, capsules or suppositories, boric acid suppositories
- Douching with hydrogen peroxide, diluted bleach water, lavender oil or yogurt
- Propolis (targets salmonella not GBS)
- Tea tree oil (targets staph infections and lice, not GBS)
- Apple cider vinegar
- Colloidal silver

These alternative treatments strengthen the immune system but are ineffective against GBS:

- Vitamin C and herbal tea
- Echinacea
- Grapefruit Seed Extract
- Goldenseal root, Oregon grape root, Astragalus root, Burdock root, NF formula EHB. (Pregnant clients should not take any of these)
- Breastfeeding.
- Skin-to-skin contact

According to the CDC, if you have tested positive, your baby's chances of getting GBS disease are:

- **1 in 200 if antibiotics ARE NOT given**
- **1 in 4,000 if Penicillin, Ampicillin or Cefazolin antibiotics ARE given four hours prior to birth.**

If any of the second-line antibiotics (clindamycin or vancomycin) are given you will still get some benefit but not as much at the first-line antibiotics. Given these risks, we strongly recommend GBS testing of all mothers as well as treatment according to CDC guidelines for mothers that test positive during pregnancy.

Infants that get the recommended first-line treatment with penicillin, ampicillin or cefazolin 4 hours before birth and meet birth center discharge criteria are offered discharge 4 hours after birth with specific home instructions for parents to watch for signs of infection and follow-up care by the midwife at a home visit in 24-48 hours.

Infants who do not get the recommended first-line treatment for the appropriate amount of time or infants that receive the second-line antibiotics are considered inadequately treated. In these cases, the

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CDC recommends observation for 48 hours in the hospital to watch for signs of infection and to have access to the lab tests and treatments necessary if an infection develops. We strongly recommend one of these options:

1. Observation of the infant for 48 hours at the hospital to watch for signs of infection. We may be able to arrange for mother and baby to be together at UNM.

2. Observation of the mother and baby for 12 hours at the birth center with specific home instructions for parents to watch for signs of infection and follow-up care by the midwife at a home visit in 24-36 hours.

The Human Microbiome: Pregnancy, Birth, Postpartum, and Newborn

The more we understand about the human microbiome the more it seems fundamental to our health. Pregnancy, birth and breastfeeding seed our microbiome and therefore have a long-term effect on health. More research is needed to explore how best to support healthy seeding and maintenance of the microbiome during this key period. Dar al Luz sponsored the showing of “Microbirth” in 2014 but you can see it online at www.microbirth.com/the-film/

We once thought that fetal meconium was sterile but research has now established that there is maternal transmission of bacteria into the fetal gut during pregnancy and that the maternal diet in the last trimester of pregnancy influences the microbiome the most. So, it is important for the mother to have a healthy microbiome to keep her healthy and to transfer healthy bacteria to the baby. Antibiotic use during pregnancy and labor can alter the microbiome of mother and baby and show alterations in the baby’s microbiome for up to a year. A healthy microbiome has been associated with less gestational diabetes, lower fasting blood sugars, less pre-eclampsia, fewer GBS+ cultures, less mastitis and less risk of eczema and colic in offspring.

Probiotics may decrease the risk of becoming GBS positive

According to Dr. Low Dog, an internationally recognized expert in the fields of dietary supplements, herbal medicine, women's health and natural medicine, focusing on probiotics early in pregnancy is one of the safest and most promising strategies for prevention of GBS colonization. A small study of Florajen 3 in pregnancy showed lower colonization counts and those with higher adherence had lower chance of being GBS positive (Hanson 2014). She recommends, taking one orally each day (starting at 26 weeks) and then consider using another product with multiple Lactobacillus and Bifidobacterium strains. This can be taken orally at night and sprinkled on a panty liner each night before bed. When clients test positive for GBS and antibiotics are used in labor, mothers/birthing people and babies could benefit from starting on probiotics shortly after birth. Recommendations suggest that the baby should stay on the probiotics for 6-12 months. See more info from Dr. Low Dog at www.drlowdog.com/resources/

Probiotics containing *L reuteri DSM 17938* (commercially available in BioGaia ProTectis – sold at Dar a Luz) have been shown in small studies to be effective in building a healthy microbiome in infants after cesarean section that is similar to infants born vaginally. It is also helpful in restoring a healthy gut in infants after antibiotic use in labor or afterwards and for infants with colic.

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A small randomized control trial in Taiwan in 2016 showed that women who were GBS+ at 35-37 weeks of pregnancy took 2 capsules of probiotics at bedtime containing L rhamnosus GR-1 and L reuteri RC-14 for 20 days. (These are commercially available in Jarrow Formulas Fem-Dophilus and ProB RePhresh). 43% of the probiotic group vs 18% of the placebo group changed to GBS negative. The study suggests that longer treatment may be more beneficial.

Ho, et al. (2016) Taiwanese Journal of ObGyn 55 (4), 515-518. Based on the current research, increasing dietary fiber and consuming more raw fermented foods with active cultures during pregnancy and starting these probiotics at 30 weeks of pregnancy have been suggested as beneficial in establishing healthy gut flora that may decrease the rates of GBS positive during pregnancy. These probiotics also improved the cure rates for bacterial vaginosis and vaginal yeast infections by helping to restore the gut flora and in turn, the vaginal flora.

Luoto et al (2010). British Jo Nutrition, 103(12), 1792-1799, found that taking *L Rhamnosus GG* and *B Lactis Bb12* during pregnancy reduced the incidence of gestational diabetes by three-fold and also reduced fetal macrosomia (babies weighing over 4500 gm). These strains taken during pregnancy and lactation have also been shown to decrease eczema in infants and may be helpful to decrease asthma and food allergies.

Although some trials have reported very promising results of probiotics improving health, the results should be reproduced in more well-designed and larger trials before use of this therapy is considered. There is no clear evidence of benefit or harm with the use of probiotics in healthy clients. In addition, further investigation is needed to determine the optimum route of administration (oral or vaginal), which strains or combination of strains are most effective and the dose and duration of use. Probiotics are not regulated by the US Food and Drug Administration (the FDA) the way standard medicines are. That means that the companies that package probiotics don't have to prove that the ingredients listed on the label are actually in the bottle. There are many options available on the market and it can be overwhelming trying to find where to start. We have looked for good options too but there is little evidence to guide us.

Some of the products we have reviewed are:

- Jarrow Formulas, Fem-Dophilus
- ProB, RePhresh
- BioGaia ProTectis for the baby
- Hyperbiotics, PRO-Moms

Suggestions for pregnancy

- Eat fermented foods like kombucha, kefir, yogurt, kimchi and sauerkraut
- Probiotics may be helpful to establish and restore your microbes
- Minimize stress, include positive thoughts and relaxing massages
- Avoid antimicrobial skin products and house cleaning agents
- Avoid unnecessary medications, especially antibiotics
- Stop smoking

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Suggestions for birth

- Vaginal birth in mother's own environment is optimal for seeding the baby's microbiome.
- Minimize the physical contact by others of the mother's vagina, perineum and baby during birth.
- Avoid unnecessary antibiotics in labor. If necessary, consider mother and baby taking probiotics.
- If the baby is born by c-section, consider vaginal swabs to "seed" the baby. Gauze is placed in the healthy vagina (not GBS+ or any other infections present) for an hour then at the time of birth the gauze is applied to the baby's mouth, face and body.
- Consider probiotics for mother and baby after c-section birth.

Suggestions for postpartum and newborn

- Majority of time after birth and for the first week of life, you and your baby should be skin to skin
- Don't bathe the baby in the first 24 hours and thereafter only use water for the first 4 weeks of life
- If in the hospital, only use your own linens from home for the baby
- Minimize non-family handling of the baby and especially skin to skin contact in the first week of life
- Exclusive breastfeeding. Take probiotics if baby is supplemented with formula
- Avoid giving baby unnecessary antibiotics. If needed, give probiotics.
- Probiotics may help babies suffering from colic and gas.
- Babies exposed to cats and dogs have a more diverse flora

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Prenatal Genetic Screening Consent Info

The American College of Obstetrics and Gynecologists and March of Dimes both recommend that all clients are offered accurate information in order to make appropriate decisions regarding the various forms of genetic screening and diagnostic testing available in pregnancy. While the midwives at Dar a Luz Birth & Health Center are not genetic counselors, we are willing to provide basic recommendations for testing according to national standards of care. We are now able to offer genetic screening through a company called NxGen MDx. Our intent in offering genetic and carrier screening at Dar a Luz is to decrease the high cost of outside screening and counseling, rates of intervention and increased anxiety that can be associated with seeing a perinatology group. If you have a personal preference or a medical indication, we can refer you to a local perinatology group for screening and counseling. Your midwife can discuss your questions and give recommendations at your first prenatal appointment or anytime in pregnancy. Please read the following information carefully and decide which option(s), if any, are right for you and your family.

What is Carrier and Prenatal Chromosome Screening?

According to current recommendations, everyone who is pregnant or considering pregnancy should be offered these two types of genetic screening:

1. Carrier Screening is a blood test used to detect inheritable genetic conditions that can be related to your ethnicity or family history. It can be done before or anytime during pregnancy.

2. Prenatal Chromosome Screening is a blood test used to detect extra or missing chromosomes in conditions including Down syndrome, Patau syndrome and Edwards syndrome and sex chromosome conditions. This test is available as early as 10 weeks or anytime thereafter in pregnancy.

Carrier Screening

This blood test can determine if a client or reproductive partner is a carrier of an inheritable condition that could be passed on to the baby (the most common example of a carrier disease is cystic fibrosis). Both reproductive partners have to be a carrier for the condition to affect the baby. This test uses whole-gene sequencing to look at the entire gene to give a high degree of accuracy for estimating the risk for genetic conditions. Results are available in about 7-10 days.

There are over 100 inheritable conditions that can be detected through carrier screening. Because it is difficult to determine your exact heritage and risk associated with ancestry, Dar a Luz recommends the Universal Panel to screen for the 20 most common conditions found across multiple ethnicities, specifically Ashkenzai Jewish, African American and Mediterranean descent. One in 6 people in the United States are a carrier of one of these 20 diseases, although the incidence of affected offspring is much lower.

If you test positive, NxGen MDx offers carrier screening to your partner at no cost in order to determine the risk of passing on that carrier disease to your child. If you and your partner are both positive, you also have access to free telephone genetic counseling with NxGen MDx.

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Tests included in the Universal Advantage Panel

1. ABCC8-Related Hyperinsulinism
2. Bloom Syndrome
3. Canavan Disease
4. Cystic Fibrosis and CFTR-Related Disorders
5. Dihydrolipoamide Dehydrogenase Deficiency
6. Fanconi Anemia Type C
7. Familial Dysautonomia
8. Fragile X and FMR1-Related Disorders
9. Gaucher Disease
10. Glycogen Storage Disease Type 1a
11. Joubert Syndrome 2
12. Maple Syrup Urine Disease Type 1a, 1b
13. Mucolipidosis IV
14. NEB-Related Nemaline Myopathy
15. Niemann-Pick Disease Type C
16. Spinal Muscular Atrophy
17. Tay-Sachs Disease
18. Usher Syndrome Type 1F
19. Usher Syndrome Type 3
20. Walker-Warburg

Additional panels can be added to screen for hematological conditions including:

1. Alpha Thalassemia
2. Glucose-6-Phosphate Dehydrogenase Deficiency
3. Beta Thalassemia
4. Sickle Cell Disease

Prenatal Chromosome Screening/Cell-Free DNA/Non-Invasive Prenatal Screening

Prenatal Chromosome Screening is available to all clients as early as 10 weeks of pregnancy or anytime thereafter. It can be helpful for some families to get early results in order to make informed decisions about their pregnancy, place and timing of delivery or need for any further diagnostic testing.

This test looks at the fragments of cell-free fetal DNA circulating in the woman's blood to determine the risk of certain chromosomal conditions for the pregnancy (Down, Patau and Edwards Syndromes and sex chromosome conditions). The results have about a 99% accuracy rate and are reported in negative (low risk) or positive (increased risk) categories. Results are typically available within 7-10 days.

Trisomy 21 - Down Syndrome

- There is an extra DNA on chromosome 21.
- Trisomy 21 occurs in about 1 out of every 737 newborns.
- Most people with Down Syndrome have mild to moderate intellectual disabilities but with support are able to participate in school, work and social life.

Trisomy 13 – Patau Syndrome

- There is extra DNA on chromosome 13 in some or all of the body cells.
- Trisomy 13 occurs in about 1 out of every 7,784 newborns.
- These babies have significant health issues including physical abnormalities and congenital heart defects and generally have a life expectancy of one year or less.

Trisomy 18 – Edwards Syndrome

- There is extra DNA on chromosome 18.
- Trisomy 18 occurs in about 1 out of every 3,788 newborns.
- These babies have significant health and neurological issues and generally have a life expectancy of one year or less.

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Sex Chromosome Aneuploidy

- Sometimes there are missing or extra sex chromosomes that can affect the development and health of a baby.

Other Screening Tests

If you started your care before coming to Dar a Luz, you may have had some different screening tests. The results of these tests are reported as a risk ratio and give you the risk of this baby being affected by specific birth defects. They will not tell you for sure if a baby has a birth defect and these tests do have some false positive results.

There are several types of screening tests other than the cell-free DNA that screen for Down Syndrome, trisomy 18, trisomy 13:

- **First trimester screen** consists of a maternal blood test taken between 10-13 weeks of pregnancy that screens for Down Syndrome and Trisomy 18 and a special ultrasound measuring the nuchal translucency to detect open neural tube defects like spina bifida and anencephaly. The blood levels of certain proteins and hormones are measured. This test detects about 83% of Down Syndrome and 80% of Trisomy 18. There is about a 5% false positive rate. If the risk is increased, clients are offered genetic counseling and other testing options.
- **Sequential screen** is a two-part screening test that provides an early, preliminary result in the first trimester and a final, complete result in the second trimester. Part 1 is a maternal blood test and an ultrasound to measure the nuchal translucency between 10-12 weeks of pregnancy. If the risk is increased at this time, clients will be offered genetic counseling and options for diagnostic testing. Part 2 is another blood test between 15-21 weeks of pregnancy. Together the results detect about 90% of Down Syndrome, 90% of Trisomy 18 and 80% of open neural tube defects.
- **Second trimester screen or Quad screen** is a maternal blood test done between 15-21 weeks of pregnancy that screens for Down Syndrome, Trisomy 18 and open neural tube defects. This test detects about 80% of each of these defects and can be done at Dar a Luz.
- **Detailed anatomy ultrasound scan** is a comprehensive exam done between 18-22 weeks of pregnancy. Most of the fetal anatomy, the umbilical cord, the placenta, the uterus and ovaries can be seen during this ultrasound. The sex can often be visible depending on the position of the baby. Not all birth defects can be detected on ultrasound but many syndromes will have physical markers that can be seen.

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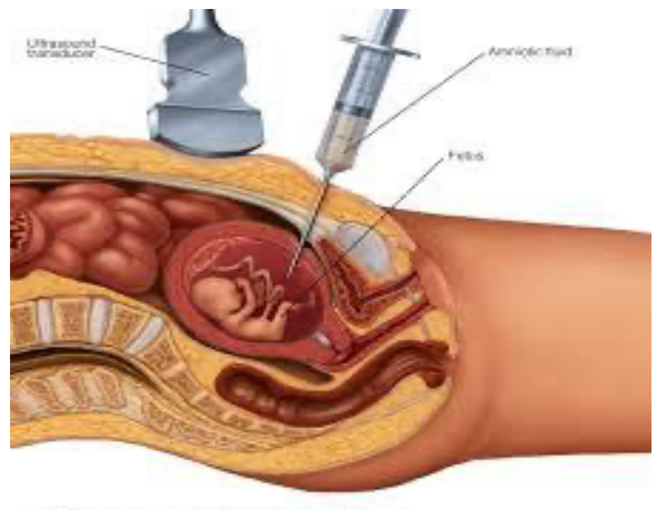
Diagnostic Testing

If your cell free DNA screen results are “positive,” your baby may have an increased risk for a prenatal chromosome condition. In the case of any positive screening results, you have access to free telephone genetic counseling with NxGen MDx and we will refer you to a local perinatology group for diagnostic testing, if desired. A genetic counselor will discuss the risks and benefits of different kinds of diagnostic testing such as chorionic villi sampling (CVS) and amniocentesis. These tests aid in either diagnosing or ruling out false positive results of chromosomal screening tests.

There are 2 types of diagnostic tests:

1. **Chorionic villi sampling (CVS)** testing is a prenatal diagnostic procedure that is performed between the 10th and the 12th week of pregnancy. With the guidance of an ultrasound, a small piece of the chorionic villi is removed from the placenta either through a needle inserted into the lower abdomen similar to amniocentesis or through a very thin tube inserted into the cervix. This sample is then sent to the laboratory for an analysis of certain genetic disorders. CVS detects over 99% of Down Syndrome, Trisomy 18 and Trisomy 13. It can also test for other specific disorders when parents are known to be carriers like Tay-Sachs disease, cystic fibrosis and sickle cell disease. CVS cannot detect open neural tube defects and other defects that do not have a known cause like autism or cleft lip, nonspecific intellectual disabilities and most heart defects. There is still a 1 in 1000 chance that even if the test is normal, the fetus may have a chromosome abnormality.

2. **Amniocentesis** is a procedure to withdraw a small amount of amniotic fluid (the fluid surrounding a developing fetus) from the uterus. The amniotic fluid contains shed cells from the developing fetus and the sample is sent to the laboratory to test for certain genetic diseases and birth defects. Amniocentesis is performed at about 16 weeks of pregnancy. Ultrasound is used to guide the insertion of a very thin needle into the lower abdomen usually below or to the side of the belly button and about an ounce of fluid is removed. Amniocentesis detects over 99% of all chromosome abnormalities including Down Syndrome, Trisomy 18 and Trisomy 13. It can also test for other specific disorders when parents are known to be carriers like Tay-Sachs disease, cystic fibrosis and sickle cell disease. It detects 96% of all open neural tube defects by measuring the alpha-fetoprotein (AFP). Amniocentesis cannot detect other defects that do not have a known cause like autism or cleft lip, nonspecific intellectual disabilities and most heart defects. (See diagram below.)



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Both Prenatal Chromosome Screening and Carrier Screening are available by two methods:

1. Dar a Luz can draw your blood in our lab and send it to the NxGen MDx lab. A certified genetic counselor from NxGen MDx will discuss the screening results over the phone with you. If you have a positive screening result, discussions between you, a genetic counselor and our midwives will help you decide what step, if any, is recommended.
   OR
2. You can request an in-person visit with a genetic counselor at Pinon Perinatal or Perinatal Associates of New Mexico. They will draw your blood and discuss the results with you including recommendations for follow-up for any positive results. Perinatology groups see all pregnant clients, but specialize in high-risk pregnancies and by nature tend to recommend more intervention and surveillance than is required for healthy low-risk clients eligible for care at Dar a Luz.

Please know we support all families in whatever decision you choose and have no preference for how you would like to proceed.

Although fetal ultrasound may be able to detect some physical characteristics associated with certain prenatal chromosome conditions, ultrasounds are not a replacement for genetic screening. Genetic screening may be recommended for follow-up after an ultrasound.

Dar a Luz requires all clients to have a Detailed Fetal Anatomy Ultrasound between 20-28 weeks of pregnancy to determine that the placenta is in a normal location and that the baby is eligible for birth at Dar a Luz.

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Ultrasounds During Pregnancy

Fetal ultrasound or sonogram is an imaging technique that uses high-frequency sound waves to produce images of a baby in the uterus. These images help your midwife evaluate your baby's growth and development and see how your pregnancy is progressing. Ultrasounds done in early pregnancy (6-8 weeks) can determine the viability of the fetus and those done around 10-13 weeks are best to help with dating the pregnancy and confirming the number of fetuses. Ultrasounds are usually done around 18-21 weeks to see the anatomy of the baby and study the placenta. Later ultrasounds are most valuable for following the growth of the baby, determining the placenta location and amniotic fluid levels as well as checking the baby's position before birth.

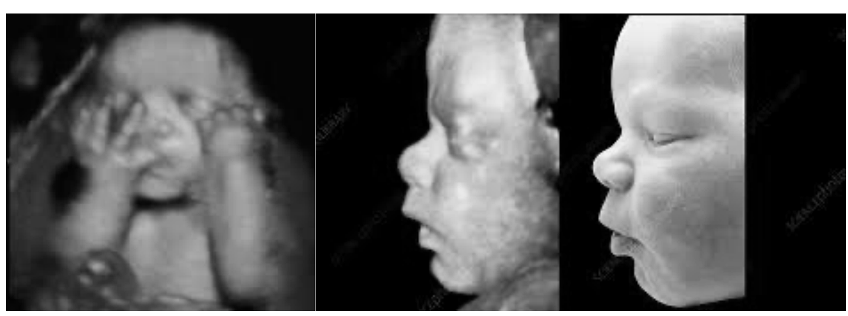
Risks of Ultrasound

Routine fetal ultrasounds are considered safe for both mother and baby. Researchers haven't noted any adverse effects of fetal ultrasounds in children followed for several years after birth. Still, caution remains important. The use of fetal ultrasound solely to create keepsakes isn't recommended. Fetal ultrasound also has limitations. Fetal ultrasound might not detect all birth defects — or might incorrectly suggest a birth defect is present when it's not.

American Institute of Ultrasound in Medicine 2018 Practice Guidelines

This guideline has been developed for use by practitioners performing obstetric sonographic studies. Fetal ultrasound should be performed only when there is a valid medical reason, and the lowest possible ultrasonic exposure settings should be used to gain the necessary diagnostic information such as evaluation of fetal or embryonic cardiac activity, fetal position, or amniotic fluid volume. A limited examination may be performed in clinical emergencies or for a limited purpose such as evaluation of fetal or embryonic cardiac activity, fetal position, or amniotic fluid volume. A limited follow-up examination may be appropriate for reevaluation of fetal size or interval growth or to reevaluate abnormalities previously noted if a complete prior examination is on record.

While this guideline describes the key elements of standard sonographic examinations in the first trimester and second and third trimesters, a more detailed anatomic examination of the fetus may be necessary in some cases, such as when an abnormality is found or suspected on the standard examination or in pregnancies at high risk for fetal anomalies. In some cases, other specialized examinations may be necessary as well. While it is not possible to detect all structural congenital anomalies with diagnostic ultrasound, adherence to the following guidelines will maximize the possibility of detecting many fetal abnormalities.



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Classification of Fetal Sonographic Examinations

First-Trimester Examination

A standard obstetric sonogram in the first trimester includes evaluation of the presence, size, location, and number of gestational sac(s). The gestational sac is examined for the presence of a yolk sac and embryo/fetus. When an embryo/fetus is detected, it should be measured and cardiac activity recorded by a 2-dimensional video clip or M-mode imaging. The routine use of pulsed Doppler ultrasound to either document or "listen" to embryonic/fetal cardiac activity is discouraged. The uterus, cervix, adnexa, and cul-de-sac region should be examined.

Standard Second-Trimester or Third-Trimester Examination

A standard obstetric sonogram in the second or third trimester includes an evaluation of the fetal presentation, amniotic fluid volume, cardiac activity, placental position, fetal biometry, and fetal number, plus an anatomic survey. The maternal cervix and adnexa should be examined.

Limited Examination

A limited examination is performed when a specific question requires investigation. For example, in most routine nonemergency cases, a limited examination could be performed to confirm fetal heart activity in a bleeding patient or to verify fetal presentation in a laboring patient. In most cases, limited sonographic examinations are appropriate only when a prior complete examination is on record.

Specialized Examinations

A detailed anatomic examination is performed when an anomaly is suspected on the basis of the history, biochemical abnormalities, or the results of either the limited or standard scan. Other specialized examinations might include fetal Doppler ultrasound, a biophysical profile, a fetal echocardiogram, and additional biometric measurements.

Information downloaded from www.aium.org/resources/guidelines/obstetric.pdf on 02/20/19.

Dar a Luz policies and reasons why you may be asked to get an ultrasound

- **Dar a Luz requires one standard ultrasound** in the second or third trimester to provide you and the midwives with basic information about your baby's health and the placenta location so that the safest location for birth can be recommended for you. We work with all the ultrasound offices in the area.
- We will recommend a first trimester dating ultrasound, if you do not know for certain the first day of your last menstrual period, have been on hormonal birth control in the last 3 months or are currently breastfeeding.
- We will recommend an ultrasound for growth if there is any question about how your baby is growing and further follow-up on complications in pregnancy like gestational diabetes and growth restriction.
- We would require a third trimester (30-36 weeks) ultrasound if your placenta is low-lying (<2cm from the cervical os) on an earlier ultrasound to be sure that is greater than 2 cm from the os.
- We use ultrasound to verify baby's position around 36 weeks or more if we are not sure the head is down.

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- We recommend a biophysical profile (measures amniotic fluid levels, fetal movement, fetal breathing and fetal tone) at 41 weeks to determine how baby is doing and if it is safe to continue watching for labor to start up to 42 weeks.
- Those who are advanced in maternal age (over 35 years) are offered more frequent surveillance due to increased risks of stillbirth in pregnancy. Risks for stillbirth increase at 38-42 weeks of pregnancy for all age groups. Healthy clients have lower risks than those with complications.

Advanced Maternal Age (AMA) Consent Info

The age cut-off for advanced maternal age (AMA) pregnancy is not uniformly defined. Historically, AMA has been defined as ≥ 35 years because this is the age at which the risk of fetal Down syndrome and the risk of amniocentesis to assess for Down syndrome were about the same. Other research suggests AMA is ≥40 years. For the purposes of Dar a Luz consent forms, we are using the standard definition of maternal age ≥ 35 years old.

Our intent in offering you this information is to help you make an informed decision regarding fetal testing in late pregnancy and possible labor management recommendations for clients who are considered advanced maternal age (AMA).

Early Pregnancy Risks

The risk of miscarriage increases with age with reported miscarriage rates up to 40 percent in 35- to 44-year-old clients and about 60 percent in clients over 45 years. Although rates of miscarriage decrease after the first trimester for everyone, the rates for older clients are still higher than younger clients.

AMA increases the risk of pregnancy complications, including tubal pregnancy, miscarriage, some fetal birth defects, low lying placenta, gestational diabetes, preeclampsia, and cesarean delivery. There is an additional increased risk of pre-term birth and fetal growth restriction.

Prenatal Care Issues during First and Second Trimesters

- Risks for Down syndrome and other genetic disorders are increased with age. We refer to perinatology practices who offer genetic consultations and genetic testing for all clients who choose to have more screening or who wish to speak to a genetic counselor.
- We require a detailed anatomy scan for all clients during the second trimester to rule out most birth defects and determine the location of the placenta.
- Age and obesity are risk factors for gestational diabetes. We require screening for gestational diabetes at 28 weeks for all clients.
- Gestational hypertension and pre-eclampsia are increased with age. We educate all of our clients on the warning signs for these conditions and screen blood pressures at each visit.
- AMA is a risk factor for a small baby. Fetal growth is assessed at each visit by measuring the fundal height (external measurement from the pubic bone to the top of the uterus) and if growth appears to be smaller than expected, an ultrasound for growth will be recommended.
- Pre-term birth is increased with AMA. Cervical length screening can be done at the 18-24 week anatomy ultrasound to determine clients at higher risk for pre-term birth. We educate all of our clients on the warning signs for pre-term labor.

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Late Pregnancy Risks

There is a risk of stillbirth in all pregnancies but based on limited research, that risk increases with maternal age and is strongest after 36 weeks' gestation. Clients 40 years of age and over have the same risk of stillbirth at 39 weeks of gestation as those in their mid-20s have at 41 weeks of gestation. This is often due to poor placental function. Those having their first baby are at higher risk for stillbirth than those who have had children before. Black women have the highest risk in all ages and in all categories. However, the risk of stillbirth at term for all pregnancies is less than 1%. (See chart below for risk of stillbirth according to age and pregnancy.)

Chances of stillbirth after 37 weeks of pregnancy

Client's age at baby's birth	First baby	Subsequent babies
Under 35 years old	1 in 270	1 in 775
35-39 years old	1 in 156	1 in 502
Over 40 years old	1 in 116	1 in 304

Third Trimester Considerations

Because there are no large randomized trials that have examined the effectiveness of routine antepartum testing in clients age 35 and older, there remains no consensus on the management of late pregnancy for them. However, in considering AMA, there are different recommendations for low-risk clients versus clients with certain risk factors. Additional risk factors may include the number of pregnancies a client has had, estimates of fetal growth, IVF, gestational diabetes, high blood pressure, obesity, socioeconomic status, race, and previous pregnancy complications. Consideration of additional risk factors may be used to develop an individualized plan for fetal testing in late pregnancy. Dependent upon risk factors, the timing of when to start weekly fetal testing can range from 36 weeks to 39 weeks gestation.

To address the risks related to stillbirth, there are current recommendations about fetal growth and ongoing testing (surveillance). Ongoing testing may include a biophysical profile via ultrasound (BPP) and/or fetal heart rate monitoring called a non-stress test (NST). Delivery in the 39th week for AMA clients is commonly offered and recommended. However, it is reasonable to alternatively choose fetal testing beyond the 39th week and wait for spontaneous labor (expectant management) provided your risk factors are low. Clients over 40 years are generally discouraged from going past 40 weeks of gestation.

Dar a Luz Recommendations

We recommend that our clients 35 years or older consider the following fetal testing and labor stimulation recommendations in the third trimester:

- All clients should continue fetal kick counts twice daily until birth. You should report decreased fetal movement to your midwife immediately so that we can offer further evaluation.
- Low-risk clients 35-37 years of age:
    - Fetal growth ultrasound with BPP & NST: 38-39 weeks (1)
    - No additional fetal testing until 41 weeks unless clinically indicated (2)
    - Expectant management of labor to begin spontaneously (2)

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- Low-risk clients ≥38 years
  - Fetal growth ultrasound with BPP & NST: 36-38 weeks (1) (2)
  - Following your growth ultrasound, begin weekly BPP & NST testing (2)
  - Labor stimulation methods to begin in the 39th week at Dar a Luz or induction of labor at the hospital (2)
- Any client over 35 years of age with risk factors (as stated above):
  - Begin serial fetal growth ultrasounds in the third trimester (2), or by 36 weeks. (1)
  - Following growth ultrasounds, begin weekly BPP & NST (2) or twice weekly BPP & NST alternating with NST testing (1)
  - Labor stimulation methods to begin in the 39th week at Dar a Luz or induction of labor at the hospital (2)

Dar a Luz Requirements

- All clients, regardless of maternal age, are required to have twice weekly fetal surveillance beginning at 41 weeks if they still want to birth at Dar a Luz.
- All clients, regardless of maternal age, would be scheduled for hospital induction at 42-0 weeks if unable to get into labor before the induction date.
- Any client of advanced maternal age who chooses to start labor stimulation methods at Dar a Luz at or after 39 weeks of gestation would be required to have fetal testing in the form of BPP and NST prior to stimulation.

Our midwives are available to discuss the risks, benefits and alternatives of remaining pregnant and waiting for spontaneous labor against the risk of stillbirth. We can explore both the options of induction and ongoing surveillance and will respect your preferences regarding timing and type of intervention.

References

(1) Info from Up-to-date, April 2017. Management of pregnancy in clients of advance maternal age by Ruth C Fretts. Reviewed by Dar a Luz Midwives 10/2019.
(2) Pinon Perinatal is one of the perinatology groups in Albuquerque that we refer clients to for ultrasounds and fetal surveillance and these are recommendations from that group.

When I was pregnant...I was a woman.
No deadlines or curtains to meet.
Whenever I thought of what was growing inside me
[I felt that it was] a miracle,
the height of creativity for any woman.

~ Barbra Streisand

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Complimentary Therapies & Activities

Acupuncture

Acupuncture is a traditional Chinese medicine therapy that involves the placement of extremely fine needles into specific points throughout the body. The treatment facilitates the body's natural flow of energy to improve functioning and promote healing. When properly performed by a licensed and experienced practitioner, acupuncture is a safe treatment option during pregnancy. Some of the benefits include:

- Relief of morning sickness, fatigue, migraines.
- Reduces stress, heartburn and improve balance.
- Reduces back and joint pain.
- Helps the mother prepare for delivery.
- Traditional Chinese medicine (moxibustion) can be used to turn a breech baby by burning a moxa (mugwort) stick near a certain point on the small toe of the foot. This increases baby's activity.
- Increases energy, reduces depression and fatigue, and relieves pain after birth.
- Helps treat hemorrhoids and lactation problems.
- May be used to help stimulate labor for a full-term pregnancy.

Chiropractic Care

Chiropractic is a natural approach to life and health. Pre-existing but unnoticed imbalances in your spine may become stressed during pregnancy. This can lead to back discomfort or pain, uneven tension on the ligaments of the uterus, and can affect the baby's position in the uterus. Chiropractic care throughout pregnancy will restore balance to your pelvis to help your body function better, decrease pain and increase your chances of a more natural and comfortable birth. The Webster maneuver can be useful in helping turn a breech baby. Chiropractic adjustments can be helpful after birth to realign the spine. Your baby may also benefit from early adjustments after birth. Some signs to look for are difficulty for your baby to easily turn the head from side to side.

Massage

When considering massage, look for a therapist that is certified in pregnancy massage so that the therapist is trained to handle the special needs of pregnancy. Some of the benefits include:

- Tranquil relaxation and reduced stress.
- Relief from muscle cramps, spasms, and pain in the lower back, neck, hips and legs.
- Increased blood and lymph circulation and possibly reduced swelling.
- Reduced stress on weight-bearing joints.
- Improves outcome of labor and eases labor pain.

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Perineal Massage

We often get questions about avoiding tearing during the birthing stage of labor and Perineal Massage. We believe the body is innately made to stretch and move for your baby, but if you're interested in doing this technique, it's not harmful. Below is the American College of Nurse Midwives (ACNM) info sheet.

PERINEAL MASSAGE IN PREGNANCY

What Is My "Perineum"?

Your perineum is the area between your vaginal opening and your rectum. This area stretches a lot during childbirth, and sometimes it tears. If your health care provider cuts an episiotomy during birth, it is this area that is cut. You may need stitches after your baby is born if you have a tear or have an episiotomy.

I'm Concerned About Perineal Tears—How Often Do They Occur?

40% to 85% of all women who give birth vaginally will tear. About two thirds of these women will need stitches.

I'm Also Concerned About Episiotomies—Are They Necessary?

An episiotomy is usually not necessary. However, sometimes your care provider may recommend an episiotomy. For example, an episiotomy can help if your baby needs to be born very quickly. Ask your health care provider to talk with you about episiotomies.

Can My Health Care Provider Do Anything to Help Me Avoid a Tear?

There are many ways that your health care provider can help to reduce your chances of tearing. For example, your provider may recommend specific pushing positions, provide gentle pressure on the baby's head as it comes out, and avoid the use of forceps.

Can I Do Anything *Before* The Birth To Help Me Avoid a Tear?

Reducing tearing has been the subject of many research studies. Several studies have found that perineal massage during the last weeks of pregnancy can reduce tearing at birth. This massage—using two fingers to stretch your perineal tissues—is performed by you, in your home, once or twice daily, for the last 4 to 6 weeks of your pregnancy. The flip side of this handout tells how to do this massage.

Does Perineal Massage in Pregnancy Help All Women?

Massage seems to work better for some women than others. Women having their first baby, women 30 years or older, and women who have had episiotomies before have fewer tears and less severe tears when perineal massage is done during the last weeks of pregnancy.

Can My Partner Help?

Yes! Many women find that it is easier to have their partners do this massage. See the flip side for more information.

Are There Any Risks to Perineal Massage During Pregnancy?

Not that we know of. It is free. It doesn't hurt. It is easy to do. And most women don't mind doing it. However, you should check with your health care provider before beginning perineal massage. And, if you believe your bag of waters is leaking, check with your health care provider before putting anything in your vagina.

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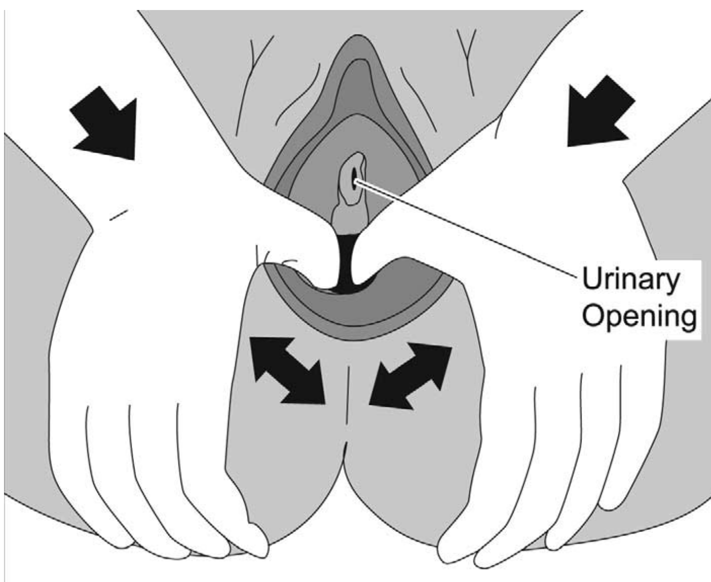

Figure 1. Perineal massage.

INSTRUCTIONS FOR PERINEAL MASSAGE DURING PREGNANCY

Here are some reasons you may want to use perineal massage during pregnancy:

- Some health care providers believe that perineal massage will increase the "stretchiness" of this area. This means you may have a smaller chance of tearing or needing an episiotomy.
- While you massage, you can practice relaxing the muscles in your perineum. This can help you prepare for the stretching, burning feeling you may have when your baby's head is born. Relaxing this area during birth can help prevent tearing.

If you wish to use perineal massage, begin 6 weeks before your due date and follow these suggestions:

Wash your hands well, and keep your fingernails short. Relax in a private place with your knees bent. Some women like to lean on pillows for back support.

Lubricate your thumbs and the perineal tissues. Use a lubricant such as vitamin E oil or almond oil, or any vegetable oil used for cooking—like olive oil. You may also try a water-soluble jelly, such as K-Y jelly, or your body's natural vaginal lubricant. Do not use baby oil, mineral oil, or petroleum jelly.

Place your thumbs about 1 to 1.5 inches inside your vagina (see figure). Press down (toward the anus) and to the sides until you feel a slight burning, stretching sensation.

Hold that position for 1 or 2 minutes.

With your thumbs, slowly massage the lower half of the vagina using a "U" shaped movement. Concentrate on relaxing your muscles. This is a good time to practice slow, deep breathing techniques.

Massage your perineal area slowly for 10 minutes each day. After 1 to 2 weeks, you should notice more stretchiness and less burning in your perineum.

Partners: If your partner is doing the perineal massage, follow the same basic instructions, above. However, your partner should use his or her index fingers to do the massage (instead of thumbs). The same side-to-side, U-shaped, downward pressure method should be used. Good communication is important—be sure to tell your partner if you have too much pain or burning!

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Dental Care

Taking good care of your teeth and gums during pregnancy is very important for a healthy pregnancy. About 25-75% of pregnant clients are affected by gingivitis. Gingivitis (inflammation of the gums) is caused by bacteria and plaque build-up on teeth and gums. Depressed immune response and pregnancy hormones can allow a more harmful type of bacteria to be present and change how the body responds to bacterial plaque. You may notice the symptoms around 8 weeks of pregnancy and it may be the worst around 36 weeks.

Symptoms of gingivitis

- Mild gum swelling
- Tenderness
- Redness
- Bleeding gums when brushing

Preventive measures

- Brush your teeth with soft toothbrush for 2 minutes twice a day using a fluoridated toothpaste.
- Floss your teeth daily. A water pic may be helpful.
- If you have morning sickness, rinse your mouth after vomiting to stop the acid from damaging your teeth. Mix 1 teaspoon of baking soda in 8 ounces of water, rinse your mouth and spit, then wait 30 minutes and brush your teeth. Ask your dentist about applying calcium-coating products daily if chronic vomiting is an issue.
- Most city tap water has added fluoride that may help prevent cavities but bottled water does not.
- Avoid sugary snacks (fruit, cookies, crackers, chips, etc) and drinks (juice, soda & diet soda, sports drinks) between meals. Choose protein rich snacks like cheese instead.
- Chew xylitol gum 4-5 x/day after meals to decrease harmful bacteria and plaque and protect your teeth.
- Use a fluoride containing mouth wash immediately before bedtime to help remineralize teeth.
- Avoid alcohol and tobacco use.
- Schedule a dental cleaning visit in pregnancy prior to 24 weeks if you have not had one in the past 6 months.
- Schedule routine dental visits every 6 months

If you have pain in your teeth or gums, you should see a dentist soon because dental infections and chronic systemic inflammation can lead to uterine infection, preterm labor, poor placenta function and growth restriction of the fetus. It is safe to get routine dental treatment anytime in pregnancy including x-rays, local anesthetics, nitrous oxide and pregnancy safe antibiotics and pain medications. Tell your dentist you are pregnant. Be sure the dentist places a lead apron over your belly if you need X-rays. Ask your midwife for a letter to give to your dentist that describes safe treatments and medicine while pregnant.

Dental health after your baby is born is important too! Those who have poor dental health will pass the cavity causing bacteria to their baby thru their saliva sharing behaviors including tasting or pre-chewing food for their baby, sharing spoons, cups or straws, cleaning a dropped pacifier by placing in their mouth or wiping a baby's mouth with a saliva moistened cloth. Parents with poor diets that are high in sugar and those who have poor dental hygiene will likely pass these habits on to their children which increases

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the child's risk for cavities. Cavities in children are five times more common than asthma and cause pain, facial tissue infections, nutritional and growth changes.

Breastfed babies are less likely to develop cavities than bottle fed babies. If bottles are used, avoid putting the baby to bed with a bottle or sippy cup of milk or juice (water is OK). Teeth are at highest risk overnight when saliva levels are low. The American Academy of Pediatrics recommends that parents gently wipe the baby's gums and teeth with a soft cloth after breastfeeding. When teeth appear, start brushing them with a soft toothbrush and a smear of toothpaste before bedtime. Children should see a dentist at 12 months of age.

Exercise

Regular daily exercise has long-term benefits for your health and your growing baby. If you are healthy, moderate cardiovascular exercise for 30 minutes a day is a safe way to exercise while pregnant. This includes brisk walking, stationary cycling, low-impact aerobics, stair climbing and swimming. You should avoid exhaustion, scuba diving, high altitude activities and activities with risk of fall or abdominal trauma.

- Helps maintain a healthy weight while pregnant
- Will help you feel better and give you more energy
- Helps relieve stress and depression
- Can help prevent constipation. Improves circulation
- May make your labor easier. May decrease your recovery time.

If you do not exercise regularly, start with low impact, moderately hard exercise at least 3 times a week for 30 minutes. If you already exercise on a regular basis, moderately hard to hard low impact or safe activities for 30-60 minutes 3-5 times a week is recommended. If you are an athlete, 4-6 times a week at 70-80% of maximum heart rate for 60-90 minutes of competitive activities as tolerated in pregnancy is recommended.

Yoga

Yoga can be very beneficial for pregnant clients — it helps you breathe and relax, which in turn can help you adjust to the physical demands of pregnancy, labor, birth, and motherhood. It calms both mind and body, providing the physical and emotional stress relief your body needs throughout the experience of pregnancy. There are certain poses that you should avoid during pregnancy. Let you instructor know that you are pregnant if you are not taking a class designed for pregnant clients. Prenatal, hatha and restorative yoga are the best choices for pregnant clients. Hot yoga is not recommended in pregnancy due to possible harmful effects of hyperthermia for mother and baby. Taking a prenatal yoga class is also a great way to meet other moms-to-be and parents, and embark on this journey together.

Dance

Dancing is a fantastic and fun exercise during pregnancy! Not only do you get the thrill of moving your body to music you love, it will also keep you flexible while toning your muscles. You can get an aerobic workout from any fast-paced dance or stretch and maintain muscle tone when you hold positions in ballet. For maximum benefit, dance for at least 20 minutes three times a week, whether it's in your living room or in class.

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Dance as you normally would but keep a few precautions in mind. Remember to warm up beforehand to prepare your joints and muscles for exercise, which also builds up your heart rate slowly. Adjust the intensity of your dancing according to how you feel. A good rule of thumb: slow down if you can't comfortably carry on a conversation. Keep your workout low-impact by keeping one foot on the floor at all times, substituting marching or stepping side to side for jumps. Your center of gravity shifts as your belly gets bigger, so pay extra attention to your balance.

Sleep

Adequate sleep is important throughout our lives but especially during pregnancy. Healthy sleep is defined as falling asleep within 5-10 minutes of going to bed, sleeping 7-8 hours and feeling well resting on arising with good energy to perform the daily activities all day long. The benefits of getting at least 7 hours sleep at night include tissue growth and repair, restored energy and important hormones are released for your body to function properly.

At least a third of adults get less than 7 hours of sleep a night. Only 40% of all women report getting a good night sleep almost every night. Working mothers and single working women are less likely to get good sleep. Noise, caring for children and sleeping with pets contribute to poor sleep. Good sleep at night is the highest prior to pregnancy and continually decreases through pregnancy and postpartum. About 40% of pregnant women and 55% of postpartum clients do not get a good night's sleep. Some lifestyle consequences of poor sleep are higher stress, less time with family and friends, too tired for sex, unsafe driving and more negative moods. Insomnia is defined as at least a month of chronic sleep loss that causes problems at work, at home or in important relationships.

Sleep deprivation affects your body too. The brain has decreased cognitive function resulting in poor memory and ability to think. The thymus gland supports healthy immune function and sleep deprivation increases the inflammatory response, which directly affects the heart and leads to build up of plaque in our arteries causing heart disease and increased blood pressure. Those people with poor sleep often have more rheumatoid arthritis and decreased muscle mass. People who sleep poorly release fewer appetite controlling hormones making them very hungry and they eat more which leads to increased fat deposits. Metabolism is altered with poor sleep, which leads to inflammation in the pancreas and insulin resistance and diabetes. Current studies show that sleep problems can lead to depression.

Many things can affect sleep in pregnancy such as frequent urination, pain or contractions, heartburn, dreams or nightmares, nasal congestion and leg cramps. Sleep disorders in pregnancy include short sleep duration, poor sleep quality, insomnia, snoring, obstructive sleep apnea, restless leg syndrome and excessive daytime sleepiness. These disorders can increase your risks for preterm birth, gestational diabetes, pre-eclampsia, increased length of labor and greater chance of having a cesarean section and depression.

Good sleep hygiene in pregnancy includes:

- Get regular exercise but do not exercise within 3-4 hours prior to sleep
- Follow recommended weight gain guidelines for pregnancy to decrease excessive weight gain
- Eat a diet with at least 60 grams of protein for adequate production of serotonin and melatonin
- Increase iron-rich and folate-rich foods to decrease restless leg syndrome
- Limit fluid intake in the evening and dim light when up to bathroom at night
- Go to sleep and get up at the same time every day of the week

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- Limit bedroom activities to sex and sleep
- Keep bedroom slightly cool
- In the hour prior to sleep, avoid stimulating activity (TV, computer, email)
- Turn off cell phones including text tones if not necessary for work
- Darken room including glow from computer screen

Suggestions to maximize sleep during the postpartum period:

- Take afternoon naps versus morning naps while baby is sleeping to get more deep sleep
- Keep mom-baby interactions to a minimum at night
- Keep lights dimmed or off for nighttime baby interactions
- Review relaxation methods before going to bed
- Get at least 15 minutes exposure to midday sun to reset your circadian rhythms
- Report any concerns for postpartum depression
- See **"Common Complaints During Pregnancy"** for over-the-counter sleep remedies that may be helpful for insomnia.

Intimacy is not purely physical,
It's the act of connecting with someone so deeply,
you feel like you can see into their soul.

~ Unknown

Sex/Relationships

It is safe to have sex during pregnancy unless you have been told not to for medical reasons. It will not hurt the baby even though some couples may be worried about this. Pregnancy can be an emotional time for you and your partner. Letting your partner know how you feel will help your relationship stay healthy during your pregnancy.

In the beginning of pregnancy, you might have a decreased desire for sex, partly due to physical changes. You may feel a need for more love and loving without sex. During the second trimester, you may feel more erotic and experience an increased libido and sexual satisfaction. You might feel better physically, more relaxed, and might seek more attention from your partner. During the last part of pregnancy, sexual desires can decrease; you might report feeling big, awkward, and uncomfortable. You might need frequent reassurance from your partner and honest sharing of feelings between you, to feel supported and loved. Explore alternative methods for intimacy which can be useful after pregnancy too.

Stress

Even though pregnancy can be a very exciting time for you and your family, it can also be very stressful. There are many physical and emotional changes. Stress can change the way you feel about your pregnancy and can affect your health. Daily physical exercise, relaxing activities and a healthy diet can help you reduce stress. If you are having trouble dealing with stress, please let your midwife know.

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Work

Whether you sit or stand a lot during your workday, you need to change your position often. Walking is fine. You may work through your whole pregnancy when you are healthy. If you have questions about work activities such as lifting heavy objects or working with chemicals, or need a letter for your employer, ask your midwife. Also, you may want to consider abdominal binders and/or compression hose for better support during pregnancy. The midwives can write prescriptions for these too.

What to Avoid During Pregnancy

- Drugs including cannabis, CBD oils, alcohol, smoking and second-hand smoke, e-cigarette vapors
- Limit caffeine-containing drinks to 2 or less per day
- X-rays of abdomen; shield abdomen if they are needed
- Chemicals that kill bugs and plants
- Harsh cleaning products, wear gloves and open windows to clean
- Cat litter from a cat infected with Toxoplasmosis. Get your cat tested and/or have someone else clean the litter daily
- Activities or sports that could cause you to fall or hit your abdomen
- Biking and hiking above 10,000 feet altitude due to limited oxygen supply
- Limit time in saunas and hot tubs to 10 minutes or less
- Eating undercooked meats and fish (See **"Nutrition and Healthy Lifestyles: Food Safety Guidelines"** for more info.)

Alcohol, Drugs, and Smoking

Alcohol: We don't know what amount of alcohol consumption can harm the baby or if there is a safe amount. Binge drinking is worse than an occasional drink in early pregnancy. It is best not to drink at all. If you drink, your baby may have Fetal Alcohol Syndrome or Fetal Alcohol Effect. These babies may be born with physical and mental problems. Let your midwife know if you or a family member is concerned about your alcohol consumption.

Opioid Drugs: During pregnancy, those who use opioid drugs like heroin, opioids, methamphetamines (meth) or cocaine are at risk for having babies with physical and mental problems or drug dependence. During pregnancy, those using opiate drugs such as heroin, Percocet® (oxycodone), Lortab® or Vicodin® (hydrocodone) or others on a frequent or daily basis, may find their babies need to stay in the hospital longer to be watched for drug withdrawal. This may also be true of those who are using other medically prescribed medicines as treatment for dependency such as methadone or Subutex® (buprenorphine). Tell your midwife if you are taking drugs. Clients with current and continuing drug use are not eligible for birth center care, but you can be referred to special programs that can help you.

Cannabis/THC/CBD: Although you may have legal access to cannabis (AKA marijuana) products through a medical card, or come from a state where recreational use is legal, the FDA strongly advises against the use of cannabidiol (CBD), tetrahydrocannabinol (THC), and cannabis in any form during pregnancy or while breastfeeding. There are no comprehensive research studies on the effects of cannabis, THC, or CBD products on the developing fetus, pregnant parent, or breastfed baby. However, the data we do have suggests that cannabis may affect fetal brain development, increase the risk of premature birth, low birth weight and stillbirth. THC has been found in breastmilk up to 6 days after use and may affect newborn brain development resulting in hyperactivity, poor cognitive function and other long-term

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effects. Cannabis smoke contains some of the same harmful components as tobacco smoke, and should absolutely not be used around a baby or children. CBD products may also be contaminated with THC or other contaminants like pesticides, heavy metals, bacteria and fungus which may pose a health risk.

Babies whose mothers used cannabis during pregnancy were 82% more likely to have low birth weight, 79% more likely to be preterm and 43% more likely to go to the neonatal intensive care unit, compared with those without prenatal cannabis exposure, researchers reported at the Society for Maternal-Fetal Medicine's annual meeting in 2019. Another study presented at the same meeting showed significantly increased odds of cannabis use among pregnant women in Colorado after cannabis legalization, as well as increased prevalence of fetal growth restriction and spontaneous premature birth.

Smoking: Smoking while pregnant raises the risk of spontaneous abortion, placenta problems, premature rupture of membranes, low birth-weight babies, stillbirth and newborn death. Those who smoke while pregnant also have a greater risk of ectopic (tubal) pregnancy. According to a study in 2017, sixteen percent of pregnant women enrolled in the Text4baby and Quit4baby (free mobile phone app) programs quit smoking after three months. Try these apps to get texts about how to have a healthy pregnancy.

Secondhand smoke: This is also harmful for you and the baby. Babies who are around people who smoke cigarettes, e-cigarettes or cannabis are more likely to have ear infections, asthma and permanent lung damage. They are hospitalized more often for pneumonia and bronchitis. Infants are at higher risk for SIDS (Sudden Infant Death Syndrome). Support is available to help you and family members stop smoking. If you are interested, let you midwife know or call 1 800-QUIT NOW.

Vaping/E-Cigarettes: People may feel safer using e-cigarettes, but research has not proven them to be safe for users or those around them.

The aerosol (not water vapor) contains nicotine and chemicals that can cause cancer, birth defects or other problems. The e-liquids come in fruit and candy flavors that appeal to children. They are poisonous if swallowed and should be kept out of reach of children. E-cigarettes are just as addictive as regular cigarettes and do not help people quit smoking. Those who are pregnant and breastfeeding, as well as children and teens, should never use e-cigarettes or be exposed to the aerosol due to the harm nicotine and other chemicals in them may cause to brain development.

Abuse During Pregnancy

There are many forms of abuse, including physical, financial, verbal, emotional, and sexual abuse; any may start or become worse while you are pregnant. Physical abuse can lead to miscarriage (spontaneous abortion). Pregnant clients who are abused have an increased risk of preterm labor and/or birth and low birth weight babies. The midwives and other staff members are a safe and confidential place for you to come to. If you are being abused, tell your midwife or call the services listed below for help.

- Safe House & Women’s Community Association Shelter (505) 247-4219
- ENLACE Comunitario (505) 246-8972
- NM Domestic Violence Hotline (800)773-3645

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Motor Vehicle Safety

A car crash is one of the biggest dangers facing your unborn baby. Car crashes kill and injure more unborn babies than babies in their first year of life. These are things you can do to keep you both safe:

1. **Call the midwife if you are in any kind of accident. Get checked at a hospital emergency room even if you feel fine. We recommend a minimum of 4 hours observation of you and your baby for possible complications!!!**
2. Wear a lap-shoulder seatbelt at all times for your safety. Wear it correctly.
3. Drive less often, if you can. Try carpooling. Plan your errands to make fewer trips. Shop online. Have people come visit you and fly for longer trips.
4. Avoid crash risks by avoiding driving or riding in risky conditions. Avoid driving at night and in bad weather or when you are sleepy or using a cell phone. Don't ride with someone who is sleepy or using alcohol or drugs.
5. Use a safe car. Keep your car in good condition by doing safety checks before driving. Choose a car with good safety ratings.

How to Wear Your Seat Belt

- Place the lap belt low, under the belly and over your hips.
- Place the shoulder harness over your shoulder and across the center of your chest, **NEVER** under your arm.
- Do not use after-market adapters.
- Move seat back as far as possible.

Travel Advice

For most healthy clients, traveling during pregnancy is safe up to 36 weeks pregnant. The best time to travel is between 14-28 weeks. At this time, you will have more energy, morning sickness is usually gone, and it is still easy to get around. Traveling is not recommended if you have certain complications in pregnancy including preeclampsia, pre-labor rupture of membranes or preterm labor. Before you travel, schedule a checkup with the midwife, have access to your medical records, bring your medications with you, be up-to-date on your vaccines, and make you travel plans easy to change.

Anytime you consider traveling during pregnancy, remember that your immunity is lower and you are at increased risk of getting sick. We recommend you research the current risks for diseases in the areas you plan to travel (i.e., measles, chickenpox, seasonal flu, Zika Virus, COVID-19, etc.). Many of these can have serious risks for you and your baby. If you must travel, frequent handwashing or hand sanitizer use and avoiding large crowds can help reduce your risks.

Later in pregnancy, extra body weight makes it hard for blood to flow through your body and may make you swell more and increase your risk for blood clots to form in the legs. This is true especially when you sit for long periods of time. Always remember that whether you are in a car, a train, an airplane or just sitting for a long time, you should get up to walk for 15 minutes at least every 2 hours, drink lots of fluids and wear loose-fitting clothes to increase your blood circulation.

When you travel, you might not use the bathroom as often as you should. This can put you at risk for a urinary or bladder infection. When you get up to walk, include a bathroom and water break to help prevent infections.

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Taking a cruise increases your risk of norovirus infection which causes nausea, vomiting and diarrhea for 1-2 days and is easily spread by eating food, drinking liquids or touching surfaces that are contaminated with the virus. Be sure there is a doctor or nurse on the ship and seek medical care if you experience these symptoms.

Some airlines may restrict travel after 36 weeks or require a note from your midwife near the end of your pregnancy saying that it is safe for you to fly. You need to check with the airline before you travel to find out what rules they may have. Book an aisle seat so you can get up to stretch your legs every 2 hours. After 36 weeks of pregnancy, it is usually recommended that travel is limited to no more than 1-2 hours from your home. Check with your midwife before you travel for long distances.

If you must travel late in pregnancy, know where to get medical care along the way and at your destination. Seek emergency medical care for any of the warning signs that are listed in this book and be prepared to have your baby where you are traveling. You can ask for a copy of your prenatal records to take with you or if you need medical care while traveling you can call the office or the midwife on call and we can fax your records to you or your healthcare provider.

Nutrition and Healthy Lifestyles

We realize that discussing weight during pregnancy can be a difficult conversation for everyone, but we feel it is an important one. We truly care about all the clients who come to us for prenatal care and want to give you the tools to be as healthy as you can during your pregnancy and afterwards. Many clients are self-conscious about their weight and may have struggled with weight throughout their lives.

Studies show that weight gain within the Institute of Medicine (IOM) recommended ranges is associated with the best outcomes for both you and your baby. Weight gains outside these ranges are associated with twice as many poor pregnancy outcomes. Weight gain below the IOM ranges is associated with pre-term birth and low birth weight babies. Gains above the IOM ranges increase the risk of complications in pregnancy including macrosomia (baby weighing over 9 pounds), gestational diabetes, hypertension, more back and pelvic pain, labor and birth difficulties, cesarean sections, problems breastfeeding and postpartum weight retention, which increases your chances of being obese in life. Some of these complications can risk you out of birth center care.

Obesity is a growing epidemic in the US. Studies show that 35.7% of women are obese before pregnancy and these women have 2-5 times higher rates of stillbirth and significantly higher rates of gestational diabetes, high blood pressure and blood clots in the veins. Obesity affects many systems of the body including estrogen production in fat cells, changes in folate and glucose metabolism, immune dysfunction and cardiovascular strain. These factors create problems in pregnancy including, placental failure with normal blood pressure, sudden onset hypertension, genetic disease and anomalies (heart defects, infections, umbilical cord accidents). Obese clients are recommended to have more frequent ultrasound surveillance to monitor fetal growth and placental function. We recommend following the IOM guidelines for weight gain in obesity for the best outcomes.

Although weight gain in pregnancy is an important tool to assess the baby's growth, we are also interested in helping clients and families make healthy life-style choices during their pregnancy that will become lasting changes.

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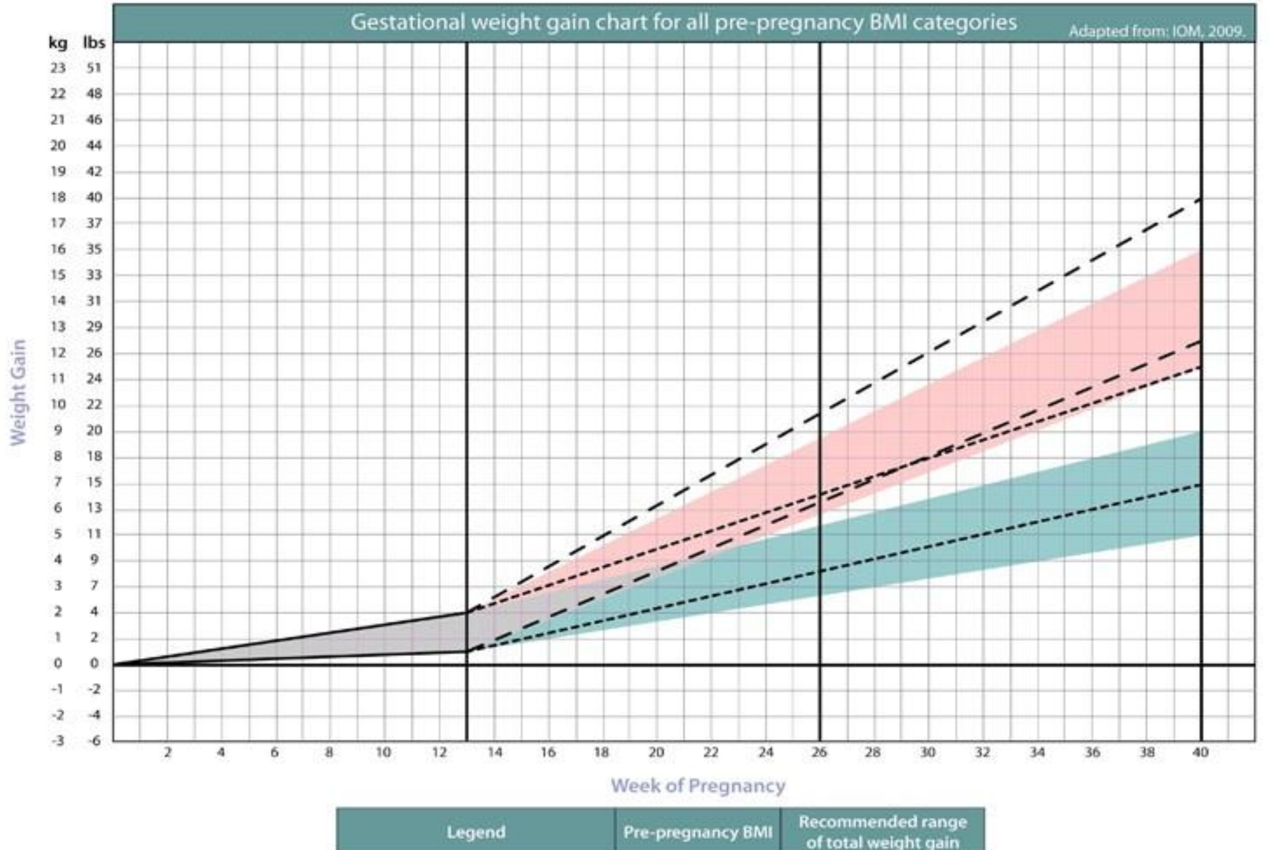
Weight Gain Guide

Where do those pounds go?	Institute of Medicine (IOM) Weight gain guide
6.5-8.5 lbs. Baby	BMI <18.5 Underweight 28-40 lbs. = 12.5-18 kg
2-3 lbs. Placenta	BMI 18.5-24.9 Normal weight 25-35 lbs. = 11.5-16 kg
2-5 lbs. Uterus	BMI 25-29.9 Overweight 15-25 lbs. = 7-11.5 kg
2-3 lbs. Breast tissue	BMI ≥ 30 Obese 11-20 lbs. = 5-9 kg
2-3 lbs. Amniotic fluid	
4 lbs. Blood	For a normal weight, you should gain about 2 to 4 pounds during the first three months and 1 pound a week for the rest of your pregnancy.
5-9 lbs. Fat stores needed for birth & breastfeeding	

Use the top graph in the chart below to find your pre-pregnant weight and height to determine your IOM recommended weight gain during pregnancy. Then use the bottom graph to mark the upper and lower range of your IOM weight gain on the 40-week line. Then draw a line from those ranges to zero and this will give you a guideline to stay within during your pregnancy. You can then chart your weight gain for your weeks of pregnancy and track your progress. If you find yourself consistently above or below the recommended range, bring in a 1-week diet recall (see the section **"1-Week Diet Recall"** for a handy chart). Your midwife can go over this with you or refer you to a nutritionist for further counseling.

Weight Gain Graph



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Recent events have increased the number of people experiencing food insecurity, food deserts in their neighborhoods and limited access to healthy, fresh foods. In 2019, New Mexico was rated at the least healthy state with 17.9% of households unable to provide adequate food for one or more of household members due to a lack of resources. The New Mexico Women Infants and Children (WIC) program provides free healthy foods, ideas for healthy eating and maintaining good health habits, support for nursing families, and connects families with other community services. Locations for local WIC offices are listed in the back of this book. You can find more information at https://www.nmwic.org

The **Supplemental Nutrition Assistance Program (SNAP)** (formerly Food Stamps), provides financial assistance to eligible New Mexicans with low income and limited resources to purchase food. SNAP benefits are simple to use with qualifying food at participating grocery stores and farmers' markets.

www.hsd.state.nm.us/LookingForAssistance/Supplemental_Nutrition_Assistance_Program_SNAP_.aspx

Healthy Lifestyle Tips

- **Eat High-Quality Food:** High-quality does not have to be high-priced.
  - Replace processed foods (prepared or highly refined) with fresh foods cooked at home.
  - Buy organic as much as possible to decrease the amount of harmful chemicals that you eat.
  - Join your local CSA (community supported agriculture) to get fresh locally grown produce delivered to your home each week. Search the web for Skarsgard Farms, Sol Harvest Farm & other local CSAs in Albuquerque.
  - Grow your own food or shop the grower's markets during the growing season. There are markets in downtown Albuquerque, Uptown area, Nob Hill, Los Ranchos, and Corrales. You can find more information about locations, dates and times on the web at www.farmersmarketsnm.org
  - Learn how to freeze or can foods that are in season when they are low priced to use the rest of the year.
- **Make Smart Food Choices:** Follow a diet of fresh veggies and fruits, whole grains and lean proteins.
  - Eat whole grains and breads and limit processed, refined "white" foods.
  - Skinless white meat, wild caught fish and lean red meats are better than high fat meats
  - It is better to bake, grill, steam or broil foods than to fry them.
  - Vegetable based sauces like marinara are better than cream sauces.
  - Fruit is better than juice – whole fruit has more fiber and less sugar and is absorbed slower.
  - Choose foods that are low in calories with high water and fiber content so you are getting fewer calories and eating more food.
  - Limit sweets to occasional treats, not every day. Try making your own deserts and decrease the sugar by ¼ to ½ in most recipes.
- **Control Your Portion Size:** Most people don't know how much food is in a portion.
  - Most restaurant meals are far bigger than a normal portion size. Try splitting a meal when you eat out or only eat half and save the rest for lunch tomorrow. A portion of meat is about the size of the palm of your hand. (See **"The Food Group Chart"** for more examples.)
  - Eat slowly and only until you are satisfied and not until you are stuffed.
  - Limit sauces and dressings to 2 tablespoons just to add flavor.
- **Listen to Your Body:** Unconscious eating is a common pitfall. Do you eat when you aren't hungry? Do you eat when you are stressed, sad or angry?
  - Ask yourself, "Am I really hungry?**"** Try drinking some water and this may satisfy you.

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- Keep a food journal to get an accurate picture of what you are actually eating. You may be surprised. You will find a 3-day diet recall form at the back of the binder. You can always fill this out and bring it to one of your visits and we will look over it with you.
  - Don't eat on the go. Sit at a table.
  - Take your time, taste your food and savor it.
  - Chew your food thoroughly and this helps with digestion.
- **Eat Consistently Throughout the Day:** Eating at least 5 small meals a day on a regular schedule will keep you satisfied and encourage an increase in your metabolism. Here's when to eat:
  - **Breakfast** within 1 hour of waking up
  - **Snack** 2 to 3 hours after breakfast
  - **Lunch** 2 to 3 hours after snack
  - **Snack** 2 to 3 hours after lunch
  - **Dinner** finished at least 3 hours before bed
  - **Snack –** some may need a snack before bedtime or during the night

Calories: You really are not eating for two, especially in early pregnancy. You only need about 300 calories more per day than a normal 2000-calorie diet beginning in the 4th month of pregnancy. Eating 5-6 small meals a day is better than 2-3 large ones. Do not diet or eat less than 1,200 calories a day or your body will reset its metabolism into starvation mode.

Protein: During pregnancy and lactation, you should get 65-70 grams of protein a day. Good sources of protein include lean meats, fish, beans, eggs, grains, and dairy products. One ounce of meat contains about 7 grams of protein. Be sure to include meats that are good sources of iron and DHA in your diet. Good sources of protein for a plant-based diet incorporate a variety of foods: tempeh, soybeans, seitan, lentils, all kinds of beans, tofu, peas and lesser amounts in vegetables, seeds and nuts.

Fiber: As a general rule whether you are pregnant or not, you need between 20-35 grams of fiber each day. Eating fiber in pregnancy helps prevent constipation. Foods highest in fiber are fruits, vegetables and whole grains.

Whole Foods: A diet rich in a variety of organic fresh vegetables and fruits, whole grains, dairy products and eggs, grass-fed beef, free-range chicken, wild-caught fish and 2-3 liters (80 ounces) of water per day is the most nutrient rich diet during pregnancy. Plant-based diets also provide adequate nutrition but require more mindful diet planning by eating a wide variety of colorful foods. Your body is able to absorb the vitamins and minerals from foods better than any supplements or vitamins. However, many of us do not always eat a balanced diet of high-quality foods and benefit from some supplementation. All vitamins and supplements are not the same. (See **"Healthy Lifestyle Tips"** for more info.)

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Food Level Guidelines

Use these food levels to help you evaluate your diet. Level 1 has the lowest fat and carbs; Level 5 has the most. You may use these levels to try new foods, or substitute a lower fat and carb food for something you are craving. When you cook from scratch and use high quality foods, some of the foods listed can be healthier than their level. Let the midwives know if you need help with planning a healthy diet.

Symbols after each food represent: + Carbs, * Fats, # Proteins

Level 1			
Apples with skin +	Chard + #	Milk, nonfat + #	Raspberries +
Artichokes + #	Cherries +	Milk, soy + * #	Refried beans, nonfat + #
Arugula +	Citrus fruits +	Muesli, raw, no sugar + * #	Rice, brown +
Avocados *	Collard greens + #	Mushrooms +	Salsa, natural, no sugar +
Beans + * #	Cottage cheese, nonfat #	Mustard +	Spinach + #
Beets +	Cucumbers +	Nectarines +	Squash + #
Bok Choy +	Egg whites #	Oatmeal + * #	Strawberries +
Boysenberries +	Fish, cold water (salmon,	Olive oil *	Sweet potatoes +
Bran +	mackerel, sardines) * #	Olives *	Tea, green or black
Broccoli + #	Fish freshwater * #	Onions +	Tofu + #
Brussels sprouts +	Flaxseed *	Pears, with skin +	Tomato sauce, no sugar +
Cabbage +	Garlic, fresh +	Peas + #	Tomatoes +
Carrots +	Granola, raw, no sugar + * #	Peppers +	Vinegar
Cauliflower + #	Kale + #	Plantains +	Water
Celery +	Lettuce, romaine, green or	Prunes +	Yams +
Cereal, whole grain + * #	red leaf +	Radishes +	Yogurt, nonfat, no sugar + #
Level 2			
Apples, skinless +	Cream cheese, nonfat #	Melon, honeydew +	Soy sauce +
Bananas +	Duck, free-range * #	Milk, 1% + * #	Squid #
Blueberries +	Granola or energy bar +	Nuts, raw + * #	String beans + #
Bread, whole grain +	Eggplant +	Ostrich * #	Sunflower seeds + * #
Cantaloupe +	Fish, farmed #	Pancakes, buckwheat + #	Tortillas, whole wheat + * #
Cheese, nonfat #	Grapes +	Papayas +	Turkey breast #
Chicken, skinless	Hummus + * #	Peaches +	Vegetable juice + #
white meat #	Juice, fresh squeezed,	Pineapple +	Veggie Burger + * #
Coffee, black or	w/pulp, no sugar +	Plums +	Venison, free-range * #
cappuccino-nonfat milk + #	Kiwifruit +	Raisins +	Watermelon +
Corn +	Mangoes +	Ricotta cheese, nonfat #	Yogurt, no sugar + * #
Cottage cheese, low-fat * #	Meal replacement bar + * #	Soy nuts + * #	Zucchini +
Level 3			
A-1 Steak Sauce +	Clams #	Juice from concentrate +	Popcorn, plain +
Angel food cake +	Coffee, cappuccino	Ketchup +	Pork tenderloin * #
Applesauce +	w/whole milk + * #	Lamb, lean * #	Potatoes, baked or boiled +
Bagels +	Crab #	Lettuce, iceberg +	Pretzels +
Beef, eye of round * #	Cream cheese, low-fat * #	Lobster #	Refried beans, low-fat + * #
Beef, London * #	Eggs, whole * #	Mayonnaise *	Rice cakes +
Beef, top round * #	French fries, baked +	Milk, 2% + * #	Rice, white +
Canola oil *	Fruit, dried +	Muesli + *	Sauerkraut +
Cheese, low-fat * #	Graham crackers +	Oatmeal, flavored +	Soup, canned broth + *
Chicken, dark meat * #	Granola + *	Oysters #	Steak, lean * #
Chicken sandwich,	Honey +	Pancakes +	Sweet-and-sour sauce + *
broiled + * #	Jam or marmalade +	Pasta, plain +	Wine, red +
Chicken taco, baked + * #	Jerky, turkey #	Peanut butter, raw * #	Yogurt, frozen, nonfat + #

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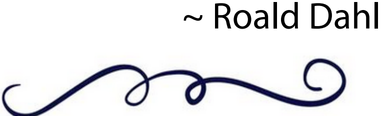
Symbols after each food represent: + Carbs, * Fats, # Proteins

Level 4			
Animal crackers +	Coconut *	Macaroni and cheese + *	Reuben sandwich * #
Beef, filet mignon * #	Coffee, iced mocha latte	Margarine *	Sherbet +
Beef, lean ground * #	w/nonfat milk + #	Meat loaf * #	Shrimp #
Beef, sirloin * #	Coffee, latte w/whole	Mexican food + * #	Sloppy Joe, lean beef/
Beef stroganoff * #	milk + * #	Milk, whole + * #	turkey * #
Beer +	Coffee cake + *	Muffins + *	Soft drinks, diet
Bread, refined flour +	Crackers +	Nuts, salted or roasted *	Soup, canned creamy + *
Buffalo * #	Grilled cheese sandwich + *	Peanut butter, no raw + *	Spaghetti w/ meatballs + * #
Butter *	Ham * #	Pepper, stuffed *	Sub sandwich + * #
Caesar salad, w/chicken + * #	Hot dogs, turkey * #	Pizza, meatless or	Taco salad w/ chicken + * #
Canadian bacon * #	Ice cream, sugar-free	Hawaiian style + * #	Tortilla, refined flour
Cheese (including	or fat-free +	Popcorn, w/salt & butter + *	or corn + *
bleu and goat) *	Jell-O +	Pork chop* #	Tuna or chicken salad * #
Chili + * #	Juice, sweetened +	Potato salad or	Vegetable oil *
Chinese food + * #	Lamb chops * #	macaroni salad + *	Wine, white +
Chips, low-fat, baked +	Lasagna, w/meat * #	Pudding, w/ low fat milk + *	Yogurt, frozen + * #
Level 5			
Alcohol, hard liquor	Chicken, buffalo wings	Creamed veggies + *	Nachos + *
Bacon * #	or nuggets * #	Creamer, nondairy *	Onion rings + *
Baked beans + * #	Chicken or fish	Doughnuts + *	Pastries + *
Beef, ground, regular * #	sandwich fried * #	French fries + *	Pies + *
Beef taco, fried * #	Chips, potato or corn + *	Gravy *	Potato skins, fried + *
Breakfast sandwich,	Chocolate + *	Hamburger, fast food * #	Pot pie * #
fast food * #	Coffee, mocha, macchiato,	Hot dogs * #	Refried beans, w/lard + *
Cakes +	iced blended, frappe,	Ice cream + *	Salad dressing, creamy *
Candy +	caramel vanilla, etc. + *	Jerky, beef, pork, venison #	Sausage * #
Cereal, sugared +	Cookies +*	Juice, sugar added +	Soft drinks, sugared +
Chicken a la King * #	Cream cheese *	Lobster in cream sauce * #	Tater tots + *

Every time my mother became pregnant, [my father] would announce to her that "the glorious walks" must begin.
These glorious walks consisted of him taking her to places of great beauty in the countryside and walking with her for about an hour each day so that she could absorb the splendor of the surroundings.
His theory was that if the eye of a pregnant woman was constantly observing the beauty of nature, this beauty would somehow become transmitted to the mind of the unborn baby within her womb...

~ Roald Dahl



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Food Group Chart

This shows the average amounts of food you need to eat every day to meet your needs.

Food Groups	Pregnancy Recommendations	Remember To
Meat, Eggs, Beans & Nuts	6 ½ oz. daily	Choose low-fat or lean meats and poultry. Choose fish high in DHA two times per week to help baby's brain develop (salmon, trout, anchovies, herring, sardines, canned mackerel) 1 oz. of lean meat poultry or fish = 7 grams, 1 oz = 1 egg, ¼ c. cooked dry beans, ½ oz. nuts, or 1 tbsp. peanut butter
Milk	3 cups daily	Choose low-fat or fat-free milk and reduced fat or frozen yogurt instead of cheese or ice cream. 1 cup=8 oz. milk or yogurt, 1 ½ oz. cheese, or 2 oz. processed cheese
Vegetables	3 cups daily	Eat dark green and orange vegetables. 1 cup= 1 c. raw or cooked vegetables, or 2 c. raw leafy vegetables
Fruits	2 cups daily	Eat a variety of fresh fruit, limit juice to 4 oz. daily. 1 cup=1 c. fruit or ¼ c. dried fruit
Grains	8 oz. daily	Eat whole grains instead of white bread and rice. 1 oz.= 1 slice bread, 1 small tortilla, or ½ c. cooked pasta or rice ½ c. unsweetened cereal
Oils	Limited	Limit fried foods. Choose monounsaturated fats. Bake, boil or grill instead. Use limited amounts of olive oil or vegetable oil instead of lard, butter & shortening.
Beverages	10 glasses (80 oz or 2-3 liters) of water daily	Limit Kool-Aid®, sodas and sweet drinks to less than 8 oz. per week. Avoid Gatorade®, PowerAde®, energy drinks and alcohol. Limit coffee to 1-2 cups per day or switch to decaf & add milk. Drink caffeine-free teas.

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1-Week Diet Recall

This is a tool for you to use to evaluate your diet.

If you need help, bring it to your prenatal visit.
Be honest with yourself and include all foods and drinks and portions size.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Breakfast						
Snack						
Lunch						
Snack						
Dinner						
Snack						

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Vitamins and Supplements

There is a huge difference between synthetic supplements (the vitamin and mineral pills that you buy at most stores) and whole food supplements (real nutrition that your body can actually use - genuine replacement parts - which comes from nature).

Two Basic Types of Nutritional Supplements

- **Synthetic Supplements:** The most common type of nutritional supplements is man-made synthetic, isolated components of the vitamin complex that are combined in prescribed amounts to give you the prenatal vitamin, Vitamin C, D, Calcium, etc. These supplements often use insoluble and therefore non-absorbable forms of vitamins and minerals that are poorly utilized by the body. You might see some improvement with these supplements initially but over time, your body will be depleted of all the other parts of the vitamin that are normally found in food sources and you may begin to notice health problems. Research now suggests that single vitamins, taken out of the food complex, may not be as effective in promoting health as eating the whole food.
- **Whole Food Supplements:** Whole food supplements are derived mainly from recognizable food sources. They contain all the food nutrients plus synergistic cofactors, phytochemicals, enzymes, vitamins, minerals, trace minerals to provide you with the strongest, natural, and most well-balanced supplement. These supplements contain all the things your body needs to absorb and utilize the nutrients. Whole food supplements may also contain some nutrients from animal tissues which only come from safe, USDA tested and approved sources. If you compare the label of ingredients on manmade vitamins to whole food supplements, you will notice that the amounts on the whole food supplements are smaller but they are of much higher quality and potency resulting in better absorption.

Folic Acid, Vitamin B12: Folic acid is essential for healthy growth of the spinal cord and helps prevent neural tube defects. Your body uses folate to produce red blood cells. You need at least 400 to 800 mcg daily. Good food sources of folic acid are found in whole grains, seeds, beans and leafy greens. Vitamin B12 promotes proper red blood cell formation and healthy neurological function and DNA synthesis. You need 2.6-2.8 mcg daily. It is mostly found in animal sources, fortified foods and some nutritional yeast. Plants do not contain Vitamin B12. If you are eating a plant-based diet or have a MTHFR mutation, you are at higher risk of deficiency and supplementation is recommended. Clients with untreated B12 deficiencies cannot use nitrous oxide in labor.

Calcium, Magnesium: Calcium is essential for bone formation. You need between 1000-1300 mg of calcium per day. Good sources for calcium include dairy products, dark leafy greens, fortified cereals, soymilk or juices, and beans. Magnesium is essential for protein synthesis, muscle and nerve function, blood glucose control, and blood pressure regulation. You need 350 mg daily and good sources include green leafy vegetables, legumes, nuts, seeds, and whole grains.

Vitamin D: Vitamin D promotes calcium absorption, affects cell growth, immune function and reduces inflammation. Maternal vitamin D deficiency in early pregnancy has been associated with elevated risk of gestational diabetes mellitus. Other associations with maternal vitamin D deficiency include increased risk of pre-eclampsia, preterm birth, low birth weight and cesarean section. Obesity is associated with Vitamin D deficiency because Vitamin D is taken up by fat cells and is not available for use in the body.

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Sensible sun exposure (exposure of arms and legs for 5-30 minutes between 10 am and 3 pm twice a week) is often adequate depending on the season, latitude and skin pigmentation. There are few foods that contain naturally occurring Vitamin D including wild-caught salmon, mackerel, herring and cod liver oil. It is fortified in some foods including milk, some juice products, some breads, yogurts and cheeses. For several years, we have screened all pregnant clients in our practice for Vitamin D deficiency and found that over 90% of clients are deficient, therefore, we recommend supplementation with 4000 IU daily during pregnancy for all clients. Supplements come in liquid or pill form.

Maternal vitamin D levels affect the newborn levels. Human milk typically contains about 25 IU or less of vitamin D per liter, but lactating clients who are taking 4000 IU daily are able to transfer enough vitamin D into their milk to satisfy their newborn's requirements of 400 IU daily. Clients who are deficient will not provide enough vitamin D for their baby's needs. We recommend supplementing the mother/birthing parent rather than giving the baby a multivitamin or vitamin D. If an infant is weaned to vitamin-D fortified infant formula (consuming at least 1000 mL per day) or a child one year of age or older is weaned to vitamin-D fortified milk, then further supplementation is not necessary.

DHA: DHA is an omega-3 fatty acid, which helps support the development and function of the brain and eyes. You need at least 200 mg of DHA daily. This can be found in certain fish, eggs, grass-fed beef.

Prenatal Vitamins: Take prenatal vitamins daily as part of a healthy well-balanced diet while you are pregnant and breastfeeding. We recommend the Standard Process whole food supplements available online at Amazon including Cyrofood, Folic Acid/B12, Tuna Omega 3 Oil, and Immuplex for a complete prenatal program.

If you are taking the synthetic vitamins, be sure to check the nutrients listed in the vitamins. All prenatal vitamins are not the same and some require you to take up to 6 vitamins per day to get the recommended dosages.

Choose synthetic vitamins that contain at least:

- 400 mcg folic acid
- 400 IU Vitamin D
- 200-300 mg calcium
- 70 mg Vitamin C
- 3 mg thiamine
- 2 mg riboflavin
- 20 mg niacin
- 6 mcg Vitamin B12
- 10 mg Vitamin E
- 15 mg Zinc
- 17 mg Zinc
- 150 mcg iodine

Synthetic prenatal vitamins may make your nausea worse in the first few months. Try to take them after you eat or at bedtime. You may try gel vitamins, chewable or a different brand to see if your symptoms are better. If you continue to have problems, talk to your midwife about other choices.

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Iron Recommendations: Clients need 30 mg of iron daily while pregnant and 60-120 mg per day if anemic. Your blood will be checked for anemia (low iron count) at least twice while you are pregnant. Clients with anemia will need to eat iron-rich foods and may need to take an iron supplement. There are several synthetic iron supplements (ferrous sulfate) and several whole food supplements. Floradix and Megafood Blood Builder are vegetarian formulas. The Standard Process supplement, FerroFood, contains animal and plant sources and can be purchased at Dar a Luz. Discuss with your midwife, which would work best for you.

For mild anemia:

- Take ferrous sulfate 1 tablet (325 mg) by mouth daily (total of 1 tablet = 60 mg)
- FerroFood 3 capsules in the morning and 3 capsules in the evening (total of 6 capsules = 60 mg)
- Floradix 30 ml in the morning and 30 ml in the evening (total of 60 ml = 60 mg)
- MegaFood Blood Builder take 1 tablet in the morning and 1 in the evening (total of 2 tablets=52 mg)

For severe anemia:

- Take ferrous sulfate 1 tablet (325 mg) by mouth in the morning and at night (total of 2 tablets = 120 mg)
- Ferrofood 6 capsules in the morning and 6 capsules in the evening (total of 12 capsules = 120 mg)
- Floradix 60 ml in the morning and 60 ml in the evening (total of 120 ml = 120 mg)
- MegaFood Blood Builder: take 3 tabs in the morning and 2 tabs in the evening (total 5 tabs=130 mg)

When taking iron, take it with water or juice and at a different time than your prenatal vitamins. Do eat or drink dairy products for at least 1 hour before or after you take iron because dairy inhibits iron absorption. Your stool (poop) may be black or green and synthetic iron pills may make constipation worse. You may want to take Colace stool softener if constipation is a problem.

Iron rich foods: Below are some good sources of iron in foods and you are encouraged to eat some of these throughout pregnancy. Cooking in iron skillets increases the amount of iron in your foods.

High Iron Foods (3-5mg/serving size)	Moderate Iron Foods (2+mg/serving size)	Low Iron Foods (1+mg/serving size)
Beef or chicken liver	Beef or lamb	Spinach, dark leafy greens
Clams, shrimp	Dried beans, lentils	Peas, green beans, broccoli
Cooked oysters, mussels	Dried dates, apricots, figs	Sweet potato, potato
Heart, kidneys	Dark meat chicken or turkey	Pumpkin
Goose, pheasant, deer, elk	Fortified cereals	Rice, whole grains
Dried seaweed	Blackstrap molasses	Egg yolks
Tofu, soybeans	Seeds – sesame, pumpkin	Nuts – cashew, pine

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Food Safety Guidelines

While pregnant, it is important to follow this guide about food safety to help make sure you and your baby stay safe.

Preparation

- Clean your hands and the area where you prepare food.
- Separate all raw meats and eggs from ready-to-eat foods.
- Wash fruits and vegetables, even if they will be peeled.
- Eat organic when possible to reduce pesticide ingestion.
- Don’t wash meat and poultry.
- Defrost and marinate foods in the refrigerator, not on the counter.
- Don’t open bulging cans. Boil home canned foods for 20 minutes.
- Cook to the proper temperature. It is best to use a food thermometer for meats because color is not always a good guide.
- Eggs should be cooked to firm.
- Reheat soups, sauces, and gravy to boiling.
- Reheat meats to steaming.
- Chill foods quickly.
- Leftovers should be refrigerated within 2 hours (within 1 hour if the day is hotter than 90°F).

Food Selection

- Follow the local advisories about fish from lakes and rivers.
    - See www.nmenv.state.nm.us/swqb/advisories/
- Avoid fish and shellfish that are raw or not cooked (oysters, clams). This includes sushi and sashimi. Cooked and vegetable versions are fine.
- Avoid ceviche.
- Avoid all raw meats and poultry.
- Avoid raw eggs and food made from raw eggs.
- Avoid juices that are not pasteurized.
- All milk and milk products (goat milk included) must be pasteurized.
- Avoid raw sprouts (alfalfa, radish, etc.). Cooked sprouts are less of a problem.
- Boil water taken from lakes and rivers when you camp or hike.
- Follow food recalls.

Contact your midwife if you have questions.

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Food Safety During Pregnancy

Health risk	Where it's found	How to prevent illness
Listeria This is a bacterium found in some refrigerated ready-to-eat foods that can cause serious problems like miscarriage, preterm delivery and stillbirth.	Deli meats and salads, hot dogs, smoked seafood, pate' and meat spreads. Milk or cheese products that are not pasteurized (Mexican-style, Queso fresco, blue or gorgonzola).	Throw away food that has gone past its "use-by" or date it expires. Reheat hot dogs, luncheon meats, and smoked seafood until steaming hot. Make sure the label says, "Made with pasteurized milk."
Toxoplasma This is a parasite that may cause an infection that can be passed to an unborn baby that affects brain and eye development. It is found in garden soil and raw meat. Cats get toxoplasmosis by killing and eating infected prey.	Undercooked meat Unwashed fruits and vegetables Infected cat feces	Wash your hands after you touch soil, sand, raw meat, or unwashed vegetables. Wash and peel all fruits and vegetables before eating. Freeze all wild meats a few days before you cook them. Don't eat raw meats. Don't adopt a sick kitten while pregnant. Have your cat tested. Have someone clean the litter box daily.
Mercury This metal can harm the developing nervous system in an unborn child or young baby.	Do not eat shark, swordfish, king mackerel and tilefish, which have high levels of mercury. Some fresh water fish may also have high levels. Follow local advisories.	Avoid only high mercury fish. Most fish commonly eaten (Shrimp, canned light tuna, pollock, catfish and tilapia) do not contain too much mercury. You can eat up to 12 oz per week instead of other meats. There are some fish (salmon, trout, anchovies, sardines, herring and canned mackerel) that are low in mercury and high in DHA. These are excellent choices to include in your diet to help your baby's brain growth.

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Childbirth Education

Childbirth Classes – Register online

We have developed a unique offering of classes that draw from many types of childbirth philosophies. You can read about all the classes and sign up for them on our website. Because of our small groups, these classes can be tailored to your individual needs. You have a choice between the Dar a Luz 5-week series or Blissborn Hypnosis® classes which are taught at the center. Additional classes for breastfeeding, newborn and car seat complete the series. The Condensed class is for clients and partners who have had a baby before, because it prepares you for natural birthing at the birth center. All required classes are included in your birth center services fees, but the Blissborn classes have an additional supply fee.

These classes are a key part of the comprehensive care given at the birth center to prepare families for a natural birth in a birth center setting. Late transfers (35+ weeks) who have taken classes elsewhere are still expected to take any classes still available, including the Condensed class or part of a series.

What is Required: Classport Checklist

We recommend starting classes around 28 weeks. They should be completed by 37 weeks of pregnancy. Partners are strongly encouraged to attend all classes (except Conscious Beginnings).

This is my first baby	
Required	**Strongly Recommended**
✓ Dar a Luz Series or Blissborn (5 classes) ✓ Breastfeeding 101 ✓ Newborns Head to Toe ✓ Carseat Clinic ✓ Interventions & Hospital Transfers	✓ Conscious Beginnings: Your First Trimester ✓ Pathfinder: Dar a Luz Classes & Services ✓ Pumping Basics ✓ Newborns Beyond the Basics I & II ✓ Infant CPR
This is NOT my first baby	
Required	**Strongly Recommended**
✓ Condensed Class (if you don't take a 5-week series) ✓ Interventions & Hospital Transfers	✓ Conscious Beginnings: Your First Trimester ✓ Pathfinder: Dar a Luz Classes & Services ✓ Dar a Luz Series or Blissborn (5 classes) ✓ Breastfeeding 101 ✓ Pumping Basics ✓ Newborns Head to Toe ✓ Newborns Beyond the Basics I & II ✓ Carseat Clinic ✓ Infant CPR
I HAVE ALREADY birthed at Dar a Luz	
Required	**Strongly Recommended**
✓ **None**	✓ Conscious Beginnings: Your First Trimester ✓ Condensed Class or a 5-week series ✓ Interventions & Hospital Transfers ✓ Any of the above classes you'd like

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Conscious Beginnings: Your First Trimester Class

You will receive an invitation for this class once you have been accepted to Dar a Luz care. The class is taught by midwives Lauren and Meagan, and is meant to be taken only by the birthing parent, in the early first trimester while you're waiting for your first midwife appointment. The purpose of the class is to bring connection to your new pregnancy and the many changes that will begin to occur within. It will give you tips on how to cope with common rough patches in the first trimester as well as healthy diet, exercise, supplements, mindfulness, things to avoid and warning signs for which you should watch. There is also time for questions and connection with other new birthing parents.

Pathfinder: Dar a Luz Classes and Services

If you're not sure which class you'll like best, attend this class. You'll meet the educators and hear about their classes and our resources, as well as some important pointers for your Dar a Luz care. Take this class any time after your first prenatal visit.

Dar a Luz Birth Class Series (5 classes)

Our 5-week Dar a Luz birth series, taught by Amity McElroy, is anything but boring or lecture-based! Tailored to the needs of the individuals within each series, the curriculum is dynamic, ensuring that we meet the needs of all the learners attending. Expect to learn the answers to all your questions like, "How will I know when I'm in labor?" and "What will contractions feel like?" plus all the ins and outs of having a birth center birth. Learn and practice coping techniques for labor--everything from breathing and guided imagery to labor positioning and massage. Then, go deeper in this class and explore coping strategies for the emotional and psychological changes ahead with birth art, group discussions and partner activities. Connect with other parents and families and enjoy the bond you all will share as birth-center parents. Partners should attend every class if possible!

- Week 1 - Introduction to Labor and Birth, including feelings about birth, anatomy, stages of labor, and the role of relaxation in birth.
- Week 2 - Early labor, including signs of labor, when to come to the birth center and what to bring, comfort measures and positions.
- Week 3 - Active labor, including movement in labor, making noise, massage, and breathing techniques.
- Week 4 - Pushing and delivery, pain medication options, interventions in labor, embracing the unexpected, and fear.
- Week 5 - Welcoming the newborn, postpartum, mother blessing, guest speaker, potluck.

Here is what some of the participants in the Dar a Luz class series have said:

"I loved how much emphasis was put on including my partner and how each birth video was different."

"Amity was awesome! I'm extremely critical of teachers/presenters and she CRUSHED IT!"

"Very enthusiastic, full of fun stories, you can really tell that she's knowledgeable and passionate. I like the variety of learning styles."

"Amity was awesome! I appreciate her detailed instruction and personal touch. The last call was so special and memorable. The sense of community was nice and helpful to know other on this journey."

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Blissborn® Birth Hypnosis Series (5 classes)

What is Blissborn? It's a hypnosis-based comprehensive birth class for analytical people. Blissborn is a science-based, complete childbirth education class created around deep guided relaxation, also known as hypnosis. (If you're wondering about hypnosis, go to www.Blissborn.com to download a free 10-minute relaxation and learn more.) We also emphasize partner skills, fear-release, pain-control, confidence through knowledge, and a deep understanding of the beautiful design of a woman's body. You're building a whole person -- your body knows how to get that person out! The vast majority of Blissborn clients achieve a more rapid and easy natural labor. Blissborn babies tend to be calmer too.

Who will enjoy taking a Blissborn class? Blissborn works well for parents who lean toward a natural way of doing things, who are interested in loading up on new information and new skills, who enjoy relaxation, and who can commit to practicing daily. If you live with anxiety, or have worries or fears about labor, birth, or parenting, Blissborn may be a great fit. Also, we find that older first-time moms benefit greatly from learning to let go on their own terms!

What should you expect to learn? Lots of tools for use in labor and birth and beyond. Partners are a big part of the class, so please bring a partner if possible (it doesn't have to be the baby's other parent). We move quickly and cover a lot of information about your body and mind and birth. After each class, you'll practice relaxation daily with an mp3 that corresponds with the class. The 6th recording is for use in labor, and there are bonus recordings for the car ride in labor and the postpartum period.

The classes are:

- **Class 1- Discovering Self-Hypnosis:** Learn a new way to think about your mind and body, and learn all about the profound relaxation you experience in hypnosis. You'll also learn a tool for "Letting Go" and returning to relaxation instantly (very useful in labor!), and you'll experience the power of visualization.
- **Class 2 - Practical Skills for Mom and Partner:** Clients need lots of support in labor! Partners deserve to be a big part of labor, too, and will learn lots of ways to REALLY help. Practice staying in hypnosis while walking and opening your eyes. We also spend time discussing birth anatomy and phases of labor.
- **Class 3 - Birth Without Fear:** Learn to transform fears into calm and confidence. This powerful class will move you beyond feeling fearful, all the way to being excited about your baby's upcoming birth day! These are lifelong skills, and powerful for everyday worries and anxiety.
- **Class 4 - Tame Labor Pain with your Brain:** Practice different ways to control sensations in hypnosis -- you'll work with your own body so you understand that being in charge of your comfort is your own natural ability. This class is a real confidence booster.
- **Class 5 - Putting it all Together:** Meet a past Blissborn couple and hear their story. Put together all the skills and info from the first four classes so you'll feel confident and excited about your birth. Learn all about birth preference documents, labor positions, and the pushing phase. Practice your skills with timed sample contractions. Look beyond birth to your plans for the baby. Also includes looking at your priorities and a discussion about advocacy in birth.

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Here is what some of the participants in the Blissborn class series have said:

“Provided me with lots of techniques to help me relax, feel more confident, and address fears about labor and birth. Can and did answer every question.”

“Laura was very kind, helpful and went above and beyond to help me grasp the material. It helps me feel more empowered and confident when it comes to birth.”

“Very knowledgeable, always calm, and compassionate. Instilling calm, confidence, and that our bodies are capable.”

“Useful skills that are transferable even after birth.”

“All wonderful, made a huge difference in state of mind, letting go of fears and connection and preparing myself and partner for birth.”

“I loved how it connected me with my wife.”

“I really loved this class. We’ve since heard from other couples who’ve used these techniques and their stories confirmed what we’re learning in class. I’m very excited to see how much it helps! Thank you!”

Condensed Childbirth Class (4 hours)

This class is a refresher class for parents who have already had a baby, or is an acceptable alternative for late transfer clients who do not have time to take a 5-week series. It covers the ins and outs of having your baby at the birth center. We discuss the differences between hospital births and birth center births, while incorporating some fun things like birth visualization. The class covers the basics of labor and birth and reviews pain coping techniques.

Here is what some of the participants in the Condensed class have said:

“Claire is empathetic, compassionate and a great teacher. Her material was presented very clearly. Easy to follow. I have more knowledge on the natural birthing process.”

“It builds confidence.”

“Great presenter and kept the audience engaged. It was fast and what is needed.”

Newborns Head to Toe

Compared to other mammals, our newborns are born immature and fragile. The first 3 months after birth are often called the fourth trimester as newborns unfold, "wake up" and start developing into the unique individuals they will be. In this class, learn what makes newborns "tick," how to figure out what your baby needs and understand her/his communication cues. We cover all the basic care like burping, diapering, and bathing. We also go over less fun (but really important) subjects like reducing SIDS, and your required shaken baby training. Learn about normal newborn behavior and appearances and what to do if something doesn't seem right. Work on your swaddling skills (bring your own blanket if you can). Most of all, learn how exciting and wonderful your new little family member will be and how to fully enjoy these early days. Recommended for all parents attending Dar a Luz birth classes. Taught by Amity.

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Breastfeeding 101

Come learn the evidence-based strategies that activate your instincts in breastfeeding and find out how amazing your newborn will be! In this class we will focus on the early weeks of breastfeeding and what you can do now to prepare. Find out how to prevent difficulties like sore nipples and low milk supply and what to do if they arise. Partners are welcomed and encouraged to come! The #1 predictor of successful breastfeeding is partner support for the breastfeeding mother. Taught by Amity.

Carseat Clinic Class

Parents wrestling with a carseat for the first time will love this informative and reassuring class with hands-on help installing the carseat. Changing carseats for a bigger child? Have questions about installing your carseat in another vehicle? Come and get your questions answered by Nancy Anthony, certified child passenger safety technician and instructor. Some think it's a dry topic, but Nancy makes this class fun. You will be glad you came, and your child(ren) will be safer because of it.

Interventions & Hospital Transfers Class

Everyone is required to take this class once! No one ever really believes that they are going to transfer, and when the midwives bring up the topic, we hear comments like, “It won’t happen to me,” or “I just want to be positive and don’t want to think about it,” or “I’m not worried about that.” The midwives hear the experiences of clients after transfer and some are very positive; others report back that they feel some level of trauma around their experience. We hear from clients who have had traumatic births with a previous pregnancy and that can affect the current pregnancy.

A recent post by ACNM (American College of Nurse Midwives) states that “Research suggests as many as 30 percent of women experience debilitating traumatic stress after childbirth, and nearly a third of those may suffer PTSD (Post Traumatic Stress Disorder), according to PATTCh (Prevention and Treatment of Traumatic Childbirth at PATTCh.org).” A birth is defined as traumatic if the woman was or believed she or her baby were in danger of injury or death, and she felt helpless, out of control, or alone.” This can occur at any point in labor and birth. It is important to recognize that it is the client’s perception that determines the diagnosis, whether or not clinical staff or caregivers agree. Even though physical injury to mother or baby can occur during a traumatic birth, a birth may still be traumatic without such physical injury. Unfortunately, clinical symptoms of full diagnosis of Post-Traumatic Stress Disorder (PTSD) can occur for mothers and partners following a traumatic birth, the effects of which impact attachment, parenting, and family wellness.

At Dar a Luz, we recognize that transfers, even though you see the need for the next level of care, are a situation that can bring up feelings of loss of control, helplessness and stress. We have listened to our clients in person and through your feedback on surveys and want to be proactive instead of reactive in preparing you as much as possible for the unexpected. We have put together a class to address your fears and answer your questions surrounding interventions and transfers. In May 2014, we started a collaboration with New Life Birth Services to be available for our families that have to transfer to the hospital immediately prior to labor or during labor. This program is a cost share between the birth center and our clients for doula care at the hospital during labor through one hour after your baby is born and includes one postpartum visit.

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In this comprehensive class, you will have an opportunity to meet the doulas at the class, as well as hear the experience of a family who has transferred to the hospital. Our counselor on staff will share information about our support groups for processing your birth experience. Then a midwife will present our transfer statistics and discuss interventions at the birth center and hospital to help you prepare for the unexpected. We have also started a birth trauma support group to help clients process their birth experiences. Since starting this program, those families that attend this class are better prepared and are having better transfer experiences. **We now require everyone to take this class once and it is offered monthly.** You may take it anytime in your pregnancy but it may be most helpful in the third trimester. Register online.

This is a summary of our statistics for clients from 2011 to 2018 that show your chances of transferring.

- For a prenatal medical problem are about 18% (most likely for high blood pressure)
- Prior to labor are about 3.6% (most likely for rupture of membranes and we can't get you into labor)
- During labor are 10.9% (usually for prolonged labor due to a mal-positioned baby and maternal exhaustion)
- Postpartum 2% (most likely for a client who is not stable after a hemorrhage or repair of extensive tears)
- Newborn transfers are about 1-2% (mostly for breathing problems that do not resolve over time)
- Emergency transfers are 1.4% (hemorrhage during labor, baby not tolerating labor, uncontrollable postpartum hemorrhage, newborn resuscitation)

The good news is that most clients do not get transferred!

- 87% of clients who were admitted to the birth center in labor had a vaginal birth at the center
- 90.5% of all clients who were admitted to the birth center in labor including transfers had a vaginal birth
- Our overall cesarean section rate for all clients who sign up for care is 9.5%

Bonus Classes

Pumping Basics

This class is an in-depth look at how to get milk OUT of the breasts, IN to the baby and manage the scheduling of being separated from your little one. Which bottle is best? Am I pumping enough milk for my baby? What about growth spurts? Learn important skills like hand expression, increasing your milk production at the pump and stimulating your let-down when you're away from the baby. Figure out how much milk to "stock pile" for a rainy day, how to know if your milk supply is getting into trouble and what to do about it if it is. Learn milk storage guidelines, coping strategies for busy pumping parents, and ways to ease your baby, your family and yourself into the periods of increased separation that going back to work or school might bring. This class is packed with information and you should have some basic understanding of how breastfeeding works on its own before taking this class. Great for already-breastfeeders or those who have taken Breastfeeding 101. We recommend coming in before your baby is born, if possible! Bring your pump if you already have one, or we have demo pumps to work with too.

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Babies Beyond the Basics

There's SO much to learn that it can't be covered in one class These classes are optional, and can stand alone. Take these classes in any order, after Newborns Head to Toe if possible (OK to take before).

Part I This one focuses on the first 6 months: Baby-wearing, cloth diapers, choosing a pediatrician, bed sharing vs. sleep training, attachment parenting, introducing pets to baby, helping siblings adjust to new baby, developmental milestones... and so much more.

Part II This one focuses on older babies and life with babies: Building your village; protecting your relationship; baby safety & childproofing basics; developmental play; introducing first foods; choosing childcare; teething; baby massage; Baby Sign Language and more!

Baby Massage

- Meets every 8-10 weeks on various dates
- Bring your baby!
- Recommended for parents with babies over 8 weeks
- Toddlers also welcome.
- $10 per person/$15 per couple.
- Anyone who cares for your baby is encouraged to attend!
- Bring any oil or lotion that you use on the baby.

Join Amity to learn about infant massage! She is certified through the International Institute of Infant Massage, and has taught at Dar a Luz, hospitals, Inspired Birth & Families, and daycare centers. Babies of any age are welcome, but those who are at least 8 weeks old will tolerate a longer massage. Older babies and toddlers are welcome too! Bring any oil or lotion that you use on the baby. Amity recommends organic cold-pressed oils such as olive, coconut, almond, grapeseed, or apricot kernel.

Some benefits of massage for baby

- Relief from colic, congestion, gas and stress
- Bonding with care giver
- Increases oxygen and respiration
- May help baby sleep longer
- Enhances Neurological development
- Increases threshold of touch
- Helps avoid overstimulation
- Improves sensory awareness

Benefits for care giver

- Feel more confident and competent
- Eases stress and encourages relaxation
- Increased bonding with child
- Improved mood

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Community Classes

The Bradley Method® is a unique 12-week series of classes that focuses on teaching families how to have natural births. The techniques are simple and effective. They are based on information about how the human body works during labor. Couples are taught how they can work with their bodies to reduce pain and make their labors more efficient.

By taking classes in The Bradley Method® of natural childbirth, you will learn about:

- Prenatal nutrition & exercise
- Relaxation for an easier birth
- Husbands as coaches
- Birth plans and more!

Birthing from Within® was conceived and developed by Pam England, MA, CNM, a home birth midwife and mother who, inspired by her own birth experiences, developed this creative, nurturing, personal way of preparing for birth and parenting. The classes have a balance of practical, useful information and creative, experiential exercises. They are personalized to your needs and interests yet focus on many types of birth. There are stimulating, lively discussions where you will not only learn about birth but also about yourself. Some concepts you can expect to learn are how to:

- Experience birth as a rite of passage
- Eat a sound diet during pregnancy and breastfeeding
- Open your body-mind before and during labor with self-hypnosis and visualizations
- Build confidence in yourself and your partner
- Ask questions and make decisions in labor
- Protect your birth space
- Push your baby out
- Welcome your baby
- Recover and plan postpartum
- Care for and feed your newborn
- Give birth from within during a Cesarean, while using pain medication, or with medical support

Birth is about much more than the wriggling of a tiny body out of a larger one.
When we birth, we don't just birth babies.
We birth ourselves, we birth our families, and we reshape our lives.

~ Sarah Wickham

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Doula Care

A birth doula is a supportive companion who is professionally trained to provide labor support and help you have a safe and satisfying childbirth experience -- however you may define that. They do not perform any clinical tasks. A doula provides physical, emotional and information support to clients and their partners during labor and birth. They give suggestion on comfort measures such as breathing, relaxation, massage and positioning. They may assist you in gathering information on the course of your labor and your options. Doulas give continuous emotional reassurance and comfort in addition to assisting partners to play an active support role.

Doulas can provide constant physical and emotional support at home, in the birth center or at the hospital. Your midwife will be with you as much as possible while still attending to their clinical duties and responsibilities for you and your baby. If you are a first-time parent or feel you need more support, we encourage you to consider hiring a doula. Doulas also provide postpartum support and placenta encapsulation services. There are many doula options to choose from. Dar a Luz hosts a “Community-Wide Doula Meet and Greet.” The event is open to everyone in our community, not just Dar a Luz clients. We invite all pregnant people and their families and anyone else interested in learning more about and connecting with doulas in the community.

Doula Support for Hospital Transfer

In May 2014, Dar a Luz began a collaboration with The New Life Birth Services, a group of doulas, available 24/7 to give a continuous labor support option to our families who must transfer to a hospital before birth. Dar a Luz shares the cost of these services with our clients making the services affordable and an extraordinary value for our families. Once you request a doula, she will meet you at the hospital and have you sign a contract for services. You are responsible for doula fees regardless of how long the doula supports you at the hospital. Come to the Intervention and transfer class to meet the doulas and learn more about these services.

The New Life Birth Services also has a monthly doula tea at the birth center for you to meet them and hear about their private hire services. They have various services to choose from including prenatal, labor and postpartum support and placenta encapsulation. Dar a Luz does not share any of the cost of private hire services.

Lending Library

Come, relax in the comfy chairs and enjoy the mountain views in our lending library. We are continually expanding our library and offer a wide variety of books on pregnancy, health and families for our clients. The books can be checked out for up to 4 weeks and we ask that you help us take good care of the books and return them so that others may enjoy them too. There is a $50 fee for each book that is not returned.

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Labor & Birth

This section will guide you through preparing for your labor and birth, as well as preparing for some of the choices you'll have to make right after the baby is born.

Preterm Labor

Premature or preterm birth is birth before 37 weeks of pregnancy. Preterm labor starts before 34-35 weeks, and will need hospital care to try to stop labor or to take care of the baby if labor is unavoidable. Premature babies may have a hard time breathing and/or eating and will need the support offered in a hospital. These babies may have a greater risk for health problems for the first 2 years of life.

About half of the preterm births happen in clients with no risk factors. Preterm labor can happen to anyone and especially if you suspect your water has broken. Prompt discovery of preterm labor symptoms improves the chances to possibly stop the labor before an early delivery.

Preterm Labor Warning Signs

(any time before 37 weeks)

- **Regular belly tightening or contractions, with or without pain**
- **More than 5 contractions in 1 hour**
- **Cramping like you may have during your period**
- **Belly cramping, with or without diarrhea**
- **Low, dull back pain that is constant or may come and go**
- **Pressure in your bottom or feeling that the baby is pressing down**
- **More discharge from your vagina or leaking of watery fluid**
- **Bleeding from your vagina**
- **Just not feeling right**

If you have any of these warning signs:

1. Empty your bladder.
2. Drink 3 to 5 glasses of juice or water.
3. Lie down on your left side for 1 hour.
4. ***If your symptoms do not change, call the midwife on call at 944-5488.***

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Late Pregnancy Warning Signs

(but may happen anytime)

Call the birth center (924-2229) or the midwife on call (944-5488) immediately if you have:

- Heavy bright red bleeding from the vagina with or without pain
- Leaking of water from vagina (clear is normal, green or brown may mean meconium is present)
- Pain or burning when urinating
- Fever more than 101°F
- Severe headache, blurred vision or other visual changes
- Severe abdominal pain or heartburn
- Sudden swelling of the hands or face
- Severe vomiting
- Pain in lower leg or lots of swelling in one leg
- Baby moves less than 10 times in 2 hours if you are at least 28 weeks

Fetal Kick Counting

Pregnant clients feel about 75% of all their baby's movements. This movement can be reassuring. Fetal movement may be felt as flips, rollovers, stretches, jabs, kicks or startles (hiccups should not be counted). Your baby has their own pattern of movements. If your baby is facing your spine, you may not feel the little kicks as much as you might if they are facing your belly.

You are encouraged to start counting your baby's movements twice a day beginning at 28 weeks of pregnancy. Please choose two times during the day when your baby is usually active to do the counts. Get in a comfortable position, place your hands on your abdomen and count your baby's movements.

Babies should move at least 10 times in a 2-hour period and this may take 2 minutes or 2 hours. Write down the time you start counting and the time you finish counting 10 movements. Use the "**Fetal Kick Counting Chart"** on the next page if you like.

If your baby has not moved 4 times in the first hour, eat and drink something to wake the baby up. Babies usually move more after you eat and at night.

If you feel less than 10 movements in 2 hours **call the birth center (505) 924-2229 or the midwife on call (505) 944-5488.**

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Fetal Kick Counting Chart

Use this chart to record your baby's fetal kick counts.

Date	Time Started	Movements Felt	Time Stopped	Comments
08-24-2021	8:30 pm	𝍸 𝍸 II	8:46 pm (16 min)	She started kicking more about 10 min after I ate dinner

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Birth Preferences Documents for Dar a Luz and the Hospital

Here at Dar a Luz, you'll probably find that most of the choices you might include on a typical Birth Preferences document are already standard practice. (See the section "**Birth Preferences: Your Care at Dar a Luz.")** Your time and effort now will pay off in labor and birth, as you make informed decisions and advocate effectively for your family's wishes. We also encourage you to keep your "Informed Consent Questions" cards in your wallets for a quick reference point. Personalize these preference documents to use when talking to your provider, doula or family.

Birth Preferences: Your Care at Dar a Luz

Your care at Dar a Luz Birth & Health Center usually includes the following:

During labor

- Individual care by a midwife during labor and birth
- Minimal use of interventions
- Intermittent monitoring of baby's heart rate
- Midwives obtaining permission to conduct vaginal exams when deemed necessary
- Eating and drinking are encouraged
- Pain relief options: sterile water papules, movement, water immersion, hypnosis, Nitrous Oxide, pain meds.
- Freedom of movement, choices of upright positioning during pushing

After birth

- Delayed umbilical cord clamping
- Rapid initiation of breastfeeding, breastfeeding support, baby-friendly practices -- we won't use pacifiers or formula, and we won't routinely suction your baby's airway
- Skin-to-skin contact, protected bonding time (usually at least 2 hours only with parent(s) of new baby)
- No baths for baby
- No hats or baby warmers for baby
- Doing the baby's routine examinations on or near you
- True Informed Consent/Informed Decline regarding the use of eye ointment and Vitamin K shots. We do not offer Hepatitis B vaccination
- Choices regarding the placenta, including our disposal, you taking it home, or doulas picking it up
- No circumcision (we don't perform this procedure)
- Newborn metabolic and critical congenital heart screening tests are done at the 24–36-hour visit

Dar a Luz Birth Preferences

Once you understand what to expect at Dar a Luz (see above), we would also like to know your other preferences. **Please share your preferences with us** at one of your visits regarding the following:

- Who will (or won't) attend the birth, including names of the partner, family, and friends
- The use of a doula
- Information about your special needs including physical and/or emotional conditions
- Your cultural/religious background and wishes
- Dietary needs
- Use of photography and video
- Cord blood banking
- Anything else that seems relevant to you!

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Birth Preferences: Your Care at the Hospital If Transferred

We also encourage you to create a Birth Preferences Document specific to a hospital transfer, and another one in case of cesarean birth.

We hope your birth experience happens entirely at Dar a Luz. It is sometimes necessary for some of our clients and babies to transfer their care to a hospital setting before, during, or after labor and birth. Dar a Luz statistical averages of all clients continuing care for 2018: Birthed at DAL: 70%. During pregnancy transfers: 25%. Prior to labor transfers: 4.7%. During labor transfers: 7%. Postpartum transfers: 3%. Newborn transfers: 3%. Total vaginal birth rate between DAL and hospital is 93%. Cesarean section rate is 7%. No maternal or fetal deaths. All of these rates are consistent with national research studies.

We have also created a template to help you craft a Birth Preferences Document for this different set of circumstances. Creating this document will be a valuable tool to remind you about your priorities when circumstances change. And making it short and clear will provide a good way to communicate your most important preferences to your care providers, including doulas, nurses, and doctors. Consider taking a tour of the hospital to get familiar with how to get there, and where to go once you're there.

The good news is that you have more options for your labor and birth today than ever before. In writing your preferences, the signed document you create clearly lays out your wishes and lets your care providers know how you define a successful birth outcome. We encourage you to frame this important document as a set of preferences, which implies an understanding that every birth is different and that situations change. Know that as a patient, you can never be forced or coerced into a procedure with which you don't agree, and you also have a right to request a patient advocate if you feel that you need one or express your grievances to a supervisor.

Some guidelines

- Keep it to one page or less if possible or it won't be a useful document – things are busy at the hospital!
- You may want to print several copies on colored paper, or laminate them (easier to find).
- It's a good idea to separate it into "Labor and birth" and "After the birth" sections and organize it chronologically.
- Include language such as "As long as all is well with myself and my and baby…" and "We appreciate your help." Please and thank you set a cooperative tone, and that's a good thing.
- You might also include language about understanding that your preferences may not all be possible now that you've entered the next level of care. At this point, we've found that how you are treated, listened to, and informed are more important than specifics about particular interventions.

Talk to your healthcare provider to find out what's possible and likely in your birth environment. Work on your Birth Preferences with your partner so you are both on the same page. Educate yourselves as you go. Make informed decisions about your plans for your baby as well by doing your research now. Some procedures are standard, but not required. Find out if they're right for you and your baby. If you want non-standard care for your baby, be sure to include it in your Birth Preferences. You can use the lists of choices below to start your research.

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Choices during labor and birth

- Who will (or won't) attend the birth, including names of the partner, family, and friends.
- The use of a doula.
- Ask about limiting the people in the room to only the necessary providers (no students, residents, etc.). Requesting privacy, doors closed. Limiting side conversations. Control of lighting and temperature.
- Information about your special needs, including physical and/or emotional conditions
- The family's cultural and religious background and wishes
- Access to food and drink and any special dietary needs
- Use of photography and video
- General wishes about interventions, drugs, tests and treatments and preferences regarding lowest levels of intervention possible during labor. Appropriate use of interventions is a part of a successful plan.
- Obtaining your consent regarding any and all procedures, tests and drugs; true informed consent about each choice includes a discussion about risks, benefits, and alternatives.
- Intermittent or continuous electronic fetal monitoring, external vs. internal, wireless monitoring while moving around, waterproof wireless monitoring for the tub.
- Showering and bathing during labor depending on your choices for pain management and your ability to move.
- Options to use alternative pain-management strategies (hypnosis, relaxation, massage, changing positions, warm water, etc.). Providers not promoting analgesic or anesthetic drugs unless you ask.
- The use of hypnosis (includes dim lights, soft music, quiet, playing an audio track, refraining from speaking to you during contractions).
- Options for stronger pain management and therapeutic rest when desired (IV narcotics and epidurals).
- Providers obtaining permission to conduct vaginal exams and receiving minimal vaginal exams.
- Options of different medications and procedures to induce and augment labor and when to use them (cook catheter/mechanical dilatation, artificial rupture of membranes, misoprostol, Pitocin).
- Freedom of movement during labor and choices for pushing positions. May be limited by pain management choices.
- Use of warm compress or cloth on perineum during pushing and crowning for comfort, and/or counter-pressure to help with pushing.
- Options for using episiotomy, vacuum or forceps to assist with vaginal birth.
- Understanding that you always have the right to get a second opinion before making decisions about any procedure, including cesarean surgery.

Choices after the birth

- Placing the baby on your chest or stomach immediately after birth for skin-to-skin contact for the first hour or longer to promote initiation of breastfeeding (within 30 minutes of birth) if the baby is healthy.
- Use of suction catheter instead of a bulb syringe (which can cause nasal swelling and oral aversion) to clear baby's airway if needed.
- Leaving the umbilical cord intact until it stops pulsing (at least 3-5 minutes) unless cord blood harvesting is desired. Milking the cord if the cord needs to be cut quickly because the baby needs immediate attention.
- Options to take the placenta home.

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- Uninterrupted contact with the baby from the moment of birth including rooming-in and co-sleeping with the baby.
- Partner accompanying the baby if the baby must leave the room (including evaluation or admission to the NICU), providing skin-to-skin contact.
- Delaying bathing and other non-essential procedures for at least an hour to bond with the baby. Waiting a day or so to bathe the baby or no bath at all.
- Delaying or avoiding procedures such as Vitamin K injection, eye ointment application or Hepatitis B vaccination -- and doing them well after the initial bonding period.
- Ask about Metabolic (PKU), hearing and critical congenital heart screening (CCHD) tests that are mandated by the state and are typically done before discharge.
- Doing baby's routine examinations in your presence, or in other parent's presence if necessary.
- Leaving the penis intact vs. circumcision (or insisting on staying with the baby during the procedure if circumcision is elected).
- Breastfeeding exclusively (avoiding formula, sugar water, pacifiers). Access to lactation consultations as needed, education on hand expression of milk and providing a pump to express colostrum and breastmilk for baby if you and your baby have to be separated.
- Options to use donor breastmilk if supplementation is needed. Informal milk sharing can be used for healthy babies but pasteurized milk is required for babies in the NICU (Dar a Luz has both types of milk). Options for using Supplemental Nursing System (SNS), finger feed, syringe, spoon, cup, etc. instead of artificial nipples when supplementing.
- How soon after the birth you would prefer to leave the hospital, if early discharge is available (in some circumstances, early discharge from UNMH might be available if you and baby are doing well. This would have to be coordinated between UNMH and Dar a Luz staff, and rarely happens).
- Your plan for newborn follow-up care – Dar a Luz for the first month beginning at day 2-3 of life or pediatrician.

Choices in case of cesarean birth

Many of the same choices above, plus:

- Partner present at all times
- Partner to cut the cord
- Delayed cord clamping for healthy newborns
- When circumstances allow (non-emergent), ask about "gentle cesarean birth," designed to promote breastfeeding, family bonding, and to enhance the experience as a more natural de-medicalized birth that would more closely approximate vaginal birth. Components include:
    - Ambience changes (dim lighting, music)
    - Another adult family member or doula present at the birth
    - Limited non-essential staff present in the room
    - Option to watch the baby being born from the abdomen through a clear drape
    - Option to see the baby immediately after birth by dropping the drape
    - Skin-to-skin care for newborns
- Other choices can include:
    - Mirror to view the birth
    - Placing the baby on your chest immediately after birth for skin-to-skin contact
    - Free one hand to touch the baby
    - No separation of parent(s) and baby
    - Breastfeeding in the recovery room
    - Doula present at all times

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SAMPLE: Birth Preferences for the Hospital

Create your own list of preferences reflecting your hopes and values

Birth Preferences of ___________________________________

We are aware that our situation may require interventions, and we appreciate your expertise.

Although our circumstances have changed, as long as our baby and I are doing well, we request the following:

General philosophy

- We are still hoping for as natural an experience as possible.
- We would like to be informed of our risks benefits and alternatives when any tests or procedures are being recommended. We want to have choices in our care and be included in making decisions.
- Please help us feel respected by introducing yourselves, honoring our privacy, waiting until contractions are over before talking to me, asking permission before any examinations or touching, and including us in any discussions going on in the room.
- In addition to the baby's parents/guardians, we would like the following guests to be present during labor and birth: ____
____
- The partner/other parent, ___________________________, is authorized to speak, act, and make decisions on my and my baby's behalf, and to go with the baby wherever they are taken.

Labor and birth

- Please don't administer any medications or procedures without our express consent.
- Fetal monitoring: we prefer external and intermittent to allow movement, if possible.
- During pushing, allow mother-directed (physiologic) pushing as long as it's effective.
- Please postpone cutting the cord for at least 3-5 minutes (and as long as possible).
- Use the suction catheter instead of a bulb syringe if required, to avoid nasal swelling that could interfere with breastfeeding.
- Please postpone cleaning and weighing the baby and administering eye ointment and injections for at least an hour to allow bonding and the start of breastfeeding.
- In case of cesarean surgery, please allow the other parent/guardian in the operating room. They will stay with the baby. Please allow the baby and me to bond as much as possible. Please reunite the us as soon as possible after the surgery, preferably immediately.

After the birth

- We intend to room-in and keep the baby with one of us at all times.
- Please do not give the baby any formula or artificial nipples – we want to nurse when the baby is hungry or have the option to give our baby donor breastmilk if supplementation is needed.
- Please apply NO vaccinations, medications, tests or procedures without our express consent.
- The baby's foreskin will be kept intact.
- We are returning to Dar a Luz Birth & Health Center for postnatal and newborn care at 2-3 days after birth. Call the midwife on call at (505) 944-5488 for follow-up plans.

Mother's signature ___________________________ Mother's name ______________________________

Partner's signature ___________________________ Partner's name ______________________________

Date signed _________________________________

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What to Expect If You Transfer to a Hospital

Keep in mind that there is a difference between planning for a natural birth in a hospital and transferring to the hospital due to complications after attempting a natural birth at the birth center or transferring to the hospital for an induction of labor due to complications in pregnancy. Some of the choices above may not be applicable in transfer situations.

We require everyone to go to the Interventions and Hospital Transfers class for a detailed presentation about transfers, and to hear from a family who has been transferred to the hospital.

At the center we provide the most supportive environment for you to have a natural vaginal birth. This includes a familiar place, continuous labor support by someone you know, space to move around in labor, tubs for labor and birth, privacy and relaxing spaces with sounds of nature, and a garden.

If problems arise, we will discuss your options with you. If we all agree that you need to transfer to the hospital, we encourage you to embrace the next level of care and all the technology that is offered at the hospital. We want you to still achieve the number one goal of a healthy mom/birthing parent and baby; the next goal is that you are able to achieve a vaginal birth. It may take up to 30 minutes or so to arrange the transfer and get records completed. For non-emergent transfers, you would follow your midwife in your personal car to the hospital. She would go with you to help answer questions and make the transfer as smooth as possible, and would stay a short time (usually 1-2 hours) until you are settled in. If there was an emergency, you would be transferred by ambulance to the UNM Hospital and the midwife would go with you. Your midwife can usually come visit in the hospital after the birth. The hearing and newborn metabolic screen done on your baby before leaving the hospital.

We usually transfer to UNM for care by Dr. Larry Leeman and the Family Medicine Team, but we do work with all of the area hospitals and we will go to the hospital of your choice. We have relationships with Presbyterian Medical Group, Women's Specialists of New Mexico and Lovelace Medical Group midwives. In case of transfer, you would have the option to hire the doulas at a reduced rate to continue your labor support at the hospital (you do not have to decide about that option before labor begins).

We are happy to continue care for you and your baby! Your Dar a Luz visit after the birth occurs about 24-48 hours after discharge, and is at the birth center. Please call us to schedule your appointments.

What Does Care Look Like at UNMH?

Almost all of our transfers go to UNMH under the care of Dr. Leeman and the Family Medicine Team. UNMH is a "Baby Friendly" hospital so their policies are designed to support breastfeeding and bonding.

Dr. Leeman's team have worked with Dar a Luz since we opened, and they are supportive of clients and their desire to be informed and have the least intervention possible for a healthy mom/birthing parent and baby.

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Care at UNMH usually includes the following:

During labor and birth

- Compassionate, respectful care from the Family Medicine Team with informed consent
- All rooms are private in labor and postpartum with room for family
- Use of lowest levels of intervention possible for labor progress and a healthy baby (may include misoprostol, Pitocin and epidural).
- Monitoring of baby's heart rate may be continuous or intermittent (on and off) and may include internal uterine pressure monitors or fetal scalp electrodes to monitor baby's heart rate. Options for wireless and waterproof monitoring may be available when moving around.
- Providers obtaining permission to conduct vaginal exams.
- Freedom of movement depending on your choices for pain management.
- Eating may be limited but drinking fluids is usually encouraged. All clients have IV access but the tubing may be disconnected, so you can move around better.
- Pain relief options: movement, water immersion in labor, nitrous oxide, hypnosis, narcotics, epidural.
- Choices of upright positioning during pushing depending on your choices for pain management.

After vaginal birth:

- Delayed umbilical cord clamping in most cases or milking of the cord if it needs to be cut quickly.
- Rapid initiation of breastfeeding, breastfeeding support, baby-friendly practices for newborns.
- Skin-to-skin contact, protected bonding time (usually at least 1 hour before transfer to postpartum unit) for healthy newborns. Then rooming in with parents is routine.
- All routine newborn exams and tests are done in the parent's room, and babies are not bathed.
- True Informed Consent/Informed Decline regarding the use of eye ointment, Vitamin K shots and Hepatitis B vaccination.
- Choices regarding your placenta, including disposal of placenta or taking it home.
- If desired, circumcision surgery would be performed on your son prior to discharge.
- Baby metabolic, hearing and critical congenital heart screening tests are done before discharge.
- Routine discharge is around 24 hours, or up to 3 days if you have a cesarean section or longer with complications.

After Cesarean Birth:

- Most cesarean births are done with spinal anesthesia so the client can be awake during the birth.
- When circumstances allow (non-emergent), UNM does "gentle cesarean births" designed to promote breastfeeding and parent bonding and to enhance the experience of the client who desires a more natural birth, one that would more closely approximate that of vaginal birth.
- Gentle Cesarean components include:
    - Ambience changes (dim lighting, music)
    - Partner and another adult family member or doula may be present at the birth
    - Limited non-essential staff present in the room
    - Option to watch the baby being born from the abdomen through a clear drape
    - Option to see the baby immediately after birth but dropping the drape
    - Delayed cord clamping for healthy newborns
    - Skin-to-skin care for newborns

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NICU care:

- Other parent can go to the NICU with the baby. Seeing baby immediately when stable and ready for transfer to postpartum (may be a couple of hours). There are limited visiting hours.
- Sick babies often do not have the energy or are not stable enough to breastfeed right away. Lactation support is available and you should be given a pump to express colostrum and breastmilk. Ask about SNS or syringe feedings if baby cannot breastfeed. Supplementation may be required. Dar a Luz has pasteurized donor milk for purchase.
- Ask about the risks benefits and alternatives for procedures. Common procedures include blood cultures and spinal taps to rule out infection.
- Babies usually have IV fluids and may be using oxygen nasal cannulas. Heart and respiratory monitors are on making a tangle of wires and tubing connected to your baby.
- Babies are under a warmer when not skin-to-skin with parents.
- There is limited privacy in wards of 4-6 beds.
- The minimum stay for babies is about 48 hours and can be up to 10 days for full term babies being treated for infection. Preterm babies are there much longer.

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Hospital Transfer Checklist

- ✓ Hospital bag
    - Labor support supplies and snacks
    - Clothes and personal toiletries for you and partner (shampoo, large pads, ibuprofen) for 2-4 days
    - Clothes, blankets, diapers for baby for 2-4 days
    - Breastfeeding supplies (pump, storage bags, bottles, sterilizing bag)
    - Anything else that you think you will need
    - Informed Consent cards
- ✓ Birth preferences document
- ✓ Bring this "Birthing Your Baby" binder or copy these pertinent sections of the binder:
    - Newborn hearing, metabolic and critical congenital heart screening
    - Explanation of jaundice and bilirubin tests
    - Hepatitis B vaccine, vitamin K and eye ointment
    - Circumcision if you still haven't made your decision
    - Breastfeeding tips and reminders
- ✓ Remember:
    - Call the midwife on call **(505) 944-5488** if you have questions or concerns.
    - A midwife will come to see you at the hospital around 24 hours after your birth.
    - You will likely be in the hospital between 24-72 after birth.
    - You can ask the nurse for a door sign when you do not want to be disturbed or need more privacy.
    - Call the midwife on call when you are discharged **(505) 944-5488.**
- ✓ Follow-up Care:
    - You are **still part of the Dar a Luz family** and you can usually continue your care with us!
    - You will receive a gift bag from Dar a Luz at your next visit, including a Dar a Luz onesie.
    - You can put your baby's name and birth date up on the sign when you come back for a visit.

Additional Notes:

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Hospital Insurance Coverage & Benefits

Attention: Your insurance plan **may not cover all hospitals in the area.** It is your responsibility to check on your hospital coverage and let the midwives know your preference when transferring to the hospital. **In labor and in emergencies, all plans will cover all hospitals.**

Insurance coverage and benefits can be very confusing. We have worked diligently to provide you with the best estimate we can for the care that you receive here at the birth center. As you know, sometimes transfer to a hospital is required. Whether it is a medical or personal choice, we recognize that it is a change in care, and we want to make sure you are informed on both the emotional and financial impact this circumstance can have on your family.

Below is a list of questions for you to ask your insurance company. We strongly encourage you to get informed about your maternity coverage and benefits in the event that a transfer to a hospital is necessary. Coverage at the birth center is completely different than a hospital birth. For example, a hospital birth requires an inpatient stay, whereas the birth center is outpatient only. Hospital benefits are not detailed by Dar a Luz and cannot be estimated by us.

Questions to ask your insurance company

Is delivery at UNMH covered in-network? ____________________

What is my current deductible? ____________ How much is met to date? ____________

Is it a calendar year plan? Will my deductible reset on Jan 1? ____________________

What is my coinsurance? ________% What is my out-of-pocket max? ____________

Will my hospital delivery (non-global) apply to deductible and coinsurance OR copay? ____________

Is my facility coverage different than my professional coverage? If so, How? ____________

Professional Deductible ________ Coinsurance ____________ Copay ________

Facility Deductible ________ Coinsurance ____________ Copay ________

Is there a separate facility fee for delivery (non-global)? ____________________

Deductible ____________ Coinsurance ____________ Copay ________

Will my baby be covered under my policy after delivery? ____________

How many days after birth do I have to add my baby? ____________

Will my baby have their own: Deductible ________ Coinsurance ________ Copay ________

How will my baby's care after delivery be covered? ____________________

____

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Post-Term Pregnancy Consent Info

Definitions

- Early term is defined as 37 weeks +0 days to 38 weeks +6 days of gestation
- Full term is defined as 39 weeks + 0 days to 40 weeks +6 days of gestation
- Late term is 41 weeks +0 days to 41 weeks +6 days of gestation
- Post-term pregnancy is defined as a pregnancy lasting to 42 weeks +0 days or longer with accurate dating.

In the United States in 2015, birth certificate data indicated that about 1 in 200 women birthed at 42 weeks or more while 13 in 200 women birthed at 41 weeks. The risk of having a post-term pregnancy is increased in first pregnancies, a prior post-term pregnancy, obesity, carrying a male fetus, older maternal age and maternal race/ethnicity of being non-Hispanic white women. Accurate dating and early US reduce the chances of having a post-term pregnancy to about 2%.

Fetal and Neonatal Risks

The risks of maternal and fetal complications and perinatal mortality (stillbirth and early neonatal death) increase the longer a pregnancy continues past 40 weeks. Perinatal mortality rises with increasing gestational age after 40 weeks of gestation, but the absolute risk of fetal death is low:

- 40 to 41 weeks: 0.86 to 1.08 per 1000 ongoing pregnancies
- 41 to 42 weeks: 1.2 to 1.27 per 1000 ongoing pregnancies
- 42 to 43 weeks: 1.3 to 1.9 per 1000 ongoing pregnancies
- >43 weeks: 1.58 to 6.3 per 1000 ongoing pregnancies

Fetal risks arise mainly from:

1. Excessive fetal growth (fetal macrosomia - a baby weighing over 9 pounds 14 ounces) are increased with longer length of pregnancy. About 1 in 100 term babies and up to 10 in 100 post-term babies are macrosomic. Complications associated with fetal macrosomia include prolonged labor, baby being too big to pass through the pelvis and shoulder dystocia (baby's shoulder getting stuck under client's pelvic bone). These could require a cesarean section for delivery or result in injury to the baby with vaginal birth.

2. Fetal postmaturity syndrome affects about 20 in 100 post-term babies which is characterized as chronic intrauterine malnutrition called intrauterine growth restriction. These babies are at increased risk of umbilical cord compression due to low amniotic fluid levels, and abnormal fetal heart rate patterns during pregnancy or labor due to a poor placental function or cord compression. Meconium passage is common and may be related to normal maturation of the gut or fetal lack of oxygen. These babies have a higher risk of low blood sugar after birth and meconium aspiration, breathing difficulties and neurodevelopmental complications like seizures and cerebral palsy.

Maternal Risks

Maternal risks include the emotional impact, prolonged or dysfunctional labor, severe perineal injury (3rd or 4th degree lacerations), vacuum delivery, uterine infection, hemorrhage and cesarean section. There are more complications in first time mothers/birthing parents than in those who have had children

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before, and the rate of complications increases from 40 to 42 weeks in all groups. Rates of vacuum delivery at 42 weeks were 20%, perineal injury was 12% at 41 weeks, and uterine infection was 7% at 41 weeks. The rates for cesarean section increase from 9% at 40 weeks, 12% at 41 weeks and 14% at 42 weeks according to Caughey & Bishop (2006).

Management Options

Clients should be counseled about the risks of induction versus expectant management (waiting for labor to happen naturally). Induction is associated with lower perinatal mortality than expectant management and does not increase the risk of cesarean delivery. The absolute benefits of routine induction are modest, however, and depending on personal values and preferences, some clients may choose to be managed expectantly. Studies show that there are reduced risks with the following management of the pregnancy from 40-42 weeks in low-risk clients.

1. Cervical ripening methods increase **prostaglandin** production and help to soften and thin the cervix so that it can be ready to dilate. Beginning these methods at 39 weeks can decrease the length of pregnancy by about 4 days. These include natural methods such as **sexual intercourse, chiropractic adjustments, acupuncture stimulation of cervical ripening and labor points, sweeping membranes** (refers to digital separation of the membranes from the wall of the cervix and lower uterine segment), **evening primrose oil** (taken by mouth and vaginally) and **ambulation**.

2. If a client chooses expectant management, twice weekly antenatal testing to monitor fetal well-being (BPP and NST at 41 weeks and NST at 41 ½ weeks) is strongly recommended starting at 41 weeks. Risks of fetal death are 1-2 per 1000 pregnancies if there is a reactive NST, normal amount of amniotic fluid and a BPP of 8/8 on antenatal testing.

3. Birth centers offer non-medical labor stimulation using natural cervical ripening methods, cervical dilating foley balloon catheters, nipple stimulation (done with a breast pump) with ambulation and enemas or castor oil cocktails beginning at 41 to 41 1/2 weeks for low-risk clients and healthy babies. These methods may be recommended earlier for clients with risk factors.

4. Hospital induction of labor at 41 weeks with medication cervical ripening agents (Misoprostol, Cervidil) and mechanical dilating foley balloon catheters should be considered for all low-risk clients. Pitocin may be needed to increase contraction frequency and strength. Recent studies agree that there is less risk of cesarean with induction at 41 weeks as long as the clients is allowed adequate time for first stage of labor (may be 48 hours or more) than risk of cesarean section in spontaneous labor after 41 weeks. These methods may be recommended earlier for clients with risk factors.

5. Hospital induction of labor at 42 weeks should be scheduled if the client does not go into spontaneous labor. Clients with risk factors will be given individual counseling about their risks and may benefit from induction prior to 41 weeks.

UpToDate : Postterm pregnancy. Accessed on 9-4-2018.
Author: Errol R Norwitz, MD, PhD, MBA
Section Editor: Charles J Lockwood, MD, MHCM
Deputy Editor: Vanessa A Barss, MD, FACOG
All topics are updated as new evidence becomes available and our peer review process is complete.
Literature review current through: Aug 2018. | This topic last updated: Jun 28, 2018.

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Cervical Ripening and/or Induction of Labor Techniques

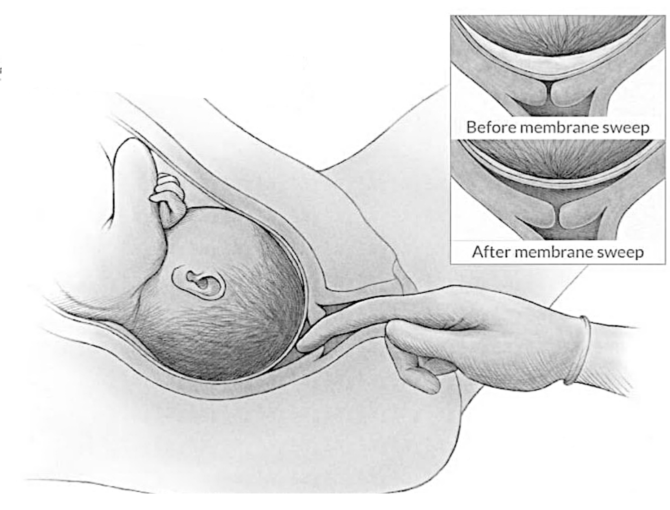
It is not well understood what actually starts labor; however, the cervix has to be soft (ripe) and contractions have to be regular and strong enough to open (dilate) the cervix for labor to start and progress naturally to the birth of the baby.

Prostaglandins can help soften the cervix and prepare it for labor contractions. They are naturally produced by women, and found in semen. There are also synthetic forms including misoprostol.

Oxytocin causes uterine contractions that help soften and thin out the cervix in early labor and when contractions are stronger during active labor it helps the cervix to dilate. Synthetic forms are called Pitocin.

Over time, there have been many methods that have been used to try to stimulate prostaglandins and oxytocin production in clients. There is little high-quality research to determine when and how to use these methods or their effectiveness and safety. Practice experience shows that these methods are likely safe and may be helpful in cervical ripening and induction of labor but the best results are achieved with a ripe cervix and on clients who have previously had a baby. Please discuss your situation with your midwife to see if any of these options could be helpful for you. Below is a list of some common alternative methods:

Sweeping the membranes is done between 39-42 weeks of pregnancy during a vaginal exam. The examiner's finger is inserted into the slightly open cervix and is used to separate the lower uterine segment from the amniotic membranes which stimulates release of maternal prostaglandins causing uterine cramping. The January 2010 Cochrane review showed that doing this is effective in bringing on labor but it causes discomfort, some bleeding and irregular contractions. There was no evidence of increased risk for maternal or fetal infection or cesarean section. There is not enough evidence to establish the safety of doing this on GBS positive clients.



The following are normal side effects from having a membrane sweep

- Spotting or bleeding less than 1 pad/hour
- Increased discharge that is clear, white, yellow, red or brown
- Irregular or regular cramping

Nipple stimulation can be done either manually or with a breast pump and is used to increase maternal release of oxytocin and cause uterine contractions. The January 2010 Cochrane review shows that it is beneficial in increasing the number of women in labor by 72 hours and reducing postpartum hemorrhage. It should only be used on low-risk clients and is more effective with a favorable cervix. There was no increased risk of cesarean section or meconium-stained fluid. There were no instances of uterine hyperstimulation.

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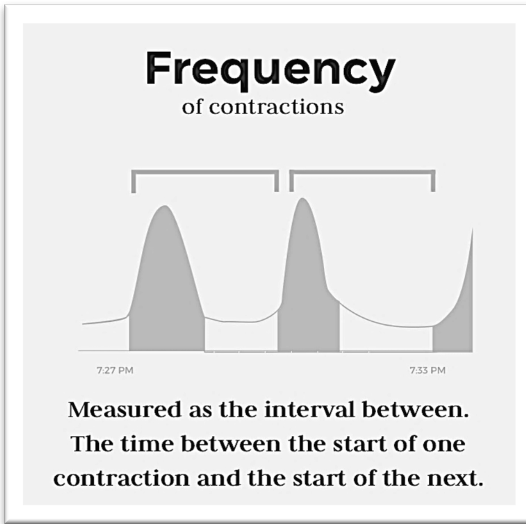
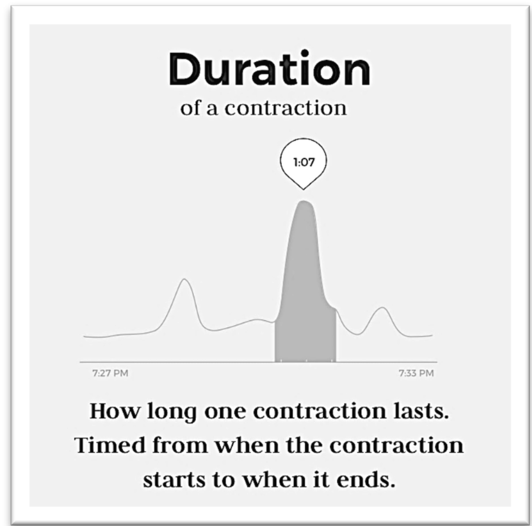
Please use the following instructions:

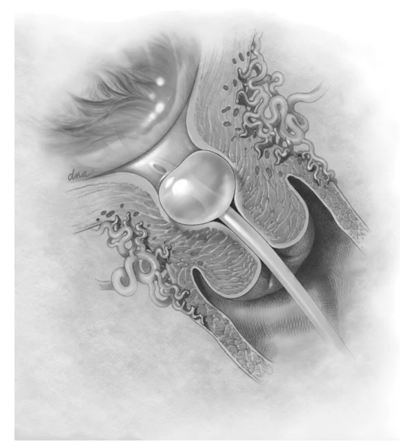
- Pump for 30 minutes, walk for 30 minutes – repeat 3 times
- Goal of pumping: contractions every 2-3 minutes lasting 60 sections. If contractions are closer together than 2 minutes, or longer than 60 seconds, then decrease suction strength or stop pumping for a few minutes to see if the contractions slow down.
- Try pumping in different positions such as kneeling, hands and knees, standing, seated on the yoga ball to put pressure on different parts of the cervix
- Use the highest suction tolerated. You can use any type of nipple cream, oil or lubricant to support nipple integrity.
- As an alternative, try walking up the stairs, curb walking, or doing squats or lunges during the walk.





Mechanical methods include placing a catheter in the slightly open cervix to put pressure on the cervix to soften and open further. This causes cramping and potential release of prostaglandins and oxytocin. The March 2012 Cochrane review found it to be good for cervical ripening and caused less hyperstimulation of the uterus than synthetic prostaglandins. There was no increase in cesarean section rates. There is insufficient evidence to evaluate the effectiveness of the likelihood of vaginal delivery in 24 hours.

1. The **placement of a catheter** requires a vaginal/cervical exam and may involve using a speculum to reach the cervix. In order to place the catheter, the cervix has to be at least 1 cm open. Once the catheter is placed between the baby's head and the cervix, the midwife with inflate the balloon using 50 cc normal saline which will cause increased pelvic pressure. The catheter will be pulled tight and then taped to the leg. The balloon can stay inside the cervix for 12 hours, at which point it will either fall out (usually causing dilation to 3-4 cm) or will need to be removed by the patient.
   - Instructions for removal at 12 hours after placement: Cut the catheter tubing with a pair of scissors, allow the fluid the drain out, remove the catheter.



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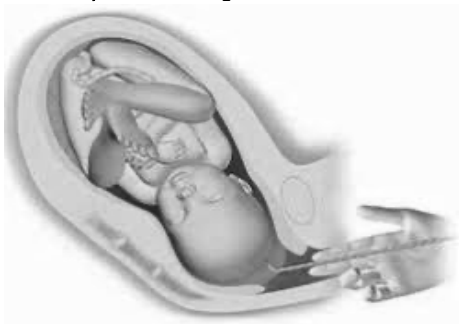
- **Acupuncture** can be used to stimulate certain points to help stimulate labor. The January 2009 Cochrane review reported limited evidence but it appears to be safe and may be effective. Women who received acupuncture had fewer methods of induction of labor than women with standard care.
- **Amniotomy or breaking the bag of waters** may be an option to help start labor in clients who have had a baby before and whose cervix is ready for labor. This is one of the most natural ways to get labor going because when the water breaks spontaneously, contractions frequently start in a few hours. It is frequently used to help labor get more regular but is poorly researched as a method of induction of labor on its own. The January 2009 Cochrane review concluded that there may be a long time interval before the baby is born and risk of infection is a concern.



  - Amniotomy is done during a vaginal exam when the midwife can feel some of the fluid behind the membranes bulging through a dilated cervix of about 4 cm. The baby's head must be down in the pelvis to prevent the cord from coming out with the water. Then a small plastic amnihook (looks like a large crochet hook) is used to nick a hole in the bag and slowly release some of the fluid. This does not hurt the baby. Once the membranes are ruptured, the risk of infection increase and usually we are hoping for a birth within 24 hours or less.
- **Sex** has long been suggested as a way to ripen the cervix or induce labor. The role of sex in starting labor is uncertain but high levels of prostaglandins in semen, oxytocin release with orgasm and nipple stimulation may all play a role. The October 2008 Cochrane review concluded that there is not enough research to determine the effectiveness.
- **Homeopathy** is the use of diluted substances and herbs to stimulate the body to react in a certain way. The May 2010 Cochrane review found no evidence to show the effectiveness of homeopathy.
- **Castor oil** can be taken orally or given as an enema. This is thought to increase prostaglandin and oxytocin release by causing frequent bowel movements, cramping and uterine contractions. The January 2010 Cochrane review found insufficient research to evaluate the effectiveness. One study found no increase in cesarean section rate, meconium-stained fluid or low Apgars compared to other methods.
  - **DO NOT TAKE CASTOR OIL ON YOUR OWN WITHOUT THE MIDWIFE MONITORING YOU AND THE BABY**. The midwives will require you to do a fetal non-stress test (20-40 minutes on the electronic monitor at the birth center) to determine if it is safe to use the castor oil.
  - If you are planning to do a castor oil induction, please call the call phone to get instruction from the midwife on call **prior to 9 AM that day**. It can take up to 12 hours for castor oil to start labor and sometimes it may not start labor at all.
  - Drink 2 ounces castor oil in a milkshake or blended with ice cream or frozen yogurt. DO NOT mix in water or juice because it will separate and it is harder to swallow.
  - Expect the first bowel movement in 2-6 hours and eat after that.
  - Increase your fluid intake including electrolytes to prevent dehydration. We recommend drinking at least 1 glass of water per hour!
  - Check in the midwife 4 hours after the first dose. You may need to repeat the same dose if no regular contractions have been stimulated.
  - Stay home all day and expect abdominal cramping, diarrhea and nausea or vomiting. Castor oil labors can cause contractions that are stronger and closer together. Talk to your midwife about the characteristics of active labor with castor oil.

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Signs of Labor & When to Call the Midwife

Knowing when to call the midwife and when you are in labor can be challenging. Here is some guidance to refer to when determining if you are in active labor and/or if it is time to call the midwife. Midwives are available to you 24/7 to address your questions and concerns. We do appreciate your consideration in not calling us in the middle of the night for non-urgent concerns and will address them during the day.

WHEN TO CALL THE MIDWIFE

All clients:

- Call ANYTIME you are concerned.
- Call ANYTIME your water breaks or you think you might be leaking amniotic fluid. Your midwife will make a plan with you on when to come to the center
- Call ANYTIME you have decreased fetal movement that does not respond to eating/drinking and counting the movements.
- Call ANYTIME with heavy bleeding (bright red bleeding that is enough to soak a pad in about an hour).
- You are welcome to call ANYTIME if you think you are in labor; however, at night, we request that you call closer to when you are ready to come in. Your midwife will make a plan with you on when to come to the center.
- Also see the section "**Tips on Early and Active Labor, and When to Come to Dar a Luz**."

For first time mothers/birthing parents:

- If you are **GBS negative**, call when contractions are about **2-3 minutes apart**, strong, you are unable to walk/talk/do anything else during contractions, they **last about a minute**, and have been this way for **at least an hour**. This could be after many hours of early labor. Listen to your body.
- If you are **GBS positive** and your **water has <u>not</u> broken**, call when the contractions are about every 3-5 minutes for about an hour and getting stronger.

For subsequent pregnancies

- When you notice a change in the character of the contractions that feel like labor, even if they are more than 5 minutes apart and not lasting a minute.
- If things change suddenly, labor feels intense or a couple contractions feel very strong, or if water breaks and you've been contracting then call the midwife, because often subsequent labors can move quickly once active labor is reached. Listen to your body.
- If you are GBS POSITIVE, and your water has <u>not</u> broken, call when you start contracting REGULARLY.

Call the on-call midwife at (505) 944-5488

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Tips on Early and Active Labor, and When to Come to Dar a Luz

How will I know when I'm in labor? How do I manage early labor at home? How long do I stay home? Will I be able to figure this out if I've never done it before? I've only been induced before, so will I know I'm in labor?

These are a handful of the most common questions asked at the birth center about how to know where you're at in labor and how to time coming to Dar a Luz. While there isn't one straightforward answer for each client, we trust that this beautiful and transcendent time in your pregnancy will unfold exactly as it should. Knowing the basics of how your body will work with you to bring your baby into your arms will help you enjoy the process, rather than be fearful of it. Also remember: bodies don't comply with a manual, and each labor is very different -- so it's possible that your labor might not exactly match this description. You are in tune and intuitive, so listen to the signs your unique body gives you. If this is not your first baby, read this section and also pay close attention to the section called **"This is not my first baby"** for more information.

What is Early Labor?

The beginnings of birth have arrived, and the day you will meet your baby is here (or close to it). Early labor is when your body begins having contractions that open the cervix, which is the mouth of the uterus, and what your baby's head is resting against. This opening of the cervix from 0 to 6 centimeters is considered the "early stage" of labor.

Some distinguishing ways early labor is different from warmup contractions:

- Warmup contractions, otherwise known as Braxton-Hicks contractions, occur throughout the third trimester as your body prepares for birth. These often feel like mild period cramping and are irregular, in no particular pattern, and don't increase in intensity.
- Early labor contractions often begin with contractions that come in irregular time intervals, are mild, and continue (typically for several hours), getting more intense and closer together as time passes. They don't stop or go away. Think of your labor over time climbing rungs of an intensity ladder. The more time passes, the more the intensity increases.
- A tip to help distinguish early labor from warm up contractions: if you're not sure, keep waiting -- it will feel different over time when it's really labor.

Signs of early labor in your body:

- Increased vaginal discharge; menstrual-feeling cramps low in the belly; back pain or cramping; vaginal, pelvic, or mild rectal pressure; and/or diarrhea.
- Irregular, mild contractions that then begin to come more regularly in a pattern you can time.
- In the early labor phase, you can usually talk or walk through your contractions, and you may still be able to smile, laugh and chat. You can likely still pay attention to the outside world, text messages, and phone calls; and maybe you're even still working or getting things ready around the house.
- Your belly may become tight or hard with contractions, increasing as time goes on.
- You may feel contractions beginning to wrap up and around the belly as time increases.

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What is Active Labor?

The active phase is when contractions are regular and strong and open the cervix from 6-10 centimeters. You might be considered active sooner or later than this -- it's really about intensity, frequency, and the rate at which your cervix dilates. Active labor is when the cervix is changing the fastest and why you often hear of someone who went from 7 cm to having a baby in just an hour or two. Especially with first babies, it may take many hours of strong contractions for your cervix to dilate (open) and efface (soften and thin).

Signs of active labor in your body:

- Contractions have moved from being mild or moderate to being **strong and regular**, and they wrap around your belly each time.
- During contractions, you will likely be pausing, breathing, and making noise.
- During contractions, you will likely no longer be able to walk, participate in conversation, laugh or text; you'll be working hard, tending to turn inward and focus.

When Do I Call the Midwife in Labor?

This is always situation-dependent, but here are the basics:

- If you've hired a doula, they will help you determine this. It's a nice item to take off your plate and get good advice on, in real time during your labor.
- **If it's your first baby,** you are usually in active labor when your contractions are **2-3 minutes apart** (the time from the beginning of one contraction to the beginning of the next), lasting **one entire minute for at least one hour**.
- **If it's your second+ baby,** you are usually in active labor when contractions are **5 minutes apart** (the time from the beginning of one contraction to the beginning of the next), **lasting one entire minute for at least one hour**. Also see the section called **"This Is Not My First Baby"** below.
- Call the midwife **at any point if your bag of water breaks** or you think you might be leaking fluid (note the time it started and the color).
- Call and let us know **right when labor begins if you carry group beta strep (GBS) infection** and would like antibiotic treatment.

When Do I Come to Dar a Luz?

Our hope is that you manage well with early labor at home, and that you come to the birth center for admission **as you're reaching the "active" phase of labor**. Before coming to Dar a Luz, you will be past the "early phase" of labor (where it tends to feel more manageable) and will probably have been in an active labor pattern for a few hours or so -- sometimes less, especially if it's not your first baby.

Why must I wait until active labor to come to Dar a Luz?

Labor can be very primal, as your animal brain takes over and your instincts and reflexes guide you. It's a pivotal life opportunity to let go, get out of your brain, and follow your body. Your primal brain needs to feel safe and comfortable for the processes of labor to work best. As you might have guessed, this happens most naturally at home, where your body can relax into its amazing work. Staying home through early labor helps labor progress more quickly and effectively, no matter what your birth setting will be. The data also show that staying out of birth facilities -- even birth centers -- until active labor

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means fewer interventions and lower cesarean section rates. We want the best outcome for you, and we pay close attention to evidence when it comes to admitting you to the birth center. This works well for the majority of our clients, but admission is considered on a case-by-case basis; it's not all about the numbers, and if you really need us, we are here for you!

What Can I Do at Home to Help Support and Cope with Early Labor?

Laboring at home in the early phase of labor can look however you'd like. Some people rest in one position on their bed and try to doze between contractions. Others must be standing, or have to sit on a birth ball, or have no choice but to move from one place to the next to cope with the growing intensity of labor. The important thing is that you listen to your body and follow its cues -- there is probably a reason your body is telling you to do what you're doing. Having a good understanding of common positions and tips that help in early labor are great tools to add to your tool box.

You will learn more in your birth classes, but here's a short list of suggestions:

- First and foremost -- consider hiring a doula! There's excellent data that show that doulas help with faster and less complicated births, feeling more supported in labor, and lower rates of cesarean section. As you will be laboring at home for a good portion of your birth, hiring a doula to come to your home in early labor to help and support you there is a great idea. It's also a lot less pressure on your partner in terms of knowing exactly what to do for you and when to do it. We love and welcome any doula in our center.
- Stay nourished and hydrated. Often, the last thing you want to do in really active labor is eat food... but it's really important your body has calories and energy to support all the hard work you're doing. Eating a good meal and regular snacks in early labor and continuously sipping on water and electrolyte drinks will ensure your body is nutritionally balanced before you run the (hypothetical) marathon of labor.
- Change positions. Movement in early labor can be extremely helpful to cope with regular contractions and pain, and may help your baby move into a better position. Whenever a position is no longer working for you, move! See the section **"Positions for Labor and Birth"** for ideas of different positions that may help.
- Water is your friend! Standing in the shower, sitting, or hanging out on hands and knees in the tub at your home are excellent tools for decreasing the intensity of labor and assisting with pain control. Consider buying a shower head that detaches. Holding a steady stream of warm water over your belly or lower back can feel really helpful.
- Try a heating pad on your lower belly or back. This time-tested trick is an excellent tool in labor.
- Consider hiring an acupuncturist to perform at-home treatments while in labor. Your acupuncturist might perform house calls once you get to know them, if they have the training, and specialize in women's health and birth. Acupressure can be helpful too. Studies show that acupuncture and acupressure may help with reducing pain, increasing satisfaction with pain management and reducing use of medicine in birth. Do some research and consider practicing prior to birth.
- Aromatherapy: essential oils can be mixed with a carrier oil such as grape seed, sweet almond or sesame oil, and may be massaged into the skin, used in a bath, or diffused into the air using a diffuser. Please note: the above methods can be used at home. At the birth center, essential oils cannot be used in the bed, the bath or a diffuser, due to babies' and other clients sensitivities.

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- Practice breathwork as a tool to relax and decrease anxiety now. Do this now, so by the time you are in labor, breathing in a pattern is something you're comfortable with and used to, and your brain and body respond accordingly.
- Also see the section **"Labor Coping Methods"** for what else might help, including interventions.

What happens if I get sent home from Dar a Luz in early labor?

While coming to the birth center for evaluation on the early side is not uncommon, admitting you in early labor is! Giving you the best care usually includes not admitting you too early, so we don't hesitate to send you back home to labor if your cervical evaluation is roughly between 1-4 centimeters. Things usually look very different when you come back, which is usually in a matter of hours. Riding in the car in labor can be difficult, so we want to help talk you through the timing of things as carefully as possible to avoid trips back and forth. Your midwife is skilled at knowing what active labor sounds like, so she may ask to hear a few contractions on the phone. We will also time your contractions while we're speaking with you and consider things such as how long you've been in labor, if this is your first baby or not, your group beta strep status, and how far away you live from Dar a Luz. Remember, never head to the birth center or anticipate coming in without speaking to a midwife first. You can rely on our expertise!

This Is Not My First Baby

If your upcoming birth is for your second or third baby, or more, you probably have a good idea of what labor looks and feels like. We advise you to trust your gut. Sometimes things can go quickly for someone who has birthed vaginally before, so you're really watching for regular painful contractions for about an hour. Here are a few key points to remember:

- Sometimes strong regular contractions only need to be every 8-10 minutes apart to make change. The important thing is to pay attention to the intensity and how labor is ramping up. If it's moving quickly, be in touch with us, trust yourself, and find your way to Dar a Luz more quickly.
- If you've had a fast birth before, the likelihood of this birth also being fast is higher. Your second labor may be roughly about half the length of your first birth – but there are no guarantees!
- If your water breaks, call the midwife ASAP. In some instances, after your bag of waters opens, things can go pretty fast.
- Make a plan for childcare well in advance, day or night, so you're not scrambling to bring something together while in labor. Have a Plan B and Plan C lined up as well… also consider pets and your house needs, and what you might do if you need to stay longer at the birth center, or if you need to transfer to the hospital.
- If your labor is progressing quickly, it's a good idea to have your childcare meet you at Dar a Luz for a kiddo hand off in the parking lot.

Closing Thoughts on Knowing What You Need to Know

Things can change quickly in labor, and each body is unique. Luckily, you don't have to hold all the knowledge about everything that is going on -- your midwife and your team will help you figure it out -- but having a good idea of the big picture and what is required of you in terms of communication and timing will help give you the confidence and understanding you need for achieving your birth center birth. If you have any outstanding questions about when to come to Dar a Luz in labor, bring them to us during your weekly visits, which will start happening after about 36 weeks. These final appointments are a perfect time to solidify plans and ask questions about birth.

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Labor Coping Methods

Clients have different levels of pain during childbirth. There are many ways to cope with it. Talk to your midwife about the benefit and risk of each one.

Natural Methods: The birth center is specially designed to give you the most support in using natural methods of coping. Our staff is experienced in many natural options. The following things can lower your pain. They can help you relax and make it easier for the baby to move into the right position for birth. These may make your labor easier and possibly shorter.

- Walk and move during labor
- Make noise if it feels good
- Use birthing balls
- Change positions often. Sit, squat, lie down or stand
- Take a warm bath or shower
- Get a back massage
- Take deep breaths and relax
- Use hypnosis, mediation, and visualization
- Listen to music
- Have a person you trust with you all the time

Sterile Water Papules: This technique is very effective in relieving back pain. Four small injections of sterile water are given just under the surface of the skin over your lower back while you are having a contraction. The sterile water stings when injected and works by interrupting the pain sensations in the brain. It lasts about 1-2 hours and can be repeated as many times as you find helpful.

Nitrous Oxide Consent Info

Nitrous oxide (laughing gas) is blended to deliver 50% inhaled nitrous oxide (N_2O) and 50% oxygen (O_2) to produce analgesia (pain relief without loss of sensation) not anesthesia (reversible loss of sensation). It is used for labor pain in many countries with high standards for safe and effective health care, such as Australia, Canada, Finland, Sweden, and the United Kingdom (UK). Although it has been used in a few hospitals in the US for over 30 years, it has been a very rare option but is becoming more available now. Nitrous oxide has been used widely in many countries since the early 1930s and no studies have shown any harmful effects on the baby.

The American College of Nurse Midwives supports the use of nitrous oxide as a choice of labor analgesia for laboring clients. The birth center started offering nitrous oxide for laboring clients in February 2013 and about 15-25% of our clients use nitrous. Nitrous oxide works by increasing the release of your own pain killing chemicals that are produced in the brain. It takes about 30 seconds after breathing in the nitrous to start feeling the effects and it takes about that long for the gas to clear your system after you quit breathing it. The pain and anxiety reducing effects of nitrous oxide vary between clients, but most birth center clients have found it helpful.

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Some of the benefits of using Nitrous Oxide include:

- It is self-administered and the client controls how much they want
- It takes the edge off the pain and decreases anxiety
- Clients remain awake and alert with the ability to move around
- There is no effect on the client's breathing
- It does not decrease uterine contractions or increase the length of labor
- It can be used anytime during labor and pushing including while in the tub.
- Nitrous may be used before or after but not with narcotic pain medicines
- Breastfeeding is not affected

Some benefits for the baby include:

- Nitrous crosses the placenta but is cleared within seconds after the baby breathes
- No effect on baby's breathing, heart rate or Apgar scores, and babies are alert and responsive
- There is no increase in meconium-stained amniotic fluid

Side effects of nitrous oxide include:

- Nausea and vomiting in about 5-36% of clients
- Dizziness in up to 39% of clients
- Some have experienced dysphoria, restlessness and anxiety
- Some may feel it more bothersome than helpful
- Discontinue if side effects are not tolerable

Clients who **CANNOT** use nitrous oxide:

- Must wait at least 1 hour after last dose of opioids to start nitrous.
- Inability to hold own face mask and self-administer nitrous
- Acute drug or alcohol intoxication or impaired consciousness
- Presence of a potential space in the head, eyes, ears, chest, abdomen, bowels or veins that could fill with nitrous gas such as pre-existing bowel distention or obstruction, increased middle ear pressure after surgery, pneumothorax, pneumoperitoneum, pneumocephalus, intraocular gas after eye surgery, or venous air embolism.
- Other conditions include cardiomyopathy which nitrous causes mild myocardial depression or pulmonary hypertension which it increases pulmonary vascular resistance.
- Documented B12 or folate deficiencies. Persons at risk for deficiencies are those with hereditary vitamin B12 deficiency disorder, MTHFR mutations, pernicious anemia, Crohn's disease, ileal disease, chronic malnutrition or pregnant clients who adhere to a strict completely vegan diet.
- Impaired oxygenation (consistently < 95% on room air)
- Fetal heart rate decelerations requiring transfer

Clients who **CAN** use nitrous:

- Laboring clients who have no contraindications
- Clients who need extensive laceration or episiotomy repair
- Clients having a manual removal of the placenta, uterine exploration or massage
- Clients who are very anxious with IV start, pelvic exam or IUD insertion

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Education on correct use of nitrous:

- only the client can hold the mask to their face
- the mask must form a good seal on their face
- instructed to inhale and exhale into the mask
- inhale slowly and deeply for 30 seconds prior to the onset of the contraction for best results
- continue inhaling through the contraction and remove the mask to breathe room air between contractions
- the client may inhale the gas continuously if they feel the need
- some clients may use nitrous while pushing but others may find it inhibits their ability to push

Intravenous (IV) Medications: The birth center has these medicines available to help dull the pain of the contractions for several hours so that you can relax and rest between contractions. You can use these several times during labor. Side effects may include nausea, vomiting and itching. About 15% of clients use these meds at the center.

Epidural Block

If you need more pain relief or rest and desire an epidural, you have the option to transfer to the hospital of your choice. This is continuous medicine that is given through a small plastic tube placed in your back. A provider who has special training in anesthesia will do this. It can be used in labor and for cesarean sections.

Benefits of the epidural block

- Epidurals can be safely administered by an anesthesiologist under close supervision in a hospital.
- This takes away most or all of the pain by numbing your body from the waist down. This gives better pain relief than other medicines.
- Epidurals can sometimes help your labor progress when you become tired and tense from the pain and cannot relax. These are called therapeutic epidurals.

Risks of the epidural block

- Your blood pressure may drop suddenly, and you may feel nauseated or light headed for a few minutes. It can be treated quickly by turning you on your side and giving you IV fluids and IV medications. Drops in blood pressure can cause decreased fetal heart rates.
- An epidural may not work at first and it may need to be adjusted or inserted again. The pain relief may not be equal on both sides of the body.
- If the epidural needle goes too far, it will make a hole in the spinal sac and you may develop a headache the next day. Some of these headaches will need further treatment.
- Nerve problems in the legs after childbirth are just as common in those who do not have epidurals as those who do. These nerve problems are almost always caused by the baby's head pushing on nerves along the birth canal and are very rarely due to epidurals.
- Major problems such as nerve damage, paralysis or infection are very rare (less than 1/20,000).

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Effects of the epidural block on labor care

- Clients who have numb or weak legs **must stay in bed**.
- A monitor is placed around your abdomen to **continuously monitor** the baby's heart rate and your labor contractions.
- A **catheter** is placed in the bladder to drain the urine during labor.
- You may be able to drink clear liquids, but you probably **will not have anything to eat** after an epidural is placed.
- Clients are **more likely to need Pitocin®** (oxytocin) to make their labor contractions stronger.
- Clients are **more likely to push longer** (1-2 hours longer) to get their baby out.
- Clients are **more likely to need a vacuum extractor** put on their baby's head to help pull the baby out. If this fails, you will likely need a cesarean section.
- Clients who use epidurals do not appear to be more likely to need a cesarean section or develop long-term back pain.
- Using an epidural doesn't increase infection in mothers/birthing parents or babies, but **might raise your body temperature**. Sometimes your baby might have to stay in the hospital longer due to this fever.

Hydrotherapy and Waterbirth

Hydrotherapy is the use of water for pain reduction. You can take a bath or shower to receive the benefits of relaxation and decreased pain. Hydrotherapy may slow your labor if you are not in active labor (>4-5 cm dilated, usually) but can also speed up your labor because of the relaxation effects. The therapeutic properties of hydrotherapy have been known for centuries. Baths, showers and whirlpools have been used for comfort during labor for many years. Over the past two decades the use of warm water immersion for the birth of the baby has aroused interest in many countries and an increase in the number of clients requesting this option for both hospital and community centered births is occurring. Hydrotherapy can also decrease blood pressure, conserve energy, reduce the need for pain medications and/or other interventions, reduce perineal tearing and cesarean section, and is rated very highly for clients, while being a gentler way for a baby to be born. About 60-80% of clients at Dar a Luz use the water in labor or birth. The midwives at the birth center are trained in water birth and can talk to you more about this option.

People are giving birth underwater now.
They say it's less traumatic for the baby because it's in water.
But certainly, more traumatic for the other people in the pool.

~ Elayne Boosler

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Water Immersion During Labor and Birth Consent Info

The use of water during labor and birth has been used for many years in hospitals and birthing centers in the US and in many other parts of the world from Europe to China with comparable maternal and newborn outcomes whether or not they give birth in water. But the recent release of the Committee Opinion on "Immersion in Water During Labor and Delivery" in April 2014 by The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) suggests water may be beneficial during labor but questions the safety of water birth based on several rare case studies of newborns with serious adverse effects. The Opinion does not support water birth unless the facility is part of a research study. This Opinion received much press and controversy but since there have been multiple high-quality, large studies that are reassuring that water immersion during labor and birth are safe and harmful effects are very rare.

In October 2016, ACOG released a new committee opinion that reflects a significant change from its past opinion by acknowledging the benefits of water immersion during labor and birth. It recommends that healthy clients with uncomplicated pregnancies should be given this option between 37 and 42 weeks. Risks and benefits of this choice should include information that there have not been enough studies to support or discourage this choice. While this new opinion is a positive step, ACOG continues to recommend against water birth in second stage labor.

Many organizations that support clients in birth including the American College of Nurse Midwives (ACNM), Waterbirth International, American Association of Birth Centers (AABC), Midwives Alliance of North America (MANA) and National Association of Certified Professional Midwives (NACPM) have given their support the use of water in labor and birth. Each has issued a position statement reviewing the available research and citing the safety of immersion in water during labor and birth for selected clients who are attended by experienced providers.

ACNM is the professional organization for nurse midwives and they have issued the "Position Statement: Hydrotherapy During Labor and Birth." This statement discusses the available research and outlines evidence-based practice for use of water during labor and birth.

It states that:

> "Labor and birth in water can be safely offered to women with uncomplicated pregnancies and should be made available by qualified maternity care providers. Labor and birth in water may be particularly useful for women who prefer physiological childbirth and wish to avoid use of pharmacological pain relief methods."

ACNM Position Statement: Hydrotherapy During Labor and Birth. April 2014

Dar a Luz is a Nationally Accredited Birth Center and participates in the AABC data collection. We feel that these data provide evidence of the safety of water birth. After analysis of these data, AABC has issued the "Position Statement: Immersion in Water during Labor and Birth." These data demonstrate that water birth, with careful selection criteria and experienced providers, does not negatively affect mothers or newborns.

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AABC Position Statement: Immersion in Water during Labor and Birth

The American Association of Birth Centers (AABC) member birth centers have read with concern the recently released ACOG/AAP Committee Opinion, "Immersion in Water during Labor and Delivery." AABC agrees that published randomized controlled trials provide evidence demonstrating the benefits of immersion in water during the first stage of labor; however, the committee opinion does not reflect currently available best evidence for the use of water during second stage and for birth. Consequently, the document has the potential to introduce inappropriate fear about the safety of water birth for families, providers, facility administrators, insurers, and others who want to make informed decisions regarding immersion in water for labor and birth.

The AABC has collected and analyzed data on the use of water for labor and water birth from our online data registry, the AABC Uniform Data Set (UDS) (now Perinatal Data Registry).

Data for these analyses were collected from a sample of 15,574 obstetrically low-risk women eligible for birth center birth at the onset of labor from January 1, 2007 to December 31, 2010. There were 3998 water births in the sample; 57.6% were in birthing tubs, 34.6% were in Jacuzzis and 7.8% were in standard bathtubs, though outcomes did not differ across tub types. These data demonstrate that water birth, with careful selection criteria and experienced providers, does not negatively affect mothers or newborns.

- Rates of postpartum and neonatal transfer from the birth center, and neonatal procedures were low for the sample in general, and were slightly lower for births in water when compared to non-water births. This has been reported elsewhere.
- This suggests that if labor is not progressing smoothly, clients were unlikely to give birth in water and speaks to the importance of anticipatory and skilled water birth providers.
- Rates of newborn transfer to a hospital were lower following water birth (1.5%) than non-water birth (2.8%)
- Rates of adverse newborn outcomes (5-minute APGAR < 7, respiratory issues, presence of infection and NICU admission) were each below 1% in the water birth sample. The total rate of any respiratory issues was 1.6% in the babies born in water and 2% in those not born in water.
- There were no incidences of pneumonia, sepsis or other respiratory infection following water birth and there were no reports of ruptured umbilical cords or newborns breathing water into their lungs associated with birth underwater.
- Midwives practicing in birth centers are trained, anticipatory water birth providers, so data generated by midwifery care provides the most accurate view of the safety of water birth.
  Approved by AABC Board of Directors: 4.1.2014

In October 2016, “A Model Practice Template for Hydrotherapy in Labor and Birth” was published in the Journal of Midwifery & Women’s Health. This template provides guidance on protocols in order to safely offer water birth as an option for families in the hospital, birth center or at home. It was endorsed by AABC, ACNM, MANA and NACPM. After reviewing the current research, opinions and position statements, Dar a Luz feels very comfortable continuing to offer low risk clients the option to labor and birth in water. We have reviewed the research with our consulting physician and he agrees that we should continue offering immersion in water during labor and birth. Almost all of our clients use water immersion during labor and the rate of water birth at Dar a Luz has been 64% over the past 3 years. We have had no adverse outcomes related to the use of water. During that time many clients have experienced the benefits of immersion in water for labor and birth.

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Benefits

- Ease of movement
- Increased feeling of being calm, relaxed, nurtured, protected and in control
- Less painful contractions and less need for pain medications during labor
- Shorter labor and less need for increasing contractions during labor
- Lower episiotomy rates and decreased likelihood of 3rd or 4th degree lacerations (requiring transfer for repair) of the perineum
- Baby benefits from you being unmedicated, with the full complement of hormones during labor and birth
- Higher rates of maternal satisfaction with childbirth
- No evidence demonstrates that immersion during labor affects rates of infection, length of pushing, type of delivery, perineal laceration incidence or severity, postpartum hemorrhage or postpartum depression.

Risks

The studies did not find increased rates of maternal, fetal or neonatal morbidity or mortality associated with labor and birth in water but risks should be explained to clients.

- **Umbilical cord avulsion (tearing).** May occur if too much traction is placed on the cord. It is typically managed with little or no negative effects if recognized and treated quickly to minimize maternal and neonatal blood loss and need for a blood transfusion.
- **Hyperthermia (high body temperature).** When the water is above 100°F, it can lead to fetal tachycardia (heart rate above 170). This is resolved easily by cooling the water to between 100-97°F or getting out of the tub.
- **Perineal laceration.** There is a decrease of extensive 3rd or 4th degree lacerations but may be a slight increase in less significant lacerations.
- **Infection.** Studies found no increase in overall maternal or neonatal infection in water use regardless of whether the membranes were ruptured or not. If the tub is not cleaned properly or there is bacteria in the water, the client and/or neonate could acquire an atypical infection. There have been reported cases of Legionnaire’s disease in hospitals and at home but this is rare.
- **Neonatal water aspiration.** In case reports, researchers demonstrated that when secondary apnea (not breathing) is present due to fetal lack of oxygen, neonates may exhibit a gasping reflex at the time of water birth that can result in the inhalation of water and potentially make resuscitation and ventilation of the lungs more challenging. If the fetal heart rate is concerning, clients should get out of the water for further evaluation.
- **Mortality.** As with conventional birth, the potential exists for death of the client or neonate. No maternal deaths have been reported, and only isolated fetal deaths have been attributed to immersion during labor or birth.

Who Is Eligible For Waterbirth:

- Single baby in head down position at time of labor
- Gestation of 37 – 42 weeks
- Normal fetal heart rate without any decelerations

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When Is Waterbirth Not Recommended:

- Abnormal vaginal bleeding and/or hemorrhage during labor
- Maternal fever > 100.4°F
- Active herpes simplex lesion, hepatitis B or C, HIV
- Musculoskeletal issues or reduced mobility that may prevent the client from leaving the tub quickly if necessary
- Epidural analgesia or anesthesia for pain management
- Using narcotics or sedating medications within one hour of getting in the water
- Conditions that can complicate birth or transition of the newborn
- Clinical judgment of the midwife that the client's condition or fetal status needs further evaluation to be safe starting or continuing water immersion
  - Slow labor progress and need to evaluate contractions
  - Abnormal fetal heart rate and need for closer evaluation
  - Difficulty during pushing and need to evaluate progress
  - Difficulty in removal of placenta, unstable mother/birthing parent or excessive bleeding after birth that needs evaluation

Dar a Luz follows evidence-based practices to minimize these risks.

- All midwives are trained and experienced in waterbirth.
- All low-risk clients are eligible for waterbirth. No exclusions for GBS positive or meconium-stained fluid.
- Clients can regulate the water temperature to their own comfort but generally between 97-100°F.
- Water is run for 3 minutes to clear any stagnant water from the lines before the tubs are filled and water is drained and replaced after 6 hours of use to decrease the risk of infection.
- Encourage drinking liquids to maintain hydration while in the tub. May use IV fluids if indicated.
- Clients may use self-administered nitrous oxide in the tub.
- Maternal vital signs are assessed every 1-2 hours; fetal heart tones are taken every 5-30 minutes.
- Non-skid surfaces on the tub floor help to insure safe movement in and out of the tubs.
- Debris removal and changing of the water are done during labor to keep a clean environment.
- Baby is brought out of the water within 5-10 seconds and face is kept out of the water while the body is immersed to keep the baby warm, and a blue chux pad is placed over the body to reduce heat loss.
- If the baby's head is born out of the water, the head remains out of the water to avoid the risk of premature gasping under water.
- Close attention is given to the umbilical cord length after birth to reduce tension and risk for tearing. Delayed cord clamping can be practiced for stable newborns.
- Strict procedures are followed to ensure the tubs and any equipment used in the tub are either disposed of or thoroughly cleaned after every use to prevent infection.
- Strict cleaning procedures are followed for terminal cleaning of the birth rooms to ensure their safety.

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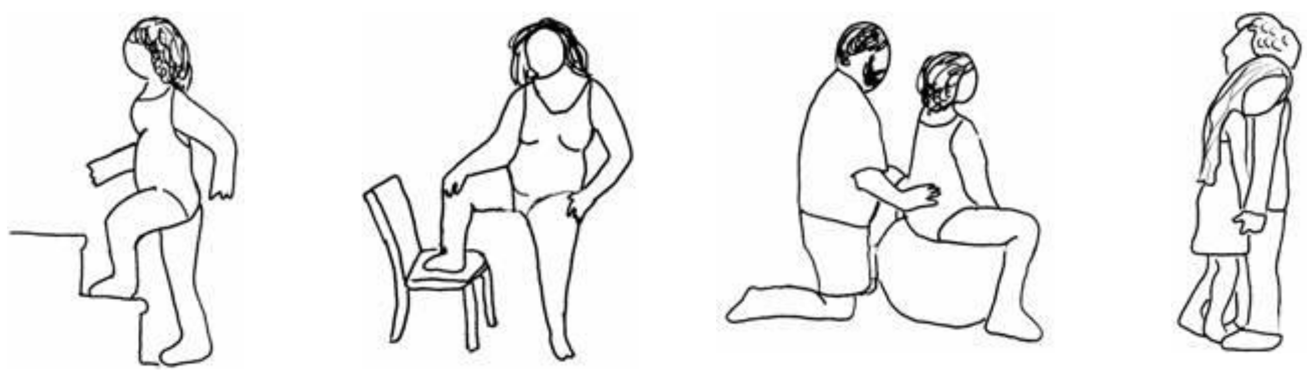
Positions for Labor and Birth

Exercises: Tailor Sit, Tailor Press, and Pelvic Tilts

Positions for Resting During Labor

Positions for Being Active During Labor



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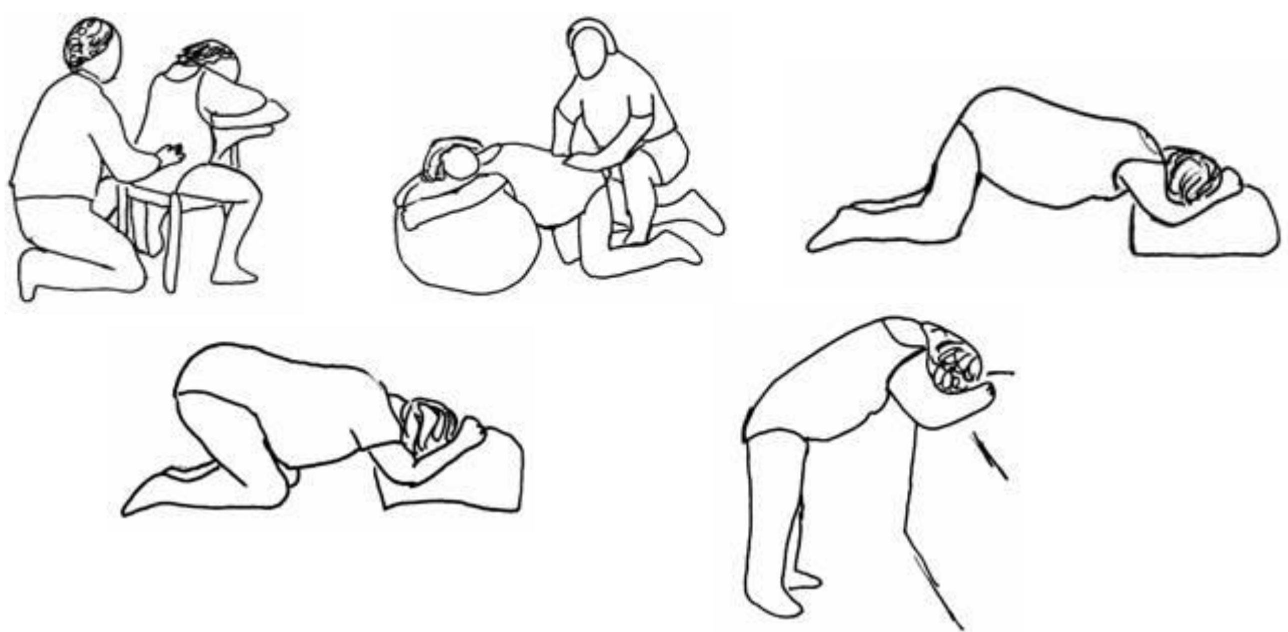
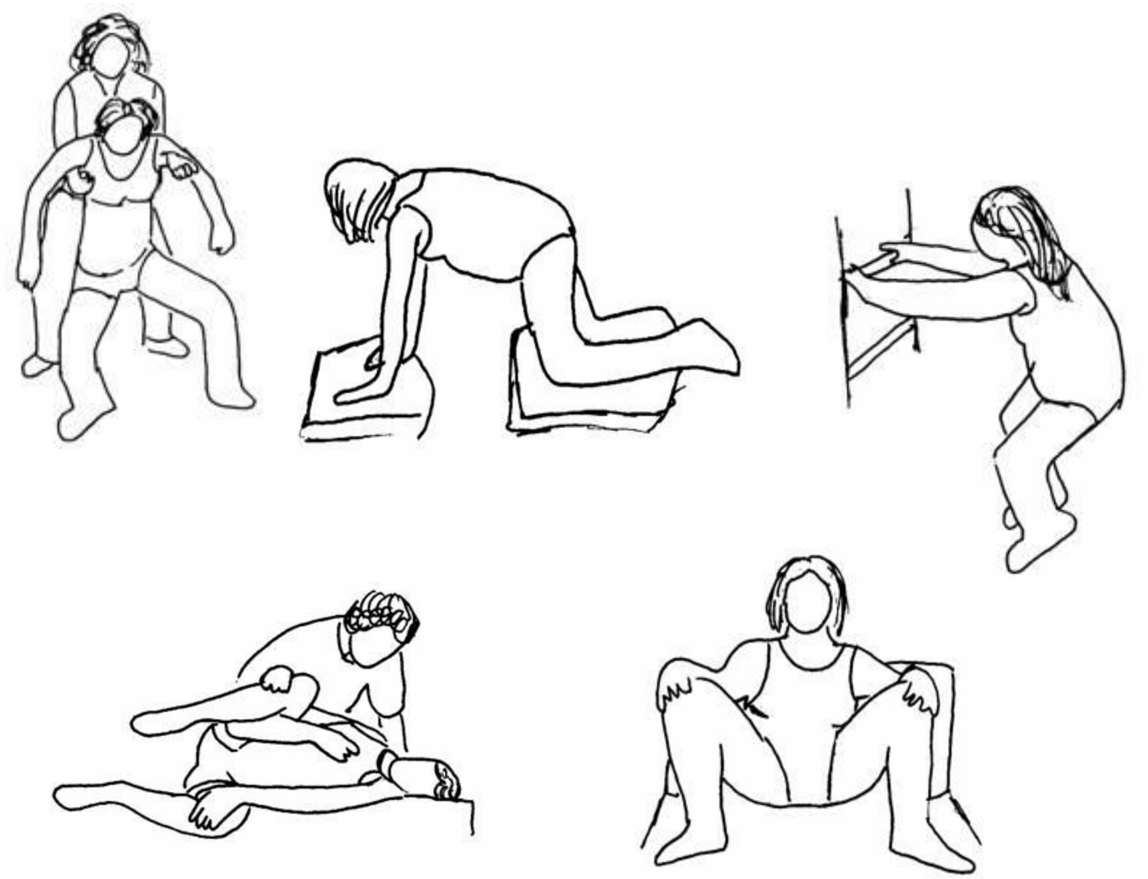
Positions for Back Labor



Positions for Birth



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Packing List: What to Bring to the Birth Center

- Your favorite protein and high calorie snacks and drinks for labor (fruit, juices, soft drinks, jello, power bars, honey, milk shakes, etc.) No low-calorie drinks – you need energy for labor!
- Food for the rest of your family
- Clothes for labor and wearing home. Partners: bring swimwear if you want to be in tub or shower.
- Shoes to walk around in the gardens (flip-flops are not good in the mulch)
- We provide mesh panties, peri-bottle (to dilute urine stream with warm water if there are any tears or stitches) and pads while you are at the center. You'll need large pads at home.
- Music on phone, camera, video recorder
- No candles please (we have flameless candles to help set the mood)
- Essential oils should be limited to small amounts on your skin, no diffusers please.
- Personal toiletries (we have shampoo, conditioner and body wash if you forget)
- Car seat installed in car
- Clothes, blankets, diapers for baby
- The birth center provides a postpartum gift bag, baby onesie
- Cooler for taking the placenta home

Labor and Birth

Most of us only get to experience labor and birth a few times in our lives. We know that you are aware of how special birth is and have chosen the birth center for a more natural and calm birth. We have created a space that supports you in having a peaceful birth with little intervention and the birth center staff is here to guard this sacred space for birth and bonding with your baby.

Imagine the world that your baby has been living in for the past nine months - one that is warm, dark, muffled noises, no smells and weightless in water. Think about ways to keep your baby's birth and transition to life calm from the baby's perspective (low lights, waterbirth if possible, no strong smells from candles or scents, calming music, voices of the most familiar people). We like to think of the first hour of life as the "Golden Hour" which is a time for your baby to transition into the world and for you to bond with your baby. This is a time to be present with your baby to observe every detail about him/her. Parents, midwives and nurses share the responsibility for observing this transition period and parents should voice any concerns they may have. Limit distractions from visitors and restrict the use of cell phones so that you can witness this miracle of life. We encourage you to cherish this precious "Golden Hour" and spend your time at the birth center to focus on bonding, breastfeeding and rest.

You can have your children, family and friends present during labor and birth; however, we encourage you to invite only the people that you feel are most supportive to be with you during this very intimate and inward focused time. Be sure that you have one adult (other than your partner) per child to supervise each child at the birth center. This allows your partner to be supportive of you and fully experience the birth. We encourage you to invite your visitors to come see you when you get home.

When you arrive in labor, you will be given a choice of the available birthing suites for your birth. We ask that you keep your personal belongings in your suite and keep the public areas (waiting room, bathroom, kitchen, education space and gardens) neat and clean for all other clients who share those spaces. Your immediate family is expected to sleep in your suite, and we cannot provide sleeping space for other family members or friends in other areas of the birth center.

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Oral Hydration and Nutrition: We encourage you to eat and drink as much as you feel like during labor. Please bring your own special foods and we will have chocolate milk, juice, popsicles, and light snacks available. If you are unable to eat or drink during labor, we can start an IV to keep you hydrated.

Fetal Monitoring: During labor, your midwife will monitor your baby's heartbeat by listening with a hand-held doppler at regular intervals. You are encouraged to be up and moving around, in the tub, or outside when the weather is nice. Electronic fetal monitors are not used during labor at the birth center. There are rare situations when the baby's heart rate is slowing and would require the next level of care at the hospital. If this were to occur, you would be involved in the discussion and decision-making process.

Induction and Augmentation (starting or making contractions stronger): Only non-medical methods of induction like mechanical dilatation of the cervix with a foley balloon, castor oil and nipple stimulation with a breast pump are used at the birth center. These methods can be very effective when used appropriately. Please consult with one of the midwives before using any of these methods, so that we can make a safe plan for how to use them. If you do not respond to these techniques, you may need the next level of care at the hospital where they can place a prostaglandin medication in your vagina (Misoprostol) or give Pitocin® (oxytocin) through your IV to start or make your contractions stronger.

AROM (Artificial Rupture of Membranes): Sometimes the midwife may recommend breaking the bag of water around the baby. This is done with a small plastic hook during the pelvic exam. This may make your contractions stronger and speed up your labor and will let us know what color the fluid is around the baby.

Birth of Your Baby: The majority of all babies are born vaginally and traditionally that rate is about 90% in birth centers. We encourage you to birth your baby where you feel comfortable, whether that is in the water, bed or somewhere in the room. Clients and their partners may choose to help catch the baby too. A midwife and a registered nurse will be with you at your birth.

Active Management (postpartum hemorrhage prevention): Midwives may recommend, or clients can choose to be given Pitocin IM or IV immediately after the baby is born but before the placenta is expelled. Research shows that this practice reduces the overall blood loss at birth. Clients who are at higher risk for hemorrhage may have had a hemorrhage in the past, had a blood transfusion for a hemorrhage, had a very long or very short labor or be anemic. The midwives will discuss these risks and options with you.

Repair of Tears or Episiotomy: Most clients have minor or no separations of the tissues in the vaginal area when the baby passes through. Some tears may need to be repaired and this is done by the midwife. In rare cases when the tear includes the rectal area, a doctor needs to do the repair at the hospital. In 1-3% of births a small cut (episiotomy) is made in the vaginal opening to help the baby come out quicker due to fetal heart rate concerns or maternal exhaustion. The use of episiotomy is rare at the birth center but when needed, your midwife will use a local anesthetic and stitches to close the tear or cut.

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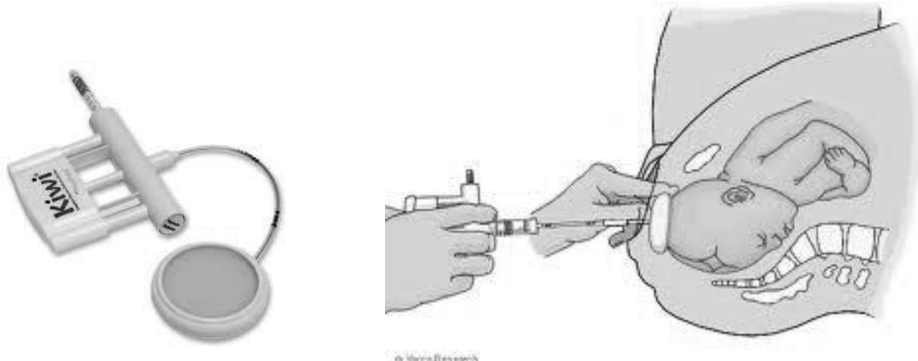
Vacuum Delivery

Vacuum assisted births are only done in the hospital. Sometimes a vacuum may be needed to help the baby out. The vacuum is a small suction cup that is placed on the baby's head. Suction is used when the client pushes to help the baby come out.



Forceps Delivery

Forceps assisted births are only done in the hospital. Sometimes forceps may be used to help the baby out. Forceps are made of metal and fit around the baby's head. This helps the doctor pull the baby out when the client pushes. The doctor will describe the risks to you and your baby if you consider this option.

Cesarean Sections

Cesarean sections are only done in the hospital. Sometimes a c-section is recommended because of problems with the client or the baby. At the hospitals, labor and delivery staff are ready 24 hours a day to do C-Sections if needed. Most cesarean births are done with spinal anesthesia so clients can be awake during the birth. When circumstances allow (non-emergent), some hospitals are offering "gentle cesarean births" designed to promote breastfeeding, family bonding and to enhance the experience of the client who desires a more natural de-medicalized birth, one that would more closely approximate that of vaginal birth. Gentle Cesarean components include:

- Ambience changes (dim lighting, music)
- Partner and another adult family member or doula may be present at the birth
- Limited non-essential staff present in the room
- Option to watch the baby being born from the abdomen through a clear drape
- Option to see the baby immediately after birth by dropping the drape
- Delayed cord clamping for healthy newborns
- Skin-to-skin care for newborns

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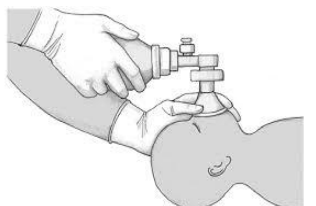
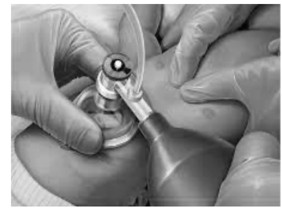
Newborn Resuscitation

All of the Dar a Luz midwives and nurses are trained in neonatal resuscitation (NRP) and practice monthly drills to maintain our skills. Babies are placed skin-to-skin on mother's chest immediately after birth and the first steps of resuscitation are given to all newborns. These include assessing for heart rate, breathing, crying, muscle tone and color as the baby changes its circulation of the blood through the heart and lungs and starts to breathe air for the first time. Those first 4 to 5 breaths are needed to clear the fluid out of the lungs and inflate the air sacks so the blood can be oxygenated. The baby is still getting oxygen from the mother as long as the cord and placenta are attached. At the same time, the airway will be cleared by wiping and suctioning the mouth (we do not use a bulb syringe because it can irritate the nose) or by placing the head lower than the body. We also dry and cover babies with warm blankets or a blue pad if they are in the water to keep them warm and this drying or rubbing can help stimulate the baby to breath and cry. All of this usually takes about a minute or less. This is all that most babies need to transition to life outside of the womb.



A few babies will need more help to clear the fluid out of their lungs if they are not breathing and crying well. We give the baby about 5 big, slow breathes of room air with the bag and mask device to help inflate the lungs. Although this can seem scary, it does not hurt the baby and most babies respond to this with regular breathing and crying and increased heart rate.

Some babies will need more breathes with the bag and mask until they can breathe on their own. At this time the cord is usually milked to give the baby as much blood as possible and then cut. The baby is taken to the resuscitation area in the birth room where you can still hear and see your baby. The midwife and nurse will tell you what is going on. Most babies respond to the additional breathes quickly with breathing, crying, increased heart rate and muscle tone including movement of the arms and legs. We will watch the baby closely for any other signs of respiratory distress including grunting, nasal flaring, blue color or poor feeding. We would also use the pulse oximeter (pictured below) to check the level of oxygen in the blood which tells us more about how well the baby is breathing. We can give specific concentrations of supplemental oxygen by mask if needed. It is rare that a baby needs more help transitioning than this; however, if the baby is stable but continues to have signs of respiratory difficulty, we would be talking to you about transferring the baby to the hospital for further evaluation and support that we cannot provide at the birth center.



Very few babies need a full resuscitation. If the baby's heart rate drops below 60 despite a full minute of effective breathing with the bag and mask, we start chest compressions and call 911. Babies usually respond to these measures before the EMS arrives, but these babies need special post-resuscitation, care. The baby would be transferred to the hospital for observation. Usually, partner or staff member can ride in the ambulance. Client would be discharged early once she is stable to join baby at the hospital. We realize this is scary and are including this information to help you be better prepared.

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Unexpected Home or Car Birth

Labor can be shorter than you expect. This happens more frequently for clients who have had a baby before but can be true for first time clients too. Those who have birthed before may find contractions get stronger very quickly. Labors that result in an unexpected birth may only be 1-2 hours from the beginning of contractions until the baby is born. The midwives take this into consideration when making a plan with you about when to call. It is safer for you to come in a little earlier to be sure that you make it to the birth center than to birth unexpectedly at home or in the car. Remember that when an unexpected birth happens, it is usually fast, the baby cries right away, and everyone is fine!

The midwives will cover what to do in this situation during the Interventions & Hospital Transfers Class and during your prenatal visit if you have a history of fast births. There are a few general tips to follow if you think you may not have enough time to make it to the birth center.

- Call 911 if the baby is coming at home so you have help.
- Call the midwife on call at 944-5488.
- The midwife will assess your situation and make a plan with you, and stay on the phone with you.
- Put together an emergency birth pack ahead of time
    - Several large towels to absorb the amniotic fluid and blood
    - A couple of large plastic bags to cover the seat and floor
    - A blanket to warm you
    - Several blankets to dry and warm the baby
    - A bowl for the placenta
- Keep calm. Your body knows what to do!
- Partners need to make the phone calls and be present for the birth
- Once the baby is born, place the baby skin-to-skin on mother's/birthing parent's chest
- Dry the baby's face and body then rub the back and feet if the baby is not crying
- Cover the baby with a dry blanket
- Cover mom with a blanket
- Do not pull on the cord. Do not cut it.
- Watch for gushes of vaginal bleeding and let the EMTs or midwife know about it.
- Don't worry about the placenta. It usually takes 5-10 (but can be up to 30) minutes to come out.
- Usually by this point, the EMTs are there or you are at the birth center.

If you have called 911, the EMTs will evaluate the client and baby and will request to transport you to the nearest hospital. Please call the midwife too so we know what is going on and can help coordinate your care. If the client is bleeding or baby is not breathing normally, we advise you to go to the hospital. Request to go to UNM and the midwife will meet you in Labor & Delivery for evaluation. If the baby is crying and pink and you are not bleeding, you may decline to go to the hospital, but you would need to feel comfortable driving yourselves to the birth center within 15-20 minutes.

If you go to the hospital, there will be an evaluation of client and repair of any lacerations. If the baby is doing well, then client and baby are discharged to the birth center for postpartum and newborn recovery for about 2-3 hours and then sent home. To date, no client or baby has been admitted to the hospital after an unexpected home birth. If you are on your way to the birth center when the baby is born, let the midwife know and then honk your horn when you arrive so we can meet you at the car. Client and baby will usually stay for the normal postpartum and newborn recovery, depending on the situation.

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Breastfeeding
and Feeding Your Baby

Breastfeeding is normal and the best way to feed your baby. Breast milk is the perfect food for your baby. It contains all the nutrients your baby needs for healthy growth and development during the first six months of life and beyond. It has disease-fighting cells that can protect your baby from many illnesses. Formula cannot match the exact makeup of human milk. Breastfeeding also provides many other health benefits.

There are three reasons for breastfeeding:
the milk is always at the right temperature;
it comes in attractive containers;
and the cat can't get it.
~ Irena Chalmers

Planning for Breastfeeding

The American Academy of Pediatrics (AAP) recommends breastfeeding for the first twelve months or longer. The World Health Organization (WHO) advises you to breastfeed for two years. While breastfeeding for a short length of time provides benefits, the longer you breastfeed the more benefits you and your baby receive. Our staff strongly supports breastfeeding and will assist you with any concerns you may have. (Also see the sections in **"Breastfeeding After Birth," "Pumping," "Screening Guidelines for Informal Milk Donors," "Supplemental Feeding Options Consent Info," "Screening Guidelines for Informal Breast Milk Donors," and Supplemental Formula Feeding."**)

Breastfeeding laws protect your right to breastfeed.

Federal and New Mexico state laws protect the right to breastfeed a child in any public or private location where she is otherwise authorized to be. Employers are required to provide a clean, private place (not a bathroom) for employees who are breastfeeding to pump. The employer is required to give the employee breaks to express milk but is not required to pay for this time.

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Advantages of Breastfeeding

For Baby

- Helps brain develop -- your child may be smarter
- Fewer ear, lung, and stomach infections
- Less constipation and diarrhea
- Fewer problems with allergies, asthma and eczema
- Helps your baby's jaw, teeth and palate form correctly
- Lowers your baby's risk of obesity, diabetes, and leukemia
- Lowers your baby's risk of Sudden Infant Death Syndrome (SIDS)

For Client

- Less risk of heavy bleeding after birth
- The uterus goes back to its normal size faster
- May help with weight loss
- Helps you and your baby to bond
- You can pump & store breast milk for later use
- Saves time: no bottles to wash or formulas to mix
- You are able to rest while you feed your baby
- May help you feel calmer and have less risk of postpartum depression
- Lowers your risk of diabetes, breast and ovarian cancer, heart disease, and high blood pressure

For Family and Society

- Breast milk saves at least $1500 per year on formula
- Saves on health care costs because your baby is sick less often
- Better for the environment due to less trash compared to formula

Breastfeeding After Birth

Skin to Skin Care: The baby is placed skin to skin on your chest immediately after birth. Then a blanket will be placed over both of you. This helps you get to know your baby. Breastfeeding is easier and your baby stays warmer next to you. Your baby feels more secure when they are skin to skin (partners can do this too). Repeated skin to skin contact helps your baby develop and increases your milk supply.

Colostrum: Colostrum is the first milk your breasts produce and it is very high in protein. This is the perfect milk for your baby. It contains antibodies to help your baby fight infections. It is made in small amounts just right for your newborn baby's stomach. It coats your baby's stomach and helps it to mature. It also protects it from certain bacteria. Babies need this first milk to be healthy.

Hand expression: Regular hand expression of colostrum from birth until the time that milk comes in has been shown to increase your overall milk supply. Stanford Medicine has some great video resources on breastfeeding and hand expression. We recommend all clients watch these videos before giving birth. med.stanford.edu/newborns/professional-education/breastfeeding.html

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Breast milk: At about 72 hours after birth, you will produce more mature milk. It is normal for your breasts to feel very full or heavy (called engorgement) for a short time. Continue breastfeeding every 1-3 hours or at least 8-12 times a day to relieve the fullness. Engorgement lasts 24-72 hours and decreases when your body produces just the right amount of milk for your baby. The more you breastfeed or pump, the more milk your body will make. Your body will adjust the amount of milk it needs for your infant the entire time you breastfeed.

Size of Baby's Stomach: On the first day of life, your newborn's stomach is the size of a marble and holds about a teaspoon (5 cc) of colostrum. By day three, your baby's stomach stretches more and holds less than one ounce (30 cc) per feeding. By day 10, your baby's stomach has stretched to the size of a ping-pong ball. It holds about two to four ounces per feeding.

Cluster Feeding: Cluster feeding or feeding frenzy is when your baby eats often and/or for long lengths of time. This makes your breasts produce more milk. While this may be a bit tiring for you, it only lasts two to three days. Then your baby will return to a normal eating pattern. Your baby normally has a feeding frenzy on the second and third day of life. It happens again when your baby is having growth spurts around three weeks, six weeks, three months and six months of life. Remember, feeding frenzy means that your baby is normal and knows what to do to help you make more milk.

Breastfeeding support: It takes a little time and practice for you and your baby to learn how to breastfeed. The nurse and midwife at your birth will help you with breastfeeding and we will send you home after your baby has nursed several times. A midwife will see you within 24-36 hours after your birth to assist you with breastfeeding. If you are having problems breastfeeding after you go home or feel like you do not have enough milk, get help right away. We have lactation experts on staff to evaluate and assist with lactation problems. ***Call the birth center (505) 924-2229 or the midwife on call (505) 944-5488 for an appointment.***

- You may have some soreness in your nipples for a few days, but this should not last long. If you have bleeding or sore nipples and they are not getting better, this is a sign that the baby is not latching on to your breast correctly. Call for help.
- You may feel like you do not have enough milk at first. Your breasts do not start making lots of milk from the start. Breast milk production works on supply and demand which means when your baby sucks and empties the milk, your breasts make more milk. Breastfeeding more often makes more milk.
- Frequent use of formula and artificial nipples may have a negative effect on breastfeeding. Your baby sucks differently on the breast compared to a bottle nipple. Your baby may be fussy and confused when you offer both. When you give formula, your baby will not be stimulating your breasts to make more milk. This may affect your milk supply. Your baby will be full of formula and may not be interested in breastfeeding. In addition, when formula is substituted for breast milk, babies often have more stomach upset, diarrhea, gas and restlessness.

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Breastfeeding Supplies

- A double electric or hand breast pump is nice to have if you are planning on going back to work or would like to store some milk so that you can be away from your baby for short periods.
- Some clients prefer a hand pump or the Haakaa suction pump.
- You will need some disposable or cloth nursing pads in case your breasts leak milk. Be sure to change the pads when they are wet to prevent an infection in your breasts.
- BPA-free plastic or glass bottles or milk storage bags (not regular freezer bags) to store milk.
- You may want to get Quick Clean micro-steam bags to clean pump parts (made by Medela).
- Lansinoh makes a very good lanolin cream for your nipples.
- You may want to get some gel nipple pads to soothe sore, cracked nipples.

Potential Breastfeeding Issues

It's roundly agreed that breast is best, for you and for your baby. We recommend at least six months of exclusive breastfeeding (or more!), and we want to support you in your success and satisfaction.

Sometimes, breastfeeding can be more of a struggle than was expected. Issues with breastfeeding can cause physical and emotional pain, worry, and sadness, and may even lead to giving up on part or all of the experience. We want you to hear this: we support you in FEEDING YOUR BABY, however you feed your baby. If breastfeeding is your goal, with sound guidance and appropriate medical support, most families can overcome these obstacles and continue breastfeeding for longer periods.

We encourage you to reach out if it's hard! First, plan on coming to our **Feeding Support Group**! Sometimes normalization, support, and advice from other breastfeeding families is just what is needed. You can also talk to your midwife at a scheduled visit. **Read on to learn more about any of these issues.** And definitely make sure you call us for a **lactation visit** with an International Board Certified Lactation Consultant® (IBCLC) on staff if you're **worried about any of the following**:

- You think your baby may not be gaining weight or getting enough milk (we can measure this).
- You think you might be making too much milk (oversupply), along with plugged ducts.
- You have serious nipple pain and/or cracked, bleeding nipples.
- You think you might have mastitis (inflammation of the breast that is often associated with fever, muscle and breast pain, and redness). Also see the section "**Mastitis**" below.
- You suspect a lip and/or tongue tie. Also see the section "**Tongue Tie (Ankyloglossia)/Lip Tie/Frenotomy Consent Info**" for more information.
- You are dealing with any level of postpartum depression. Also see the sections "**Postpartum Warning Signs**" and "**Depression and Anxiety During and After Pregnancy**" for more info.

Problems: Watch for these and call us if you need us!

Inadequate milk intake

This is one of the most common worries in new breastfeeding relationships. Although it's not always the case, if this is happening, there are two possible causes. One might be **not enough milk production**, and one might be your **baby not extracting enough milk**. There can be medical reasons for both, but sometimes it can be caused by the way feeding is happening. Reach out -- let us reassure you, help figure out if it's happening, and if so, help you find solutions. Be sure to let us know **how often and amount of time feeding is happening, if you're pumping, and how much your baby is peeing and pooping**.

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Pain in the nipple and/or breast

Common causes of nipple and breast pain include:

1. **Nipple injury** -- usually caused by your baby's sucking pattern or a breast pump (see #1 below)
2. **Engorgement** -- when breasts are very full of milk; possible excessive milk supply (see #2 below)

2a. **Plugged milk ducts** -- a hard tender lump that doesn't empty with feedings (see #2 below)

3. **Infections of the nipple or breast, including mastitis or candida** (see #3 below)
4. **A tongue tie or lip tie** -- when the baby's tongue or lip(s) cannot move as freely as they should, making it harder for the baby to suck. See the section ""**Tongue Tie (Ankyloglossia)/ Lip Tie/Frenotomy Consent Info**" for more information, and call us if you need an assessment.

Less common causes of nipple and breast pain include:

- Skin disorders (such as dermatitis or psoriasis) affecting the nipple
- Nipple vasoconstriction (blood vessels in the nipple tighten and don't let enough blood through)
- Torticollis – when baby's neck is set in a way that makes it hard for them to nurse on both sides).
- An uncoordinated sucking pattern.

1. Recommendations for at-home treatment of nipple injury:

- Make sure baby is properly positioned on the breast; change baby's nursing position to change the pressure points on the nipple.
- Be sure to break the suction before removing the baby from the breast, so the baby isn't popping off. See also "**Postpartum Changes: What to expect over the next few days**" for more info.
- Promote milk let-down before feedings with the use of heat and/or massage.
- Evaluate baby for possible oral anatomy causes (lip/tongue ties, high palate, recessed chin).
- After each nursing and/or pumping session, express a drop of breastmilk and rub into the nipple, allow to air dry completely to form a protective seal, then apply a nipple cream for healing (oil-based creams such as "Motherlove" work well).
- Rinse nipples gently with clear water after nursing.
- You can also make a salt water rinse to use at home. This special type of salt water, called normal saline, has the same salt concentration as tears and should not be painful to use. To make a normal saline solution:
    - Mix 1/2 teaspoon of salt in one cup (8 oz) of warm water. Make a fresh supply each day to avoid bacterial contamination. You can also purchase individual-use packets of sterile saline solution.
    - After breastfeeding, soak nipple(s) in a small bowl of warm normal saline solution for 1-2 minutes -- long enough for the saline to get onto all areas of the nipple. Avoid prolonged soaking, as this can cause more cracking. Alternately, put the saline solution into a squeeze bottle and squirt it on gently and generously, making sure to get it on all areas of broken skin.
    - Follow up with application of breastmilk and/or nipple cream.
- If using disposable breast pads, be sure to change them frequently.
- Use hydrogel pads to help speed healing (Lansinoh Soothies or Medela Tender Care Hydrogel): After feeding and nipple care, apply hydrogel pad directly to and keep in contact with the nipple anytime you are not feeding or pumping. Use for 2-3 days and discard. Repeat as necessary.
- Consider use of a nipple shield and/or pumping for 1-2 days to allow nipples time to heal.
- **If nipple damage persists or worsens, call the office for a lactation visit for evaluation.**

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2. Recommendations for at-home treatment of engorgement and plugged ducts:

- If breasts are still painfully hard and full despite regular feedings, or you suspect a plugged milk duct (a hard tender lump that doesn't seem to be emptying with feedings) you can try the following at home to help aid milk removal and soften the breasts. It is important to get the milk moving and get the plugged area resolved before it progresses to mastitis.
    - Apply a warm compress to the area for 5-10 minutes prior to feeding and/or pumping.
    - Apply ice packs to breasts AFTER feeding.
    - To help with latching, try this reverse pressure softening technique
        - Use your fingers to push the milk/swelling back into the breast around the areola/nipple, until it softens enough for your baby to latch onto effectively.
    - Use gentle massage while feeding, starting above the painful area and moving down toward the nipple.
    - If needed, take help decrease swelling and inflammation by taking acetaminophen (Tylenol) 1000mg every 6 hours, or ibuprofen (Advil or Motrin) 800 mg every 8 hours
    - Try using a silicone breast pump or "Haakaa" on the opposite breast while baby feeds, to help remove some milk without having to stimulate breasts more with the electric pump.
- If still painfully engorged/plugged, pump with electric pump for 10-15 minutes; ideally after applying heat and feeding. Note: Only pump long enough to soften the breasts and provide relief -- over-pumping causes breast overstimulation, and continued or worsening engorgement. Massaging and hand expressing breasts in a hot shower after a feeding may also help.
- If you experience recurrent plugged ducts, try a Sunflower Lecithin supplement, which decreases the viscosity (stickiness) of breastmilk, therefore decreasing the risk of plugs. Try these capsules: "Legendairy Milk Sunflower Lecithin"; or this powder: "Micronutrients Organic Sunflower Lecithin." Both are on Amazon.) Recommended dosage is: One 1200mg capsule 4 times per day for treatment, then one 1200mg capsule 1 to 2 times per day for prevention.
- **Call us if engorgement or plugged duct persists for more than 48 hours,** despite good breast emptying and comfort measures, **or if a fever or symptoms of mastitis develop** (see below).

3. Breast Infections

Mastitis

Mastitis is an inflammation of breast tissue that can lead to an infection of the breast. It can happen at any time, but it is most common in the first six weeks postpartum. If you do have an infection, your health care provider will probably put you on antibiotics. Risk factors include damaged nipples, unrelieved engorgement or clogged ducts, a poor latch, oversupply, illness (mom or baby), infrequent or missed feedings, rapid weaning, pressure on the breast (a tight bra), and maternal stress or fatigue. Lactation mastitis can cause a mother to feel run down, making it difficult to care for their baby and sometimes lead to weaning the baby before they intend to. Continuing to breastfeed, even while taking an antibiotic to treat mastitis, is safe for mom and baby, and encouraged until the inflammation clears.

Call (505) 924-2229 during business hours, or call the on-call midwife after hours at (505) 944-5488 to set up an appointment if you have any of the following symptoms:

- A firm, red, and tender area of the breast that is warm to the touch
- Pain or burning sensation that is during breastfeeding and/or continuous
- A fever higher than 101°F or 38.5°C (be aware, fever can be masked by pain medications)
- Muscle aches, chills, malaise, or flu-like symptoms

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To help manage mastitis at home after being seen, you can:

- Take all of your antibiotics as prescribed and on time (if they are prescribed).
- If you don't start to feel better within a couple of days of starting antibiotics, call us to see if you need a different antibiotic or have a different issue.
- Continue breastfeeding and/or pumping on your baby's schedule – this is important for both your baby and you! Breastfeed even while you are being treated, and get help with your feeding techniques. Try to make sure your breasts are emptied well with each feeding.
- Take a pain reliever: acetaminophen (Tylenol) 1000mg every 6 hours, or ibuprofen (Advil or Motrin) 800 mg every 8 hours for discomfort.
- Prior to feedings, apply a warm compress to the breasts for 5-10 minutes, or submerge breasts in a large bowl of warm water. You can add a few tablespoons of Epsom salts to this soak.
- Apply cold compresses or ice packs after feedings.
- Try green cabbage leaves between feeding for relief. Wash well, and refrigerate or freeze. Crush one so it forms to your breast better, and hold it in place with your bra. Do not let the cabbage leaf cover your nipple. Leave it on for 20-30 minutes (until it wilts). Use up to 3 times per day.

Infection of the nipple or breast, caused by bacteria or candida

Nipple infections and some breast infections can be difficult to discern and we recommend calling for advice and an appointment if you suspect you may have nipple or breast pain due to a bacterial or yeast infection (also called a candida infection or thrush). Symptoms include:

- Having breast/nipple pain that is out of proportion to an apparent cause. When severe, it is sometimes described as a "stabbing ice pick" sensation.
- Burning nipple pain that persists during feeding and persists after feeding.
- Having a personal history of vaginal yeast infections; having recently been on antibiotics
- Having discolored, shiny or flaky skin on the nipple.
- Having an infant who is showing signs of thrush (white spots not caused by milk residue that don't wipe off, on the tongue, cheek, roof of the mouth, lips, or gums) or a rash in their diaper area. Pro tip: If it's showing up on both ends of your baby, there's a good chance it's all through their gut, too. They might also seem uncomfortable during feeding.

Treatment will depend on your assessment of symptoms by the midwife. If a bacterial infection is suspected, treatment is generally just needed for you, and not your baby. Continued breastfeeding is still safe and recommended during treatment.

If yeast is suspected, it will be important to also assess the baby too, and treat both you and baby simultaneously. If a yeast infection is diagnosed, home treatment can be helped by trying the following:

- Air out your breasts, change breast pads frequently, and wash nursing bras at a high temperature.
- Look at your diet: Yeast feeds on sugar. You may want to consider limiting refined sugars, refined carbs, and alcohol (which should be limited during breastfeeding anyway). You might also try adding more coconut oil, fermented foods, and probiotics to your diet.
- Continued breastfeeding is still safe and recommended during treatment.

Please reach out if something is hard! We are here to help! And remember, we support you, no matter what feeding your baby looks like to you.

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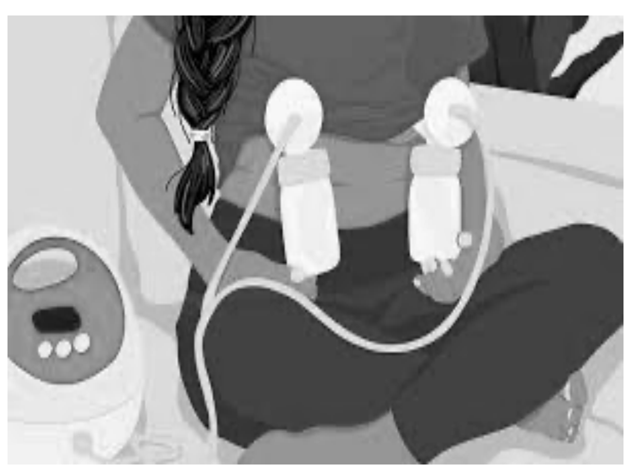
Pumping



It is normal to have questions about pumping and storing breast milk and we encourage you to attend a Pumping class to learn how to use your pump. Most insurance companies cover breast pumps, but you need to research which pump is covered and where to get it. Let the midwife know what you want and where to get it and we can write a pump prescription for you. Bring it with you to the class. We also keep a few breastfeeding supplies at the center for purchase and have some pumps to loan to our clients. The Women Infants and Children (WIC) offices may have pumps to loan or free pumps if you are in their breastfeeding program.

Why would I want to pump?

- We may recommend nipple stimulation with a pump to stimulate labor.
- You may want to pump to stimulate milk production and increase milk supply.
- To collect milk to feed to a premature baby who may have difficulty latching.
- To relieve discomfort during engorgement and allow baby to latch easier.
- To give sore nipples time to heal.
- To express milk for someone else to be able to feed your baby.
- Keep milk supply up while separated from baby or unable to nurse.

What kind of pump should I choose? A hand pump is sufficient for occasional supplementation, but a double electric pump may be better for more frequent use. When choosing a pump consider whether it is a trusted brand name, suitable for your pumping needs, closed or open milk system, hospital or consumer grade, covered by your insurance plan, and if you want to use one complete system (pump, bags, bottles, nipples) or several that meet your needs. Some common brands of pumps are Medela, Spectra and Haakaa (manual pump).

When should I start pumping? Normally your baby will be the best source to build your milk supply and remove milk from your breasts. After breastfeeding is well established (usually around 2-3 weeks after birth) you may want to consider starting to pump. In certain situations, it is advisable to pump sooner. If you are unable to nurse your baby, your baby is not latching well or not nursing enough, you may want to pump to build your milk supply and to feed your baby expressed milk. Also, if you experience engorgement, you can pump a small amount of milk to relieve discomfort and to help the baby latch by softening the breast.

How do I increase my milk supply with a pump? Double pumping raises the hormone prolactin and may increase milk supply and lessen the time spent pumping. Some experts recommend trying the ‘third breast’ technique (pump the breast after baby nurses) or pump in between feedings. Empty the breast completely during pumping. Empty breasts make milk. Try pumping 5-10 minutes past the last drop of milk. Try using a breast shield to stimulate different areas of the breast while pumping.

What is “hands on” pumping? Studies have shown that using your hands to massage, compress, and express milk while pumping can increase the amount of milk expressed by 48%, contained twice as much fat as using the pump alone and increased overall supply.

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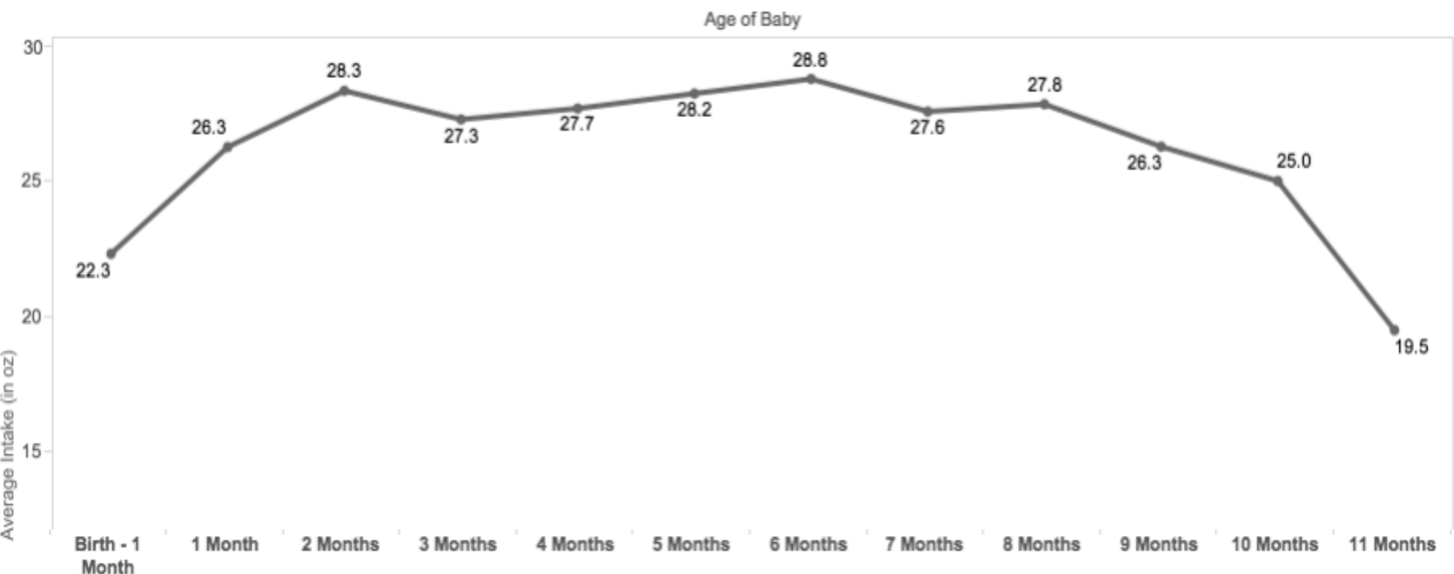
Where can I get help with pumping? If it is a problem with your unit refer to your user manual or customer service. For other questions or concerns ask your midwife, nurse, lactation consultant, or breastfeeding peer counselor. Consider attending the pumping class or breastfeeding support groups.

- Dar a Luz Birth and Health Center (505) 924-2229
- National Breastfeeding Helpline (800) 994-9662
- Hotline for medications with breastfeeding (806) 352-2519
- NM Breastfeeding Task Force (505) 933-9163
- WIC (505) 841-4173
- La Leche League Helpline (505) 821-2511 or (877) 452-5324 outside of Albuquerque

Average Breastmilk Intake by Age



Breastmilk calculator: www.momjunction.com/breast-milk-calculator/#gref

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Milk Storage Guidelines

Storage of Human Milk for Term Infants

Note: When thawing frozen milk, label as thawed when completely thawed [i.e., no ice crystals present]. Use the time when completely thawed to base acceptable time limits for use, rather than when it is taken from the freezer.

Human Milk	Room Temperature	Time in Refrigerator	Time in Freezer
Freshly expressed	≤ 6 hours	≤ 5 days	Ideal: 3 months Optimal: ≤ 6 months Acceptable: ≤ 12 months in a deep freezer [-4°F]
Previously frozen, thawed in refrigerator but not warmed	≤ 4 hours	≤ 24 hours	Do not freeze
Previously frozen & brought to room temperature	For completion of feeding – up to an hour at room temp & then discard.	≤ 4 hours	Do not freeze
Infant has started feeding	For completion of feeding & then refrigerate ≤ 4 hours.	≤ 4 hours	Do not freeze
Thawed previously frozen pasteurized human donor milk	≤ 4 hours	≤ 48 hours	Do not freeze
Frozen pasteurized human donor milk in a deep freeze	Not applicable	Not applicable	9-12 months from pumping date

*Recommendations taken from Human Milk Banking Association of North America (HMBANM)****
Best Practice for Expressing, Storing, and Handling Human Milk in Hospitals, Homes, and Child Care Settings. Frances Jones, 4th Edition, 2019, pages 49-51, 81-82, 140-141.

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Milk Storage and Guidelines from the CDC
(which are more conservative)

ACCESSIBLE VERSION: https://bit.ly/2dxVYLU

STORAGE AND PREPARATION OF BREAST MILK

BEFORE EXPRESSING/PUMPING MILK

Wash your hands well with soap and water.

Inspect the pump kit and tubing to make sure it is clean.

Replace moldy tubing immediately.

Clean pump dials and countertop.

STORING EXPRESSED MILK

Use breast milk storage bags or clean food-grade containers with tight fitting lids.

Avoid plastics containing bisphenol A (BPA) (recycle symbol #7).

HUMAN MILK STORAGE GUIDELINES

	STORAGE LOCATIONS AND TEMPERATURES		
TYPE OF BREAST MILK	**Countertop** **77°F (25°C) or colder** *(room temperature)*	**Refrigerator** **40 °F (4°C)**	**Freezer** **0 °F (-18°C) or colder**
Freshly Expressed or Pumped	Up to **4 Hours**	Up to **4 Days**	Within **6 months** is best Up to **12 months** is acceptable
Thawed, Previously Frozen	**1–2 Hours**	Up to **1 Day** *(24 hours)*	**NEVER** refreeze human milk after it has been thawed
Leftover from a Feeding (baby did not finish the bottle)	Use within **2 hours** after the baby is finished feeding		

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STORE

Label milk with the date it was expressed and the child's name if delivering to childcare.

Store milk in the back of the freezer or refrigerator, not the door.

Freeze milk in **small amounts of 2 to 4 ounces** to avoid wasting any.

When freezing leave an inch of space at the top of the container; breast milk expands as it freezes.

Milk can be stored in an insulated cooler bag with frozen ice packs for **up to 24 hours** when you are traveling.

If you don't plan to use freshly expressed milk **within 4 days**, freeze it right away.

TH W

lways thaw the oldest milk first.

Thaw milk under lukewarm running water, in a container of lukewarm water, or overnight in the refrigerator.

Never thaw or heat milk in a microwave. Microwaving destroys nutrients and creates hot spots, which can burn a baby's mouth.

Use milk **within 24 hours** of thawing in the refrigerator *(from the time it is completely thawed, not from the time when you took it out of the freezer).*

Use thawed milk **within 2 hours** of bringing to room temperature or warming.

Never refreeze thawed milk.

FEED

Milk can be **served cold, room temperature, or warm.**

To heat milk, place the sealed container into a bowl of warm water or hold under warm running water.

Do not heat milk directly on the stove or in the microwave.

Test the temperature before feeding it to your baby by putting a few drops on your wrist. It should feel warm, **not hot.**

Swirl the milk to mix the fat, which may have separated.

If your baby did not finish the bottle, leftover milk should be used **within 2 hours.**

CLE N

Wash disassembled pump and feeding parts in a clean basin with soap and water. **Do not wash directly** in the sink because the germs in the sink could contaminate items.

Rinse thoroughly under running water. ir-dry items on a clean dishtowel or paper towel.

Using clean hands, store dry items in a clean, protected area.

For extra germ removal, sanitize feeding items daily using one of these methods:

- clean in the dishwasher using hot water and heated drying cycle *(or sanitize setting).*
- boil in water for 5 minutes *(after cleaning).*
- steam in a microwave or plug-in steam system according to the manufacturer's directions *(after cleaning).*

June 2019

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

FOR MORE INFORM TION, VISIT:
https://bit.ly/2dxVYLU

296657-

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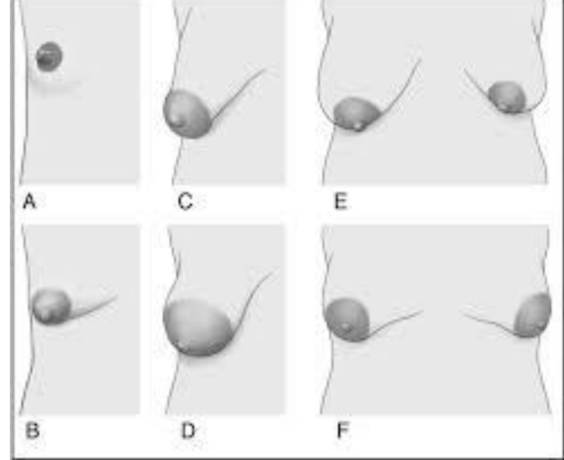
Supplemental Feeding Options Consent Info

Dar a Luz supports a client's right to make choices in all areas of your life, including how you feed your baby. Whether you breastfeed or use supplemental milk to feed your baby, the most important thing is that you and your baby are bonding and your baby's needs are being met. There are several reasons why you may choose to supplement your baby with your own pumped milk, pasteurized breast milk, informally shared donor breast milk or formula for a few days to many months. These situations can include:

- Delayed lactation (milk not coming in by 2-3 days after birth) due to birth complications
- Inadequate milk supply may be due to inadequate breast stimulation or insufficient breast tissue
- A baby who is too sleepy to nurse due to jaundice
- A baby who has a painful latch causing nipple damage
- Poor transfer of milk to the baby due to breast anatomy or baby's mouth anatomy (tongue or lip tie)
- A baby who is not vigorous at the breast which can be due to low birth weight or early term gestation
- A premature baby or a baby in the NICU who may be evaluated for infection
- A baby who is not gaining weight adequately, increased weight loss
- Just needing a break or letting someone else feed the baby so you can get more sleep
- Going back to work and being unable to pump enough milk
- Having a medical condition that requires medications that are not safe for breastfeeding
- Simply not enjoying breastfeeding and choosing an alternative feeding method

There are various medical complications and conditions that can affect the milk supply and may require supplemental feedings to meet the baby's needs. They may include:

- Premature birth
- Pre-eclampsia
- Cesarean section
- Postpartum hemorrhage resulting in anemia
- Maternal obesity
- Previous breast surgery, especially breast reductions
- Insufficient glandular tissue (breast hypoplasia) – physical signs may include:



  - May have small or large breast and will produce some milk but may not be enough
  - May have more than 4cm of flat space between breasts
  - One breast much larger than the other
  - Tubular shaped breasts (the breast has a narrow base and its volume is long rather than round)
  - Overly large and bulbous areola (as if they are a separate structure attached to the breast)
  - Absence of breast changes in pregnancy, after birth or both

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Options for Supplemental Feeding

Determining the preferred option for supplementation involves a process of informed decision-making on the part of the parents, in consultation with their midwife or pediatrician.

Options include (see below for more information on each):

1. Biological mother's/parent's milk is always first choice
2. Donor human milk from a milk bank is the next best and safest choice
3. Human milk substitute (commercial formula) is acceptable
4. Unpasteurized donor human milk (informal milk sharing) carries the most risk

1. Biological Mother's/Parent's Expressed Breast Milk

Benefits

- Protects baby against short and long-term risks (gastrointestinal problems, respiratory infection, ear infections, SIDS, obesity)
- Supports cognitive development
- Protects mothers against type 2 diabetes, certain breast and ovarian cancers
- Affordable and environmentally friendly

Risks

- Risk free (unless breastfeeding is contraindicated)

Dar a Luz offers lactation support to maximize your milk production and effectively feed your newborn. Ways to increase the milk supply include hand expression, pumping to stimulate the breasts, mother's milk teas and herbs. Effective feeding strategies can include feeding from a spoon, finger with feeding tube, supplemental nursing systems, nipple shields, and bottle.

2. Donor Human Milk from a Milk Bank

Benefits

- Best alternative for premature and medically vulnerable newborns
- Rigorous donor screening for health problems, medications, communicable diseases (HIV, HTLV, Hepatitis B & C)
- Strict milk collection and handling guidelines
- Holder pasteurization prevents transmission of pathogens

Risks

- Limited availability
- Cost may be prohibitive
- Pasteurization affects some components of human milk

We keep available for sale a small supply of 4 oz bottles of frozen pasteurized milk from the Denver Milk Bank (approximately $31 per bottle); primarily used for babies in the NICU or families who prefer

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pasteurized milk. Due to the cost and lack of availability of the milk, it is not available for long-term use. See the section “**Milk Depot**” for more information.

3. **Human Milk Substitute (Commercial Infant Formula)**

Benefits

- Readily available
- Acceptable substitute
- Considered safe

Risks

- Expensive
- Inferior composition, not human milk - made from cow’s milk, soy or specialty formulas
- Risk of contamination of product in manufacture or during preparation
- Increased short and long-term health risks (gastrointestinal problems, respiratory infection, ear infections, SIDS, obesity)
- Reduced cognitive development
- Not environmentally friendly

Dar a Luz recommends an organic formula that is ready-to-feed for all newborns less than a month of age. See the section “**Some Good Formula Choices**” for more information.

4. **Unpasteurized Donor Human Milk (Informal Milk Sharing)**

See the sections “**Dar a Luz Informal Donor Breast Milk**” and “**Four Pillars of Safe Breast Milk Sharing**” for more information.

Benefits

- Provides an option for raw human milk, which has some of the same benefits as mother’s own milk; however, each parent must be informed of the potential risks to determine the best options.
- Avoids formula, often cheaper than formula
- Allows community support

Risks

- It is difficult to know that a donor’s health and life style is safe for milk sharing; smoking, alcohol, some medications (both prescription and over the counter), herbal supplements, and street drugs can pass into human milk. Although the risk of disease transmission is thought to be low, bacteria and viruses such as HIV, Hepatitis B & C, HTLV (Human T-cell lymphotropic virus) could be passed through the milk of someone who doesn’t know they have these. Cytomegalovirus (CMV) can be found in breast; however, this is a common virus and most worrisome for premature babies.
- In-home heating (flash heat treatment) of shared milk has been suggested as a way to reduce the risk of disease transmission, but there is no research to define the appropriateness of this method. There are concerns about over or under heating, and this method does not remove all risks.
- If human milk is not collected and stored properly, bacterial growth could make your baby sick.
- The freezing process reduces the virus viability.
- Milk purchased online may be diluted with water or cow’s milk, or something else may be added.

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Dar a Luz Informal Donor Breastmilk

Dar a Luz Birth & Health Center is supportive of all clients in their feeding choices for their babies; however, it does NOT condone buying milk on the internet. Dar a Luz agrees with the research that milk bank processed milk is the safest human milk option. Although Dar a Luz does not endorse the informal sharing of donor breast milk, the donated milk is a community service for our families and is available free of charge to clients who are making an informed choice to use the informally shared milk.

Dar a Luz accepts unpasteurized human milk. We know most of our donors, but cannot make any claims about the safety of this milk. We have established policies to minimize the risks of informal milk sharing:

1. We accept milk from healthy donors approved by the Denver Milk Bank as well as Dar a Luz clients and community clients approved by Dar a Luz.
2. We don't accept milk from donors who use unapproved medications or drugs, tobacco or alcohol.
3. Donors have been screened in the past year for STIs including HIV I&II, Hepatitis B & C; those results must be reviewed by a midwife or IBCLC lactation consultant. We are not currently screening for HTLV I & II.
4. All donors have completed a health history. This includes medications, supplements and herbs consumed when the milk was pumped. Most medications are safe with breastfeeding and the bags of milk are labeled. The forms have been reviewed by a midwife or IBCLC lactation consultant.
5. None of the informal milk offered at Dar a Luz was purchased online.
6. Dar a Luz encourages our donors to use safe milk handling and storage practices. We hand out a copy of these guidelines to each donor.
7. Once we accept the frozen milk, it is stored in our freezer.

Dar a Luz has a limited supply of informal breast milk that has been donated and makes it available to families who have made an informed decision to use the informal milk. We offer it to families in need depending on the supply available. Typically, the informal milk is given out in small quantities and intended for the short-term needs of healthy term newborns up to 2 weeks of age. If a long-term supply of donor breast milk is desired, we may be able to connect you with another Dar a Luz donor or you may find other donors on Eats on Feets or Human Milk 4 Human Babies Facebook pages.

Recommendations taken from: Human Milk Banking Association of North America (HMBANM) www. Perinatalservicesbc.ca on 07-22-2019. F. Jones, 2019. Best Practice for Milk Sharing Outside of a Milk Bank, For Profit Milk Facility and Formula.

Informal Breast Milk Donor Screening Guidelines

Informal Donor Breast Milk Bought Online

Donor milk that is being sold on the internet can be contaminated and diluted with other liquids that may cause adverse outcomes in infants and is NOT supported by any milk sharing organization.

Private Arrangement Milk Sharing (PAMS)

PAMS originated with the organization *Eats On Feets* in 2010. The philosophy of PAMS advocated by this organization centers on the Four Pillars of Safe Breast Milk Sharing including informed choice, donor screening, safe handling, and home pasteurization. Other websites that advocate for informal milk-sharing, such as *Milk Share*, and *Human Milk 4 Human Babies*, contain lots of information and resources on this topic. Parents need to take whatever measures they deem necessary to ensure the safety of the milk they are obtaining for their babies.

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Four Pillars of Safe Breast Milk Sharing

Donor Screening

The recommended requirements for PAMS would be the same as outlined for an eligible donor to a milk bank including the donor filling out a questionnaire on lifestyle, medical history, medication and herbal use and submitting to blood testing to rule out any transmittable infections. Testing does not ensure that the milk will be "safe" for the baby due to the inability to screen prior to every donation. However, nobody can ensure the safety of formula feeds either, or the degree of risk if baby receives a human-milk substitute.

Safe Handling & Collection Guidelines

- Take a bath or shower daily.
- Before pumping, wash hands thoroughly with soap and warm water.
- Wipe your nipples and breasts with a clean, damp wash cloth (no soap), and don't touch them after washing.
- Pump into a clean container. Wash hands again if you touch anything else while pumping.
- Pour your pumped milk directly into a milk storage bag and seal it.
- Help us prevent loss of milk by not overfilling the milk storage bags.
- If interrupted during pumping, cap the milk and put it in the refrigerator. Finish within 30 minutes.
- Label each bag is with your name and date of collection.
- Place the milk in the rear or bottom of your freezer, where it is coldest.

Home Pasteurization

Flash heating is a low-resource heat treatment option developed specifically to address HIV in human milk to enable infected parents to express, heat treat, and feed their own milk to their biological children in resource-limited circumstances. This method has also been shown to acceptably address growth of E. coli, S. aureus, and b-hemolytic streptococci but it does not kill all viruses. Flash heating of milk is accomplished by placing the feeding of milk in a glass container in a pan of water sufficiently deep to submerge the glass container to above the level of milk without submerging the vessel completely and bringing the water to a boil. The milk is immediately removed from heat and quickly cooled to feeding temperature by placing the container of milk in a pan of ice water. Flash heating, described previously, is not an equivalent or interchangeable method of heat treatment to flash pasteurization. Flash pasteurization is a commercial method of heat-treating milk and other fluids requiring specialized equipment and precision heating and holding of fluids at 316°F/158°C for 15 seconds, with rapid cooling.

Informed Choice

Families are encouraged to consider the risks and benefits of milk sharing and research their options so that you can make an informed decision on which feeding options you feel are best for your baby. We are available to discuss the benefits and risks of donor breastmilk sharing.

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Milk Depot

Dar a Luz is the first location in New Mexico to offer donation services to the Mother's Milk Bank in Denver, CO. If you're interested in donating, first contact the milk bank and complete their screening process. After approval, we can draw your blood, and we can ship your donated milk to the milk bank. Milk drop off and blood draws both happen Wednesdays from 9:30 am to noon.

Donor Milk Banking

Milk that has been collected from volunteer breastfeeders who are healthy, non-smokers with adequate milk supply. They have been screened for lifestyle, medical history, medication use and had screening labs to rule out HIV I&II, Hepatitis B & C, syphilis and HTLV I&II (human T cell lymphotropic virus). They follow strict guidelines to collect, store and ship the milk in a safe manner to the milk bank. The milk is mixed, pasteurized, cultured and packaged in jars and frozen at the milk bank. There is not enough supply to meet the needs of preterm and at-risk babies and it costs about $7-8 per ounces which may be cost prohibitive for long-term use in term infants. Milk Bank processed breast milk is the most screened and safest option available. To be eligible as a milk donor, one must:

- ✓ Be confident in your milk supply and produce milk in excess of your own baby's needs
- ✓ Be willing to donate a minimum total of 150 ounces throughout your time as a donor
- ✓ Not have any medical condition that prohibits you from giving blood
- ✓ Be in excellent health: no chronic illnesses or history of major medical issues, cancer, or leukemia
- ✓ Have no history of hepatitis after age 11 or positive tuberculosis tests
- ✓ Be a non-smoker and refrain from using tobacco or cannabis products of any kind
- ✓ Have not received blood or blood products or organ or tissue transplants in the past 12 months
- ✓ Have no history of intimate contact with anyone at risk for HIV/AIDS
- ✓ Not be taking vitamin supplements that exceed 2000% Daily Value (DV)
- ✓ Take only approved medications and herbal supplements/teas.
- ✓ Mothers' Milk Tea/products containing fenugreek/other herbs AREN'T compatible with donating.
- ✓ Consume less than 24 ounces of caffeinated beverages a day (2-3 cups of coffee)
- ✓ Wait 12 hours after drinking any alcoholic beverage to collect milk to donate
- ✓ Be motivated to practice exceptional hygiene and careful milk collection and storage methods
- ✓ Be willing to undergo blood testing
- ✓ Be less than 18 months postpartum when collecting the milk

Mother's Milk Bank: rmchildren.org/mothers-milk-bank **Phone** (303) 839-6782 **Fax** (303) 839-6783

How Much Should I Leave for My Baby When I Am Away from Them?

They usually drink about 25-30 ounces of milk per day, and 3-4 ounces at a time. Consider sending or keeping extra milk or formula on hand. Also see above, "**Average Breast Milk Intake by Age**."

- **2 weeks to 3 months old:** 2.4 ounces/per pound/per day
- **3 to 5 months old:** 1.8 ounces/per pound/per day
- **5 to 7 months old:** 1.6 ounces/per pound/per day

Example: A 2-month-old who weighs 10 lbs., who nurses 9 times a day, who will be at the sitter for 9 hours (averages 24 ounces/day [2.4 oz. x10 pounds]; 2.6 ounces/feeding [24 oz./9 feedings]; will have about 3 feedings at sitter's) would need at least 9 ounces sent per day – plus some extra.

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Best Bottle Choices

Best Bottles (especially for breastfed babies)

Philips Avent: This bottle is made of borosilicate glass, which means you can safely take it from the fridge to boiling water. It has a wide textured nipple that is great for breastfed babies.

Comotomo: This slow-flow soft silicone nipple mimics a breast and helps baby be active in letting down the milk. Silicone is safest when not heated, so use another container to heat milk.

Pura Kiki: This stainless-steel bottle grows with your baby: the nipple can change to a sippy top and then to a sport top. This bottle has a narrower nipple shape, which works better for some babies.

Dr. Brown's Natural Flow Original Newborn Bottle: A unique venting system eliminates air bubbles during feeding, reducing the likelihood of gas, spit-up and colic. Some lactation consultants recommend starting with a preemie nipple to help transition to a bottle.

Playtex Baby Nurser with Drop-In Liners: This bottle works with pre-sterilized silicone or disposable liners. It has a wide textured nipple that is great for breastfed babies.

Lansinoh Momma Breastmilk Feeding Bottle: Over 50 years of research went into this bottle, with its ergonomically-designed nipple which mimics a breast, and a venting system to reduce air intake.

Munchkin Latch BPA-Free Bottle: For the perfect latch, featuring a flexible nipple designed like an accordion, stretching just like the nipple of a breast, and an anti-colic valve located at the bottom (takes a bit of work to clean).

These recommendations include ideas from mamanatural.com and babylist.com

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Supplemental Formula Feeding

Supplementing with formula is another option that parents have to feed their baby. Parents often ask which formula to use, and from our research, the best option is an organic formula. You might also ask your pediatric provider if they have any recommendations. There are different types of formulas from regular to organic and those made from cow's milk to soy. It comes as powdered, liquid concentrate or ready-to-feed. Always use ready-to-feed formula for the first month of life and follow the directions to prepare formula properly. It is dangerous to heat formula in the microwave. "Hot spots" in the formula can burn the baby's mouth.

Supplies

- You will need about 10 bottles (safe plastics or glass) that hold 4 to 8-ounces if you plan to bottle feed only (see the section **"Best Bottle Choices"** below).
- You will need to choose a nipple – there are slow flow and regular nipples in many different shapes.
- Some clients choose to use a supplemental nursing system (SNS) to feed their baby. Milk flows from a bottle through a small plastic tube that is taped to the nipple while baby feeds at the breast. You can also use the SNS to do finger feeding.
- For short term supplementing, babies can be fed by syringe or spoon to avoid artificial nipples.
- Pick up a bottle/nipple brush to clean the bottles. Putting nipples in the microwave damages them.
- It is not necessary to sterilize the bottles unless you have a premature baby.

Formula calculator: www.enfamil.ca/feeding-my-baby/tools/formula-calculator

Guidelines

- Sanitize bottles and nipples prior to first use.
- Do not microwave formula! Hot spots are dangerous.
- Use formula within 2 hours of mixing (or store in fridge for up to 24 hours). Do not save remaining formula for next feeding -- throw away any unused formula from the bottle within 1 hour after starting to feed your baby.
- Opened powder formula is only good for one month after opening.
- Check expiration dates and keep up with recalls.
- Some babies will drink more from a bottle because of a faster-flowing nipple. Pace feeding so not to overfeed baby or have them swallow too much air. Make sure they're getting burped well, too.
- Know that dark smelly poop is normal for formula fed babies.
- Consider premixed liquid for newborns.

Babies are such a nice way to start people.
~ Don Herald

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Some Good Formula Choices

- **Holle Stage 1 Organic Bio Infant Milk Formula** is Amity's best recommendation! This made -in-Germany formula follows strict European guidelines. It is known for holistic, sustainable production from cows raised on biodynamic Demeter farms). No starch, gluten, soy or corn syrup.
- **HiPP Stage 1 Organic (Bio) Combiotic Infant Milk Formula** is a hypoallergenic made -in-Germany formula that follows strict European guidelines. Non-GMO, with no added sugars, wheat, gluten, or peanuts.
- **Similac Pro-Sensitive Infant Formula** is a well-known, trusted brand with an exclusive blend of nutrients specific for brain and eye development. Comes as a large size powder version or a pre-made liquid formula.
- **Target Up&Up Infant Non-GMO Formula with Iron Powder** is a great buy, and is a milk-based formula with DHA, an omega-3 fatty acid, plus vitamins and minerals for brain, growth, and immunity.
- **Bobbie Organic Infant Formula** is first organic baby formula to receive FDA approval, and is a mom-created formula with no fillers.
- **Happy Baby Organic Infant Formula Milk Based Powder with Iron Stage 1** is made with organic lactose and provides key vitamins and minerals that are found naturally in breast milk, as well as prebiotics. Stage 1 is designed for the first year, and Stage 2 is for older babies.
- **Earth's Best Organic Dairy Infant Formula**, is an organic, all lactose milk-based powder formula that contains Omega 3 DHA and Omega 6 ARA fatty acids, as well as iron, lutein and prebiotics. It's Kosher, too, and non-GMO.
- **Enfamil Nutramigen Hypoallergenic Colic Baby Formula, Lactose Free Milk Powder** is a hypoallergenic go-to for gas, constipation, and sensitivities. Has DHA and ARA for brain and eye development.
- **Similac Pro-Total Comfort Infant Formula, Easy-to-Digest in Ready to Feed Servings** is an easy to find solution for gas and fussiness, in ready-to-feed bottles.
- **Earth's Best Organic Low Lactose Sensitivity Infant Formula**, is organic and low-lactose to help with gas and crying. Includes Omega-3 DHA, Omega-6 ARA, iron, lutein and those prebiotics.
- **Else Plant-Based Complete Nutrition Formula for Toddlers** is great for picky eaters or those with allergies that restrict certain foods from their diet. It's plant-based and cruelty-free, and contains no hormones, GMOs, or antibiotics, dairy, soy, gluten, or corn syrup.

These recommendations include ideas from scarymommy.com

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Postpartum & Newborn

By the time you reach 37 weeks, you will want to have things ready at home for your baby's arrival.

Preparing for Baby

You will probably need the following:

Bassinets, Co-Sleepers, Cradles: On the beginning, you may want to have your baby close to you especially at night. There are several options to explore including bassinets and cradles can be in your room. Co-sleepers can be attached to your bed or placed in your bed.

Bed: When your baby can sit up and is mobile you may want to get a crib that meets Consumer Product Safety standards www.cpsc.gov/Regulations-Laws--Standards/Rulemaking/Final-and-Proposed-Rules/Full-Size-Cribs

Be sure the bars are no more than 2 3/8 inches apart so that your baby cannot slide through or get stuck. Do not use cribs with drop sides. You will need sheets and waterproof pads.

Baths: There are many options for bathing your baby including taking a bath with you or buying various small plastic tubs and seats to put in the tub. You can also put a sponge lining in a large plastic dishpan or the kitchen sink when you bathe your baby. Protect your baby from hard edges and hot water that can cause burns. It is OK to put your baby in the water before the cord falls off but dry the cord area and keep it clean afterwards. When cleaning the cord: use a soft cloth, water and mild baby soap. **Do not use alcohol.** You will also need baby shampoo or soap and 2 to 3 soft bath towels.

Keeping Baby Warm: In colder weather (under 70°F), your baby will need several layers to keep warm. Start with a onesie and diaper, covered by a sleeper and then wrap them in a blanket. In hot weather (over 80°F), you can reduce the clothing to a single layer. The rule of thumb for dressing a newborn is to put them in the same amount of clothing you are comfortable in plus one layer, usually a blanket.

Thermometers: You will need a thermometer to take your baby’s temperature when he/she is sick. **Digital thermometers are the most accurate.** Temperatures can vary widely with the temporal or ear scanners. Taking it under the arm is best. Do not take a rectal temperature. Do not use a glass thermometer that has mercury in it.

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Disposable Diapers: You will change your baby's diaper about 10 to 12 times a day at first and you can expect to use about 5,600 diapers over the next 2½ years that your child is in diapers. Disposable diapers over this time period can cost around $3000. It is estimated that it takes about 500 years for a single disposable diaper to decompose. There are other eco-friendly disposable alternatives including chlorine-free, flushable, compostable, plastic-free and managed wood pulp fillers. Many of these options are available online or at some area stores.

Cloth Diapers: It is estimated that you can save up to $2350 by choosing cloth diapers. There are many cute and easy options available in cloth diapers at local stores and online. There are even patterns for you to make your own.

Some of the advantages to use cloth include:

- Easy to use and adorable
- Work better than disposables – less blowouts
- Are not filled with toxic cancer-causing chemicals that are harmful for your baby
- You can sell them or donate to someone when you're through using them
- Cloth makes toilet training easier by allowing the toddler to feel when they are wet
- Disposables use 2 times more water and 20 times more raw materials to make than cloth

There are many options in cloth diapers. They include:

- Pre-folded cotton used with covers which are the most economical (about $400 can set you up)
- Snappi – Pinless closure system used with pre-fold diapers
- All-in-ones – include cover, insert and closure system all made into one diaper, very easy
- Pocket or sleeve diapers – similar to the all-in-one but has a removable absorbent liner
- All-in-twos or hybrids – similar to pocket diapers but the insert is laid in the cover, not a pocket
- Soakers and inserts are an absorbent layer used with pocket or hybrid diapers.
- Fitted are like all-in-ones but you have to use a cover with them
- PUL covers and wool covers are used with pre-folded and fitted diapers as a moisture barrier.
- Cloth wipes are used to clean your baby

Cloth diapering resources

Cloth Diapering Mamas of Albuquerque Facebook Group

Fluff University www.fluffloveuniversity.com

Rio Grande Diaper Service (505) 877-6311

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Connecting with Your Baby

Simple Tools® for Mothers

by Karen Strange – reproduced with permission

Please use these tools to help you understand a new way of being in connection with your baby during the perinatal period. The baby shall be referred to as she in this text.

We are the story of what has happened to us up until now, from conception through birth and to the present. The story is laid down emotionally, psychologically and physically, in our connective tissue, in the fluids of our body and in our bones. The story of what happened to us wants to get told to someone who is listening. Hearing the story and acknowledging what happened with empathy is the repair and where healing occurs. How your baby moves and acts is actually her way of telling you her story, which is her history. The question to ask is, "What is the story here?" Your baby is always showing you her story or history. Can you slow down and be present to hear what your baby is saying?

You are the regulator/architect of your baby's brain and nervous system and the baby forms according to whatever you are feeling/experiencing. For example: If your baby is crying for what seems to be no reason, notice how that makes you feel inside and notice that you may be upset. Then calm/settle/ground yourself. Take a breath. Your baby may be responding to or regulating herself off of your nervous system. How are you feeling in that moment? **Your baby responds to what is happening in your nervous system.** In telling the story and naming what is happening or happened, you are helping the baby integrate the story (experience) of what is going on. The more you pause in storytelling, especially when you feel your own emotions rise, the better for you and your baby.

Periodically throughout the day (especially after a heightened emotional state), **take an "Oxytocin Moment**." Oxytocin is released when you do anything pleasurable. This is especially important during gestation as the release of Oxytocin helps baby's brain become wired with a calm temperament and the capacity to self-regulate emotional states. This is the capacity to return to a calm and focused state after being excited (upset, angry, hurt). **Oxytocin is what heals the body** and helps prevent complications in the mother. Do this prenatally to establish a common, well-worn "mental groove" so that you will have the capacity to return to it after the birth. It is a great habit to get into for your health and to be in tune with your baby.

After birth, your baby may not know she is out, that she made it. Adults understand that there is an inside and an outside, but she may not know this. She may be stunned by what has just happened. **Birth is a big experience for both mother and baby.** Something you could say, slowly, to your baby is: "You are out now, you made it, you can take a breath now." You can do this anytime something intense happens, (possibly during an interruption in the birth sequence). Once it is over, you could say, "You made it, it is over, and you are safe now. Yes, that was a lot, and it is over". This allows the nervous system to come down from emergency mode. After birth, you could say to the baby, "I am so happy you are here, I love you." Feel your feet; it is good if you, the mother, take a breath here too. **Take a moment to look around. Acknowledge to yourself as well that you made it, it is over and you are safe!**

The most important place to start is by slowing down. Slowing down is achieved by the practice of grounding. This is so important to "know/feel" in your body. As you begin to understand the baby's experience and perception of birth and of being in our world, you will understand the importance of slowing down through grounding and pacing. This allows the baby to stay current with what is going on in her environment.

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Grounding: Feel your feet on the floor or the weight of your body on the floor or chair, the place where your body has the most contact with the floor or chair. This is a place to which you can bring your attention. Take a moment and feel this place. Doing this slows your internal rhythm or pace and helps you to become more present. Every time you take a breath you down-regulate (or slow down) your autonomic (automatic) nervous system, meaning you move away from an activated, fast-moving internal rhythm to a slower, more-balanced state of being. This enables you to establish a better connection with your baby.

Pacing: Follow your baby's cues or body language; they mean something. Notice - is she fussy, is she looking at you or looking away, is she squirming or settled quietly and just watching you? If she is on the active side, it means you need to slow your pace with frequent pauses to ground yourself (grounding is a way to slow the pace: as you feel the weight of your body making contact with the seat or floor, this process takes time to remember to do, but it will begin to help slow things down). Pauses are part of nature and definitely part of your baby's rhythm. Your baby's brain waves are 6-10 times slower than yours. The baby needs you to slow down so the baby does not get overwhelmed.

Pacing and grounding help you be more present and are the MOST important parts of being in tune (or attuned) with your baby! The baby responds and reacts to your inner emotional state, so becoming more aware of your energetic presence, slowing down, and grounding can help you becoming more in tune (attuned) with your baby. In utero, your baby is conscious, aware, super-sensitive, intelligent, building neural connections, and laying down memory. She is very much experiencing whatever you are experiencing, only more so, more sensitive and more aware of her environment. Once she is born, she does not have the muscle control you have and she does not have the capacity to speak language with the words you use. But she DOES understand the intent of what you are saying. She is always communicating with you, telling you her story. Once you understand this big piece, the rest is simple. There are no secrets you can keep from your baby, so talk to your baby, and more importantly listen to what your baby is showing you and telling you. Acknowledge that she is telling you something important. Then remember to tell her what is going on.

Differentiation: It is important to differentiate your experience from your baby's (whether the baby is inside or the baby is outside). Your baby feels everything you feel; she is synchronized with you, her mother. If you are upset, tell her what you are feeling and that it is your experience. It is not about her, though you know she can feel it. To your baby, the whole entire world is you, her mother. Differentiation helps create healthy boundaries. In the same way that children of divorce think they caused the divorce because the world revolves around them, your baby needs to be told that she did not cause what is bothering you. It did not happen because of her. During the first few weeks after the birth, the mother and infant are still in many ways undifferentiated, like still being in utero or inside the mother's womb, one and the same. You and your baby have been together as one from the beginning. It takes time (usually years) to complete the separation that begins at birth. Babies are undifferentiated physically, emotionally and psychologically from their mothers until birth. At birth they become physically separate (differentiated) and yet are still undifferentiated emotionally and psychologically. The mother may not be aware of the extent of this connection because the baby is now outside of her body, but the baby will not know she is separate from her mother for many months. The mother and the baby are deeply linked emotionally and delicately tuned into each other.

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Remember, in utero, your baby is conscious, aware, super-sensitive, intelligent, building neural connections, and laying down memory. This continues once the baby is outside of her mother.

Talk to your baby! More importantly, listen to your baby! She is communicating with you. Then the question is, what is she communicating to you? Acknowledge that you hear her, that you see her, and that what she is expressing matters to you. This is what each of us (baby, child, teen, adult, everyone) is looking for (and needs) when communicating with each other. -Karen Strange

4 Ways to Communicate with Your Baby

• **Tell your baby what you are going to do before you do it** – Examples: Before changing her diapers, before putting on a new shirt, before picking her up, say, "I'm getting ready to do this." Then again right before you do it say, "Here comes the new diaper (or shirt or whatever)." Babies process slower and need time to take in what you say. It is good to take a pause after telling them what you are going to do. With the slower pacing and pausing, the baby learns that she can trust you.

• **Tell your baby what is going on** – Examples: that you are transferring to the hospital, that you are worried about a bill, that you are going to a big meeting, that you just had a fight with your partner and you are upset, whatever it is about. You can reassure her and tell her that she is not the reason you're upset, but it's important to acknowledge that she feels your strong emotions. Even if you do not completely acknowledge the strong feelings inside you, your baby feels what is going on inside of you although she does not know the cause unless you tell her. Then, take a breath so that you can slow down (down-regulate) and become the place of safety for the baby. The baby feels this. This helps wire the baby's brain for self-regulation (the baby will eventually be able to regulate (come out) of their own emotional states because they learned this ability through mirroring and experiencing their environment (which is their mother).

• **Tell the baby what you want her to do** – Example: in labor, ask the baby to turn a certain way so she will come out more easily. If the baby needs resuscitation, tell her "I need you to take a big breath and come into your body...That's it! Now you can take another breath, and another one..." You can say this even if the care providers are working on the baby.

• **Tell the story of what happened** - Telling the story acknowledges what happened. Naming how you feel, again, encourages differentiation. Naming helps the nervous system to feel heard. When the baby feels heard, the nervous system settles. Naming is a basic tool for mindfulness of what you are experiencing in the moment. It is an acknowledgement of what is. The story must be told slowly (pacing) with pauses, eye contact and grounding. Then, reflect back what you see from the baby (following the baby's cues). Examples of what to say to your baby: I am sorry (empathy) for what may have happened, I know you felt that, it was not your fault and you did nothing wrong. I know that was a lot! You are safe now, here let me help you feel safe... Then, you, the mother, should take a breath, feel yourself on the floor, be present. And remember to tell your baby "I love you!"

A word on Rupture and Repair... Ruptures are mis-attunements, misunderstandings, mis-connections, miscommunication, an interruption in a sequence. Ruptures happen all the time: in utero, during labor, after the birth, as we grow up and in all of our relationships. Repairs can happen whenever there is a rupture. First, you, the mother, need to "make sense" of the experience (integrate) so that you become a safe place for the baby/child.

If you take a breath and ground. You, the mother, can then say "I'm sorry that happened to you, I did not know" or "I was sad (tired, angry, confused) and I know you felt that. It is not about you (again, differentiation) but rather about me and my..." Then, you could also say something like "I love you, you are

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safe now." These are all examples of repairs. **Repairs lead to stronger attachment and trust** than if the rupture had never occurred. Repairs can be done at any age.

Things to consider

• It can be a good thing to have someone track the baby's journey through the birth process and after. Maybe consider having a "baby doula," someone that tracks the baby's journey and is there for the baby. Have them tell the baby they are following her passage/journey through the birth process. Just like a mother has a birth attendant and/or a doula, she (the baby) has someone there for her for the whole process. The "baby doula" would listen to what the baby might be communicating and supporting what it might be like in there for the baby.

• Check out Dan Siegel's book, "Parenting from the Inside Out."

• And remember, it's not just what you do or say that matters, but rather how you are on the inside. How are you on the inside?

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It's not just what you do or say that matters,
but rather how you are on the inside.
How are you on the inside?

~ Karen Strange

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Attachment Parenting

Attachment Parenting (AP) is not a new concept but is a description of a way of parenting. Parents who raise their children without violence help them to become adults with a highly developed capacity for empathy and connection. AP is about **forming and nurturing strong connections between parents and their children**. No matter what our childhood story may be, AP challenges us to treat our children with kindness, respect and dignity, and to model in our interactions with them the way we'd like them to interact with others.

In the last sixty years, the behaviors of attachment have been studied extensively by psychology and child development researchers, and more recently, by researchers studying the brain. This body of knowledge offers strong support for areas that are key to the optimal development of children. The Attachment Parenting International website summarizes these findings into eight principles:

1. Prepare for pregnancy, birth and parenting
2. Feed with love and respect
3. Respond with sensitivity
4. Use nurturing touch
5. Ensure safe sleep, physically and emotionally
6. Provide consistent loving care
7. Practice positive discipline
8. Strive for balance in your personal and family life

Additional resources

- Attachment Parenting International www.attachmentparenting.org/
- Abby Bordner (Santa Fe) www.abbybordner.com/
- Albuquerque Attachment Mamas Facebook Group
- Dr. Sears www.askdrsears.com

Babywearing

Babywearing is seen in many traditional cultures and it is the practice of keeping your baby or toddler close and connected to you as you engage in daily activities. There are a variety of carriers from the traditional papoose boards of Native Americans to the modern wraps, slings, and carriers. Babywearing benefits parents, family, other caregivers and the baby by promoting bonding, supporting breastfeeding, helping combat postpartum depression, making caregiving easier, and can be a lifesaver for parents of high-needs children. Carried babies tend to sleep better, feed more frequently, grow faster and cry less.

Most modern carriers are in these groups: Wraps, Ring Slings, Pouch Slings, Meh Dais, or Buckle/Soft Structured Carriers. Deciding which carrier to use depends upon the age and size of the baby, who is going to wear it, ease of use, cost and personal preference. Ask other parents about their experiences. YouTube has lots of how-to videos.

Additional resources

- Babywearing NM (website and Facebook group**)** www.babywearingnm.org/
- Baby Wearing International www.facebook.com/babywearinginternational/

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Bed Sharing with Your Baby

Deciding where your baby will sleep is a personal family decision. Current American Academy of Pediatrics (AAP) guidelines on infant sleep recommend placing your baby to sleep on their back in a crib in the parent's room. Sharing the adult bed is not recommended. The AAP's advice against bed sharing, however, has been challenged in the literature by a number of scholars in pediatrics, psychology, and anthropology as being incompatible with cultural preferences, exclusive breastfeeding practices, and infant sensory–neural development. The risk of sudden infant death syndrome (SIDS) is reduced by 50% when an infant is placed on their back to sleep and by sleeping in the same room as the parents (co-sleeping) but not in the same bed.

Bed sharing infants have been noted to breastfeed twice as often as solitary sleeping infants. This is helpful in increasing the milk supply, protecting against SIDS, and serving as an opportunity to meet the sensory demands of the infant. Because the AAP recommends breastfeeding exclusively for the first 6 months and continued breastfeeding for 1 year or more, it appears that safe bed sharing practices have the potential to facilitate successful breastfeeding during the critical first year of life. Sharing a bed with your baby can help you feel closer to your infant, tend to their needs more quickly and allow you to get more rest. Because there is a risk for SIDS, asphyxiation, or entrapment of your baby when in your bed, it is important to follow some simple safety guidelines.

Practices for Safe Bed Sharing

- Breastfeed your infant exclusively for 6 months
- Place your baby to sleep next to the mother and not between parents.
- Place your baby on their back when sleeping.
- Never leave your baby alone while asleep in an adult bed.
- Remove heavy blankets and pillows from the bed. Use a light blanket and adjust the room temperature for comfort.
- Make sure that there are no spaces between the mattress and the wall or headboard.
- Use the largest adult bed you can afford and take precautions to prevent your baby from falling out.
- Do not place the baby's bed/crib near a heater and turn off any electric blankets when your baby is in bed.
- Do not overdress your baby. Overheating is associated with an increased risk of SIDS.
- Do not bed share if overly tired or sleep deprived.
- Check bed and remove other hidden dangers such as small toys, plastic bags, ribbons or string.
- Tie back loose, long hair to prevent accidental suffocation.
- Do not bed share with your child if you are under the influence of drugs or alcohol, or sleep aids such as Ambien or narcotics such as Fentanyl, Oxycodone or Percocet.
- It is **not safe** to sleep with your infant on a couch, armchair, recliner, beanbag or waterbed.

Sources: UNICEF UK Baby Friendly Initiative, Academy of Breastfeeding Medicine Protocol Committee and The University of Notre Dame Mother-Baby Behavioral Sleep Laboratory.

ACNM Position Statement: "Safe Infant Sleep Practices," September 2017

For more information on how to safely bed share: www.cosleeping.nd.edu/safe-co-sleeping-guidelines/

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Baby Sleep

All parents want their babies to sleep well and some even seem to make a competition out of whose baby sleeps the longest at the earliest age. Each baby is unique and different strategies work for different babies at different ages. Parents are different too and some strategies will work better for you than others. It helps to understand what normal sleep patterns are so that we can set realistic expectations and choose strategies that may be effective.

Birth - 2 Months

- Total sleep of 14-18 hours scattered throughout the day and night
- The day starts around 7 am
- Naps up to 8 hours a day. You may want to wake babies if naps are over 2 hours in the second month of life because your baby will be hungrier at night and wake up more often.
- Nighttime sleep starts about 10 pm and wakes frequently to feed. The longest stretches are about 3-5 hours.

2 - 4 Months

- Total sleep of 13-14 hours
- The day starts around 6 am
- Naps 2-3 times a day for a total of 4-8 hours.
- Nighttime sleep starts around 9 pm and wakes to feed 1-2 times through the night. The longest stretches are about 5-6 hours. Make sure the baby is full when they go to bed so they will sleep longer.

4 - 8 Months

- Total sleep of 12-14 hours with more defined nap and nighttime sleep
- The day starts around 6-8 am
- Naps 2-3 times a day for a total of 3-5 hours.
- Nighttime sleep starts around 9 pm and may be "sleeping through the night" with a long stretch of 6-8 hours

8 - 12 Months

- Total sleep of 12-14 hours
- The day starts around 6-7 am
- Naps 2-3 times a day decreasing to 2 naps by 12 months totaling 2-4 hours
- Nighttime sleep starts around 7-9 pm with the longest stretch of 7-9 hours

Some of the strategies that are helpful to calm your baby and to get the best sleep for you and your baby are:

- Use the 5 S's to calm your baby from Happiest Baby on the Block. (Swaddle, Side or Stomach Position, Shush, Swing, Suck)
- Use safe sleep practices – bed sharing, crib in your room or sleeping in a separate room
- Learn the cues of when your baby is tired. Put your baby to bed early.
- Keep your baby in sleep mode at night by limiting stimulation

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- Establish a bedtime routine at an early age - consistent time, bath, dental care, stories, songs, feeding, bed
- Manage how long your baby naps and don't miss naps – be consistent
- Know your baby's temperament and find a strategy that works with it
- Use noise to even out the sounds – white noise, music, TV, fans
- Use motion to calm baby – babywearing, swings, walking, stroller and car rides
- Be prepared for setbacks – Just when you think you have it mastered, it changes!
- Take care of your self – ask for help even if you are not sure you need it
- Additional Local Resources: Tekla Johnson www.teklajohnson.com/ (Private consults, classes)

Circumcision vs. Natural Male Anatomy

So here you are, at a crossroads, facing a possible dilemma as the birth of your son approaches. People are asking what you are going to name him? What's the theme of his room? Are you going to breastfeed? Co-sleep? But does anyone ask you if you are planning to circumcise? Maybe it comes up at your baby shower, or when you are talking to your sister or your best friend about whether they circumcised their son. But are we really thinking about this? Or are we just passing over this issue?

Here at Dar a Luz, we don't believe in just passing over this issue. So, we ask you to ask yourself: why did I choose Dar a Luz? What's important about my birth? How do I believe my baby should come into this world? Many of you have many of the same answers to these questions: I don't want medication; I want compassion; I want to know who's there; I am meant to birth my baby without intervention; I want a *natural* birth. You get the point. So now, you are faced with circumcision… and many parents don't think about it much more than yes or no based on a gut feeling. We invite you to take a closer look before making an irreversible decision.

In 1999, the American Association of Pediatrics (AAP) was neutral on circumcision but in 2012 they changed their position to favor circumcision and issued this position statement:

"Male circumcision is a common procedure, generally performed during the newborn period in the United States. In 2007, the American Academy of Pediatrics (AAP) formed a multidisciplinary task force of AAP members and other stakeholders to evaluate the recent evidence on male circumcision and update the Academy's 1999 recommendations in this area. Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV. The American College of Obstetricians and Gynecologists has endorsed this statement."

The current position statement has met with much criticism from European doctors and the scientific community. They struck back in a scientific journal article, saying that "only one of the arguments put forward by the American Academy of Pediatrics has some theoretical relevance" and that the other claimed health benefits "are questionable, weak, and likely to have little public health relevance in a Western context, and they do not represent compelling reasons for surgery before boys are old enough to decide for themselves." Complete rebuttal articles can be read on the AAP website at www.pediatrics.aappublications.org/content/130/3/585

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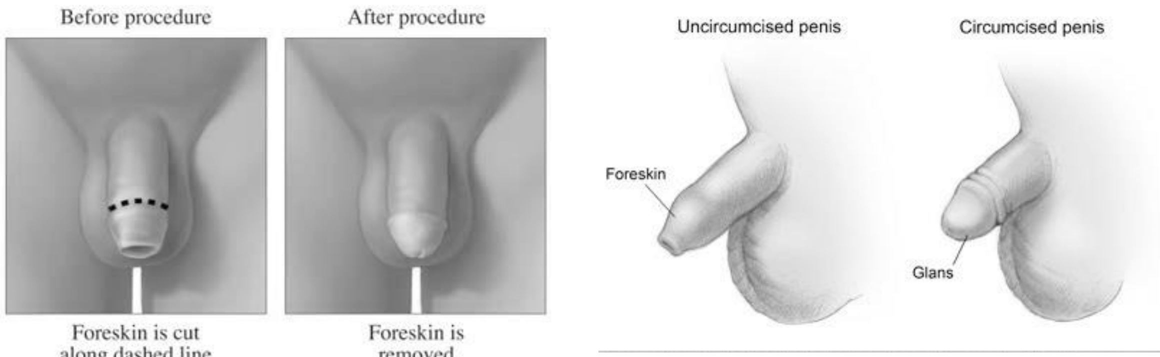
What is male circumcision?

Male circumcision is the separation and removal of the foreskin from the glans of the penis. The foreskin is a richly innervated structure that protects the glans and plays an important role in the mechanical function of the penis during sexual acts. Recent studies [which the AAP did not take into account] suggest that circumcision desensitizes the penis and may lead to sexual problems in circumcised men and their partners.



How is male circumcision done?

There are three devices that are used to circumcise a penis: the Gomco clamp, the Mogen clamp and the Plastibell device. All of these follow the same procedure:

1. Estimate the amount of external skin to be removed;
2. Dilate [force open] the preputial orifice so the glans can be visualized;
3. Bluntly tear the adhesion of the inner preputial epithelium from the glans;
4. Place the device on the glans;
5. Leave it in place long enough for hemostasis (blood clotting);
6. Amputate and remove the foreskin. (American Association of Pediatrics, 1999)

The base of the glans then forms a scab, and attaches to the newly cut skin on the baby's penis as it heals.

If circumcision surgery is chosen, the AAP absolutely supports and encourages all providers who perform circumcisions to use appropriate analgesia (pain relief), such as a lidocaine block. Without the use of analgesia, babies have been shown to experience increased pain and physiologic stress including increased heart rate, blood pressure and cortisol (stress hormones) and decreased oxygen saturation.

Natural Male Anatomy vs. Circumcision: Weighing the Risks

"In all studies to date, **the risks of circumcision have always exceeded any alleged benefits**, a fact that is often not made clear to parents." (*Circumcision and the Code of Ethics*, George C. Dennison, MD, MPH, 1996)

The Risks of Circumcision

In the United States, the number of newborn males that are circumcised is thought to be anywhere between 50-60%. That number has declined over the last 20 years, when nearly 90% of infant males were circumcised. Circumcision is one of the most common surgeries in the country and the most common for all newborns; in fact, the US is the only country in the world that circumcises the majority of its males for

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non-religious reasons. While it is done very often, like all surgeries it has risks. The risks include but are not limited to:

- Bleeding, usually controlled with pressure and bandages; sometimes requiring sutures; sometimes requiring blood transfusion (rare)
- Infection requiring local or systemic antibiotics
- Wound separation
- Urinary retention
- Damage to adjacent tissues and organs
- Decreased sexual pleasure and potential sexual problems for them and their partners

Short-term effects after circumcision:

- Discomfort in diapers (urine stings)
- Altered sleep patterns and activity levels
- Altered mother-infant interaction
- Increased irritability
- Disruptions in feeding and bonding

Some recent small studies suggest that circumcision impacts sexual pleasure:

- Removing the foreskin decreases the sensitivity to light touch
- Erection can be painful for young men due to stretching skin over the penis
- Circumcised men may need more friction to reach orgasm than men with an intact foreskin

The Risks of Uncircumcised Males

1. Urinary Tract Infection (UTI)- the majority of UTIs happen in the first year of life with an increased risk being in uncircumcised boys. However, the risk is less that 1% and is often due to other anomalies of the urinary tract. Breastfeeding has been shown to have a threefold decrease in UTIs. No studies have ever been done comparing UTIs in breastfed vs. formula fed infants.
2. Penile cancer- the US has one of the lowest rates of penile cancer in the world: about 1 in 100,000 men. Other risk factors that increase the risk of penile cancers include a previous genital condition, genital warts, >30 sexual partners, and smoking. It appears that good hygiene, as seen in the US, is preventative.
3. HIV/STDs- the acquisition of sexually transmitted diseases including HIV has more to do with behavioral factors than circumcision status.

Parents and care providers each have an ethical duty to the child to attempt to secure the child's best interest and well-being. Dar a Luz supports each individual's right to choose what is done to their body in this regard – and this includes the infants who will grow up after having been in our care. We do not perform circumcision.

Parents who choose this route need to arrange this to be done by a pediatric provider who still performs this surgery. If you do choose this route, do your research, and talk to your physician about what to expect.

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Sudden Infant Death Syndrome (SIDS)

The cause of SIDS is unknown. It has been linked to babies lying on their stomachs, overheated babies and mothers who smoke while pregnant. There have been cases where adults have laid on their babies. Some babies have been trapped in their beds or smothered by soft bedding. These are some ways to reduce the risk of SIDS:

- Use cribs that meet Consumer Product Safety standards.
- Always place your baby on their back to sleep for every sleep time.
- Supervised, awake tummy time is recommended daily to facilitate development and minimize occurrence of positional flat heads (plagiocephaly).
- Always use a firm sleep surface. Do not put your baby to sleep on waterbeds or soft surfaces.
- Car seats and other sitting devices are not recommended for routine sleep.
- Do not use home monitors or other devices marketed to reduce the risk of SIDS.
- Put the baby's crib in your room but do not share your bed for the safest sleeping environment.
- Avoid sharing your bed with other kids when your baby is in the bed and remain awake.
- Keep your baby lightly clothed during sleep. Avoid covering baby's head or overheating.
- Use sleep clothing such as "sleep sacks" instead of loose sheets or blankets during sleep.
- Keep soft objects or loose bedding out of the crib including toys, pillows, blankets, wedges and positioners.
- Bumper pads should not be used in cribs. There is no evidence that they prevent injuries and there is a potential risk of suffocation, strangulation or entrapment.
- Do not smoke, drink alcohol or use drugs during pregnancy or after birth.
- Breastfeeding is recommended and associated with reduced risk for SIDS.
- Pacifiers have been shown to decrease the risk for SIDS. Introduce after breastfeeding is well-established and offer at nap time and bedtime.
- Evidence suggests that immunization reduces the risk of SIDS by 50%.

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Shaken Baby Syndrome – State Law Requires This Training

UNDERSTANDING SHAKEN BABY SYNDROME

Shaken baby syndrome (SBS) is a form of child abuse. It is NEVER okay to shake a young child. You can badly hurt or even kill your child. You can learn ways to cope with a crying baby. You can also share what you've learned with everyone who cares for the baby. Knowing the danger and sharing ways to cope can prevent SBS.

EVERY YEAR 1,200 TO 1,400 BABIES IN THE US ARE HURT BY SHAKING.

1 out of 4
victims of SBS DIE

The rest may have life long brain injury, including

- Permanent brain damage
- Paralysis
- Deafness
- Learning disabilities
- Developmental delays
- Cerebral palsy
- Blindness
- Seizures/Epilepsy
- Behavioral disorders
- Permanent vegetative state

A PERSON USUALLY SHAKES A BABY BECAUSE THEY GET STRESSED OR FRUSTRATED WHEN THE BABY IS CRYING AND WON'T CALM DOWN.

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WHAT TO DO WITH A CRYING BABY

20 Tips From the National Center on Shaken Baby Syndrome

Remember, nothing works all the time. And that's OK. There are many other things you can try. Crying does NOT mean there's anything wrong, with you or your baby!

It's normal to sometimes feel frustrated. If you get frustrated, it's okay to put your baby down in a safe place, like their crib. You can walk away for a few minutes, take some deep breaths to calm yourself down or call a friend if you need to. It's OK. Your baby is safe in the crib. Be sure to check on your baby every 5-10 minutes.

Try something simple:

1. Feed your baby. Hunger is often the main reason babies cry.
2. Burp your baby. Gas can be very painful.
3. Check your baby's diaper. Does it need changing?
4. Give your baby something to suck on, like your finger. (Once in a while, you can give your baby a binky.)
5. Look your baby in the eye and smile.
6. Kiss your baby.
7. Lightly kiss the bottom of your baby's feet.

Comfort your baby:

8. Wrap your baby snugly in a light blanket. (This is called swaddling.)
9. Give your baby a lukewarm bath. Stay with your baby the whole time.
10. Massage your baby gently on the back, arms, or legs.
11. Sing softly. People all over the world sing lullabies to crying babies.
12. Calm your baby with soft words like "it's OK." (This can help comfort both you and your baby.)
13. Hum in a low tone against your baby's head.

Distract your baby:

14. Run a vacuum cleaner or dishwasher to make "white noise." This may take your baby's mind off crying.
15. Take your baby for a ride in the car. (Make sure baby is in a rear-facing car seat in the back seat.)
16. Rock with your baby in a rocking chair. This may relax you both.
17. Push your baby in a stroller.
18. Put your baby in a baby swing for a slow, rocking motion.
19. Place your baby underneath a lighted mobile.
20. Dance slowly while holding your baby... and relax!

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Childcare Notes for the ____ family

While We're Out…

Cell phone number(s) ______________________________ & ________________________________

We will be at

Name_________________________ Phone number: ____________________________

Address ____

We should be home around: ____ A.M. / P.M____

In case of emergency

If you can't reach us, call ____

If that doesn't work, call ____

Things to remember

House Rules

What to do with a crying baby

Try something simple

1. Feed the baby. Hunger is often the main reason babies cry.
2. Burp the baby. Gas can be very painful.
3. Check the baby's diaper. Does it need changing?
4. Give the baby something to suck on, like a binky.
5. Look the baby in the eye and smile.
6. Call us if you need help.

Comfort the baby

1. Wrap/swaddle the baby in a light blanket.
2. Give the baby a lukewarm bath, staying with the baby the whole time.
3. Massage the baby gently on the back, arms and legs.
4. Sing a soft lullaby to them.
5. Hum in a low tone against their head.
6. Calm and comfort them (and yourself) with words like "It's okay."

Distract the baby

1. Make some white noise by running the vacuum cleaner or dishwasher.
2. Rock the baby in a rocking chair – this can be calming to both of you.
3. Push the baby in a stroller.
4. Put the baby in a swing on a low, slow setting.
5. Place baby under a lighted mobile.
6. Dance slowly while holding the baby, and relax.

Remember that nothing works all the time, every time! **And that's okay.** There are many other things you can try. Crying does NOT mean there's anything wrong with you or the baby! It's normal to sometimes feel frustrated. If you get frustrated, it's okay to put the baby down in a safe place, like the crib. You can walk away for a few minutes, take some deep breaths to calm yourself, or call a friend if you need to. It's okay, the baby will be safe for a little while, while you calm down. Just be sure to check on the baby every 5 minutes or so, until you feel ready to pick them up again in a safe way.

Remember, **never, ever shake a baby!** It can lead to death or permanent harm to their brain and body.

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Newborn Care While at the Birth Center

Delayed Cord Clamping: Clamping the cord at 3-5 minutes after birth allows the baby to get most of the blood in the placenta. The benefits to the newborn are increased levels of iron, decreased risk of anemia, fewer transfusions and fewer incidences of intraventricular hemorrhage (bleeding in the brain). Other studies have found the impact of delayed clamping is particularly significant for infants who have low birth weights, are born to iron-deficient clients, are premature, or those who do not receive baby formula or iron-fortified milk. Given that Mother Nature provided breastmilk for babies and not formulas, you would think she also supplied that valuable source of iron for a reason too.

Cord Blood Banking: Cord blood is the few ounces of your baby's blood remaining in the umbilical cord and placenta which has traditionally been discarded as medical waste following the birth of a child. Scientists and medical researchers discovered that cord blood contains stem cells and progenitor cells (similar to those in bone marrow) that have the ability to replicate or develop into additional cells which can be used to treat life-threatening diseases. Cord blood transplants have been used in the treatment of leukemia, lymphoma, sickle cell anemia and more than 70 other diseases. Research continues in many areas and it is hopeful that cord blood will be successful in the treatment of new diseases in the future. However, the likelihood that a low-risk child would need its own stored cells is estimated at 1 in 20,000 (Dr. Sarah Buckley, *Gentle Birth, Gentle Mothering*, 2005). Some of the reasons why you may want to consider banking your baby's cord blood include:

- Cord blood is an exact match for the child.
- Cord blood has a 30% probability of being an exact match or very close match for each brother or sister.
- Provides the opportunity for a family to potentially benefit from cord blood's current and possible future uses.

There are several options available for cord blood banking and they fall into two categories:

- **Private banking** of your child's cord blood which is usually more expensive. (Close to $2000 initially and then a yearly storage fee over $175 per year.) You will need to sign up for this service with the cord blood bank and provide the kits to the midwives at birth for collection. You are responsible for shipping the blood.
- **Donation to a public bank** where the cord blood is available to anyone. This is free but must be arranged in advance with a participating facility. We will collect the blood at the birth but you are responsible for getting the kits and shipping the blood.

Right after birth: We believe that you and your baby should be together unless there is a medical reason that requires us to separate you. We promote a gentler birth experience and only give stimulation to the baby when needed. We do not use a bulb syringe to suction a baby because there is evidence that this can actually damage the baby's throat and nose. If suctioning is needed, we use a very small plastic tube attached to suction equipment to remove any mucous that may be problematic. You will be encouraged to keep your baby skin-to-skin for the first 2 hours of life to help your baby stay warm. This is a better way to regulate the baby's temperature than putting on a hat. We can check the baby while he/she is on your chest in most cases. We encourage you to breastfeed soon after birth and will help you get breastfeeding started before you go home.

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The first 2 hours are called the "Golden Hours" and we encourage you to spend this time breastfeeding and getting to know your new baby. We hope you will consider delaying family visits and time spent on social media and phones during this time. Your baby needs your full attention to bond, and we'll be monitoring their transition after birth. Between 2-3 hours after birth, your midwife will do an initial newborn exam while your baby is beside you. Most families are ready to go home in 4 hours after birth. Some may need closer monitoring for up to 12 hours.

Antibiotic Eye Ointment Consent Info

New Mexico state law requires that erythromycin antibiotic ointment be placed in the newborn's eyes immediately after birth. This is done to reduce the risk of an unknown gonorrhea or chlamydia infection that the newborn may have been exposed to when passing through the vagina. The resulting infection is called gonococcal ophthalmia neonatorum which can result in corneal scarring, ocular perforation and blindness. About 1% of newborn eye infections are caused by gonorrhea, up to 40% are caused by chlamydia and 30-50% are caused by bacteria that live on the skin and in the lungs, vagina, stomach, and intestines which are easily treatable and do not cause blindness.

Anyone who is sexually active can get chlamydia or gonorrhea through vaginal, anal, or oral sex. A male partner does not have to ejaculate in order to give the infection to his partner. Re-infection is possible after a previous treated infection. Most people have either no symptoms or mild symptoms. You can avoid both chlamydia and gonorrhea if you are in a monogamous relationship in which both partners have been tested and are uninfected. If you are not in a mutually monogamous relationship, then you can reduce your risk by using latex condoms every time you have sex. Your risk of getting chlamydia or gonorrhea is higher if you are young (under the age of 25), if you have multiple sexual partners, if your partner has other sexual partners, or if you live in an area where there are high rates of infection.

The diagnosis and treatment of gonorrhea and chlamydia in pregnant clients is the best method for preventing neonatal gonococcal disease. Newborns of those who lack prenatal care, have a history of sexually transmitted infections or substance abuse are at the most risk. The prevalence of gonorrhea in pregnancy is less than 1 percent. There is a 30 to 50% chance of the infection being transmitted to the newborn at birth. The U.S. Preventive Services Task Force, Centers for Disease Control and the World Health Organization recommend that all newborns be given preventive medication.

Preventive treatment with 0.5% erythromycin ophthalmic ointment is considered about 80% effective. A small amount of this ointment is placed inside the lower eyelid of each eye within the first 2 hours of birth. Side effects from the treatment include temporary blurring of vision from the ointment and possible redness and irritation if there is an allergic reaction to the antibiotic.

Dar a Luz tests all pregnant clients for chlamydia and gonorrhea at their first prenatal visit and treats all partners when there is an infection. We recommend that clients should be retested for chlamydia and gonorrhea if they have a new sexual partner, or if they suspect or are unsure if their partner has had a new sexual partner, since the initial testing. We recommend retesting anytime for pregnant clients who are at risk of infection. We offer retesting at 36 weeks for clients at risk or anyone choosing to decline the preventive eye treatment.

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Vitamin K Consent Info

What Is Vitamin K?

Vitamin K is a fat-soluble vitamin needed for blood clotting. We cannot make Vitamin K ourselves, and we don't store it very well in our body. We get Vitamin K1 (also known as phylloquinone) from leafy green vegetables. We can also get Vitamin K2 (menaquinone) from bacteria that live in our intestinal tracts. Vitamin K1 from plants makes up about 90% of our overall Vitamin K levels, while Vitamin K2 from bacteria makes up only about 10% of our overall Vitamin K intake. Foods rich in Vitamin K1 include: leafy greens, cabbage, spinach, kale, chard, cauliflower, broccoli, turnips, brussels sprouts, banana, kiwi, avocado and soybean oil.

Vitamin K is necessary for our bodies to activate clotting factors that help the blood to clot. These blood clotting factors are present in normal numbers at birth, but are not activated fully due to low levels of Vitamin K. This deficiency intensifies because they make only 10% of their own blood clotting proteins after feeding is well established and the gut is colonized with bacteria. Lactobacillus (primary gut flora for breastfed babies) does not synthesize Vitamin K. Severe vitamin K deficiency can develop quickly in breast fed infants (breastmilk contains only 1mcg/liter vs. 53mcg/liter in formula) putting them at increased risk for "Vitamin K deficiency bleeding" (VKDB). This bleeding can occur unexpectedly and serious hemorrhagic complications can occur. These are 100% preventable with vitamin K intramuscular prophylaxis.

Vitamin K deficiency bleeding can follow one of three patterns: early, classical, and late.

- **Early VKDB** happens in the first 24 hours of life. Early VKDB is usually seen in babies born to those who took medicines that interfere with Vitamin K. These medicines may include warfarin (Coumadin), seizure medications, and tuberculosis medications. The bleeding usually happens in the skin, brain, and abdomen (Shearer 2009).
- **Classical VKDB** happens in days 2-7 of life, usually during days 2-3 and is more common than late VKDB. This is when levels of Vitamin K are lowest. Common bleeding sites include the gastrointestinal system, umbilical cord site, skin, nose, and circumcision site. The official cause of classical VKDB is listed as "unknown," but breastfeeding and poor feeding (<100 mL milk/day or <3.4 ounces milk/day) are major risk factors (Shearer 2009). Recent reviews show that the number of newborns affected is between 0 to 0.44% (0 to 440 out of 100,000). This type of VKDB is usually mild and involves bleeding at the umbilical cord site or circumcision site. However, blood loss can be significant, the mortality rate of classical VKDB is very low in developed countries.
- **Late VKDB** happens after the first week of life, usually during weeks 3-8. The bleeding usually happens in the brain, skin, and gastrointestinal tract. Bleeding in the brain is often the first sign of late VKDB. Late VKDB happens in exclusively breastfed infants who did not receive a Vitamin K shot. Some infants may also be at higher risk if they have undetected gallbladder disease, cystic fibrosis, chronic diarrhea, and antibiotic use. (Shearer 2009). Although late VKDB is rare, the consequences can be catastrophic. More than half of infants who develop late VKDB will have bleeding in the brain. The mortality rate for late VKDB is approximately 20%. (Shearer 2009; Lippi and Franchini, 2011). One study that looked at 131 cases around the world found an overall death rate of 14%. Of the surviving infants, about 40% had long-term brain damage.

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Late VKDB (after the first week of life) is the most dangerous kind of VKDB (Shearer 2009).

- When infants do not receive any Vitamin K at birth, statistics from Europe show that 4.4 to 10.5 infants out of 100,000 will develop late VKDB. Rates are higher in Asian countries (1 out of every 6,000 infants).
- When infants receive oral Vitamin K at least three times during infancy (typically at birth, one week, and four weeks), anywhere from 1.4 to 6.4 infants out of 100,000 will develop late VKDB.
- When infants receive the Vitamin K shot at birth, anywhere from 0 to 0.62 infants per 100,000 have VKDB. In an 18-year period in the United Kingdom, only two babies who received the shot had late VKDB brain bleeds, out of 64 million births (Busfield et al. 2013).

Delayed cord clamping raises iron levels because cord blood is rich in iron. In contrast, cord blood has extremely low levels of Vitamin K1 (<.05 micrograms per Liter). Vitamin K1 is poorly retained in the body, and the Vitamin K1 that is stored is primarily in the liver, not in the bloodstream. So although delayed cord clamping increases iron levels, it is highly unlikely that this would help raise Vitamin K levels enough to prevent VKDB (Shearer 2009; Olson 2000).

Circumcision sites are frequently listed as a site of bleeding when infants have classical (first-week) VKDB. Unfortunately, circumcision often takes place when Vitamin K levels in the infant are lowest—during days 2 and 3 of life (Shearer 2009). Infants who are circumcised and whose parents decline Vitamin K may be more likely to experience bleeding at the circumcision site, especially if the baby is breastfed. In a large clinical trial in the 1960s, researchers found that administering Vitamin K at birth can decrease the risk of bleeding during a circumcision. In this study, infants who were born on odd-numbered days received a Vitamin K shot at 24 hours of age, while infants who were born on even-numbered days did not. Bleeding occurred after circumcision in 6 out of 240 infants (2.5%) who received Vitamin K, and 32 out of 230 infants (13.9%) who did not have the Vitamin K shot (Vietti, Stephens et al. 1961).

Safety

One study in 1990 attempted to show an association between intramuscular vitamin K administration and increased incidence of childhood leukemia and cancer but after twenty-four years of studying the possibility of a link between Vitamin K and childhood cancer, researchers have now come to the conclusion that there is no evidence supporting a relationship between Vitamin K and leukemia or other childhood cancers (Shearer, 2009). Recent research on childhood leukemia suggests that an in utero chromosomal translocation event combined with a postnatal promotional event results in clinical leukemia. This further lessens the likelihood that injectable vitamin K has any significant relationship to leukemia. The vitamin K injection has been used for many years with no proven safety issues. Rarely has severe reaction (anaphylaxis) been reported with intramuscular injection. There are rare cases of a minor dermatologic reaction at the injection site.

It has been reported that some parents refuse the injection because they are concerned about ingredients in the shot, which the parents call "toxins." Dar a Luz addresses this concern by using the preservative-free version of Vitamin K.

The ingredients in a shot with NO preservatives include:

- 1 mg of Vitamin K1, a fat-soluble vitamin derived from plants
- 10 mg of Polysorbate 80, which helps Vitamin K1 (a fat-soluble Vitamin) dissolve in liquid for the injection. Polysorbate 80 is made from natural sorbitol and plant-based oleic acid, is used in a

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wide variety of foods, medicines, and vitamin supplements, and is included in the Handbook of Green Chemicals.

- 10.4 mg of Propylene glycol, which helps absorb extra water and maintain moisture in certain medicines. Propylene glycol has been recognized as safe by the FDA for use in food products.
- 0.17 mg of Sodium acetate anhydrous, a mixture of salt and bicarbonate, that is used to adjust the pH of the injection
- 0.00002 mL of Glacial acetic acid, also known as vinegar, that is used to adjust the pH of the injection

Treatment

The American Academy of Pediatrics has recommended vitamin K for prophylaxis since 1961 and today it is the standard of care. There is no proven oral version of Vitamin K available for infants in the U.S. The shot is absorbed more easily than the oral version and has a delayed release effect that protects against both classical and late bleeding. It is routinely given intramuscularly 1 mg in the lateral thigh of newborns soon after birth to rapidly activate (4-6 hours) the clotting factors and prevents "vitamin K deficiency bleeding". We strongly recommend the injectable vitamin K because it gives the best protection to newborns with proven safety.

Oral administration of vitamin K at birth, one week and 4 weeks has been shown to have similar effectiveness in preventing early onset bleeding but babies are still at risk for late onset bleeding with a rate of 1.4 to 6.4 per 100,000 births. More research is needed to determine the optimal oral dosing regimen to decrease the risk of bleeding. There is no licensed oral form of vitamin K in the United States but the injectable form can be given orally. Another source for oral vitamin K is Bio-K-Mulsion by Biotics Research Corporation which can be ordered online. It supplies 500 mcg per drop.

There are several different regimens for giving oral vitamin K:

- 2-4 mg oral vitamin K after first feeding and then 2 mg at 2-4 weeks and again at 6-8 weeks.
- 2-4 mg oral vitamin K after first feeding and then 2 mg within the first week and weekly while breastfeeding (this seems to be the most effective regimen based on limited evidence)
- 2mg oral vitamin K after first feeding and then 2 mg within first week followed by 150 mcg daily for 13 weeks.

Even with full compliance with these oral regimens, cases of bleeding have occurred. Full compliance is difficult to achieve because doses are missed and if the baby vomits or regurgitates within 1 hour of an oral dose, the dose should be repeated. Babies do not absorb the oral Vitamin K as well either. In addition, one study found that maternal vitamin K supplements of 5 mg/day raised infant vitamin K levels to near formula fed levels. When exclusively breastfed babies are given oral vitamin K, we strongly recommend that clients take 5mg/day oral supplementation to further protect from late onset bleeding.

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Going Home

Discharge from the Birth Center: You and your baby are able to go home when you are both stable. This means the baby is able to eat, maintain their temperature in a normal range and breathing and heart rate are normal. For you, this means you are able to eat, have been able to urinate, your vital signs are normal and your bleeding is a normal amount. The family is usually able to go home in about 4-5 hours and we encourage you to go home in that time frame. If you are recovering at the center and another laboring client comes in, we may ask to move you to another room so that they may use the birth room after it is cleaned. If there is a medical condition that requires you to be monitored more than 12 hours, you may need transfer to a hospital. You will find detailed Postpartum Discharge Instructions in this section. The nurse will go over the Postpartum Discharge Instructions Summary handout with you before discharge. Please take time to read these.

It is a long-standing tradition at the birth center for partners to change the marquis to announce the birth of your baby. Please be ready to change the sign before you go home, otherwise there may not be time to do it later. If the weather is not favorable or other circumstances prevent you from doing that the midwife will put the baby's name up for you. You may ring the bell during daylight hours the day of the birth or on one of your visits.

Placenta: Traditional Chinese medicine has used placenta for centuries to treat a variety of ills including fatigue and insufficient lactation. Many of our clients are learning about the rich nutrients that the placenta provides to help balance your hormones, enhance your milk supply and increase your energy. Your placenta is rich in progesterone which helps with depression and iron to decrease anemia. Those who use their placenta report fewer emotional issues (postpartum depression), have more energy and tend to enjoy a faster, more pleasant postpartum recovery. None of these reported health benefits have been confirmed by any research studies.

If you plan to consume your placenta, we recommend using only healthy placentas from a normal labor and following safe guidelines for preparation to reduce the risk of transfer of viral infections like Zika, HIV or hepatitis. Some clients prepare the placenta fresh and others prefer to encapsulate it. If you plan to encapsulate it, bring a cooler to store your placenta so that you can take it home or call your doula to come pick it up. It usually costs around $200-300 to have someone to prepare it for you. Some families plant their placentas under a new tree in honor of their baby. If you do not want your placenta, do not throw it away in the trash. It must be disposed of properly as biohazardous waste and we can do this for you.

Carseat Safety

New Mexico state law requires that your baby be in an approved car seat. You will need to install a car seat in your car to take your baby home. Please read the product information sheet on the car seat for correct use and see diagram below. It is the parents' responsibility to know how the car seat works and place it in the vehicle using a seat belt and/or latch system. The birth center offers a monthly car seat installation clinic given by Nancy Anthony, a Certified Child Passenger Safety Instructor, who can inspect your car seat to see if it is correctly installed. Birth center staff is not responsible for improper placement or restraint of car seats in a client's vehicle. You may contact Safer New Mexico Now for car seat fitting clinics at 1-800-231-6145. For more information on the New Mexico Car Seat Safety and Distribution Program, call (505) 332-7707 or e-mail info@safernm.org.

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Car Seat Safety for Infants and Toddlers

Infant Carrier Car Seats

(can ONLY be used rear-facing)

Presented by

Nancy Anthony, CPST

Dar a Luz Birth & Health Center

Convertible Car Seats

(convert from rear-facing to forward-facing)

ALWAYS:

- ***ALWAYS*** Register your car seats to be notified of recalls.
- ***ALWAYS*** Check used car seats for recalls before using.
- ***ALWAYS*** Read and follow instructions in your car seat and vehicle owner's manuals.
- ***ALWAYS*** Adhere to the weight and height limits of your car seat.
- ***ALWAYS*** Use the correct belt path.
- ***ALWAYS*** Make sure your final installation passes the 1-INCH TIGHTNESS TEST. (Try to slide the seat side to side, and front to back, gripping the seat on both sides at the BELT PATH.)
- ***ALWAYS*** Install rear-facing car seats at a proper recline angle (follow indicators).
- ***ALWAYS*** Keep harness straps adjusted properly (at or below the shoulders for rear-facing), and snug enough that you can't pinch any slack.
- ***ALWAYS*** Keep the retainer clip level with the child's armpits.
- ***ALWAYS*** Keep child properly and snugly harnessed whenever they are in the car seat, even when outside the vehicle. Loose or unbuckled harnesses present safety risks.

NEVER:

- ***NEVER*** Install rear-facing car seats in vehicle seating positions with front air bags.
- ***NEVER*** Swaddle or dress child in bulky clothing before harnessing in car seat.
- ***NEVER*** Leave child unattended in car seat for extended periods of time.
- ***NEVER*** Let child sleep in car seat overnight.
- ***NEVER*** Leave child in car seat on high surfaces like countertops.
- ***NEVER*** Leave child in car seat on soft surfaces like beds or couches.
- ***NEVER*** Use a car seat that is expired, has been in a crash, has a frayed or damaged harness, or is missing parts.
- ***NEVER*** Add extra padding, strap covers, blankets, pillows, or other "after market" items to your car seat. This includes anything under or around the child or the harness system.
- ***NEVER*** Lubricate the buckle.

Installing with Seat Belt vs. LATCH

Use one method, not both (unless allowed by manufacturer). Both are equally safe when used correctly. Experiment with both, and use the one that gives you the tightest and easiest installation.

LATCH: Make sure the lower anchors you're using are for the seating position you've chosen. Not all seating positions in your vehicle are equipped with LATCH (check your vehicle owner's manual if not sure).

SEAT BELT: Remember to lock/switch the seat belt retractor (or use LOCK-OFFS if your car seat has them).

Extended Rear-Facing

Rear-facing car seat use is associated with a significantly decreased risk of injury, especially injuries to the head, neck, and spinal cord.

NHTSA recommends keeping children rear-facing as long as possible, up to the top height or weight limit allowed by the particular seat. It's the best way to keep them safe. Once a child outgrows the rear-facing car seat, he or she is ready to travel in a forward-facing car seat with a harness and a tether.

HealthyChildren.org

babytrend.com

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Discharge Instructions for Client and Baby: Birth to 2 Weeks

Congratulations! Whether you have a birth at the center or at the hospital, we are so proud of you. We have included the full discharge instructions here so that you can be better prepared for the first 2 weeks after birth. You always have access to the midwives so if you have any questions at all, you can call the office at (505) 924-2229 or the midwife on call at (505) 944-5488 and speak to one of the midwives. Don't be afraid to call us for anything.

Postpartum Changes: What to expect over the next few days

You'll feel very sore. It is normal to feel achy and sore in places that you never knew you would. You have used every muscle in your body during labor and birth and so this is the time to honor your body and rest. **No matter how well you feel when you get home, these first few days at home are for rest and recuperation.** It is very easy to overdo your activity in the first couple of weeks after birth. You should:

- Sleep during the day with your baby (they tend to be more alert and feed better at night).
- Eat nutritious foods- the better food you eat, the better you feel and the heartier milk you make.
- Drink plenty of water- you need a lot of water for a good milk supply.
- Have people bring you nutritious meals that you can freeze.
- Have other friends and family help with chores- limit your activity to taking a shower for the first 3-4 days.
- Limit your activities to caring for yourself and your baby.
- Not lift anything heavier than your baby.
- Let others clean, cook and supervise household needs (including older siblings).

You may be surprised by how much rest it takes to fully recover from birth and how little extra time there is for tasks other than eating, sleeping and caring for your newborn. Clients who do too much in the first couple of weeks after birth have more exhaustion, more baby blues and more stress. No matter if this is your first or fourth baby, you need time to recover and you owe that to your body.

Physical Changes

- **Bleeding**: The uterus bleeds from the vessels where the placenta was attached and it takes several weeks for those vessels to close completely. Most clients bleed like a heavy period for 1-2 days after birth. You might bleed more when you get up to use the restroom or when you are showering. After a couple of days, the bleeding is more like a moderate period and then decreases to a light period and then to a dark brown or yellowish discharge. Your bleeding may last for 4-6 weeks total and that is normal. Passing a clot or two up to the size of a golf ball is normal if you haven't been up for a while. Clots are usually old blood and have been sitting in the vagina for a while and have been exposed to oxygen. Change your pad every time you use the restroom.
    - **Not Normal: Bleeding more than a pad an hour, many clots that keep coming out or foul-smelling blood/discharge (like something rotting).**

- Cramping: Cramping is the work your uterus is doing to get back down to its normal size. It is mostly in response to breastfeeding and the surge of oxytocin every time your baby starts to nurse. Cramping especially while nursing is normal. Cramping usually worsens with subsequent babies as the uterus has to work a little harder to get back down to its normal size. A heating pad may help but Ibuprofen works best and is safe for breastfeeding. You may take 800 mg (4 regular tablets) every 8 hours for as long as you need it. If ibuprofen alone is not giving you relief from

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cramping, you may take Ibuprofen 600mg every 6 yours and alternate that with Tylenol 1000mg every 6 hours. Do not take more than 4000mg of Tylenol in 24 hours.
  - **Not Normal: Pain in your uterus that is more than menstrual cramping- the pain should not feel like you are in labor again.**

- Swelling: Legs and feet often swell more after birth. This usually returns to normal within a few days after the birth.
  - **Not Normal: Swelling, tingling or numbness in one foot or leg or a painful red spot in one of your legs.**

- Breasts: Breast milk comes in within 2-3 days for most moms. When breast milk comes in, it is not unusual to get a low-grade fever (<100.0 F). Always wash your hands or use hand sanitizer before you nurse your baby to decrease the risk of mastitis (an infection in the milk ducts). See below for more information on feeding, engorgement and sore nipples.
  - **Not Normal: A firm, tender red spot on one or both of your breasts along with a fever of >100.4 F and body aches.**

- Nipples: Nipple tenderness is a normal part of breastfeeding but it shouldn't hurt so bad that you want to crawl the walls. It is normal to feel some tenderness when the baby first latches and up to about a minute after. Do not pull your baby off when you are done nursing- instead, slip a finger in the baby's mouth and break the suction. Use lanolin or any nipple cream that is safe for the baby to help heal any injuries.
  - **Not Normal: hickies on or around the nipple, bleeding or terrible pain**

- Bowels: Many clients are scared of having a bowel movement after birth. The worst thing you can do is get constipated. Drink plenty of fluids, eat fresh fruit and vegetables and take in plenty of fiber. All of these things will prevent you from being constipated. And relax: our bodies are very good at regulating these things and most clients find their first bowel movement was nothing more than normal and soft.

Witch Hazel Pads/Padsicles/Peri-Pops

Use this recipe to make your own frozen postpartum pads that will be very comforting:

- Witch hazel (preferably alcohol-free)
- Aloe vera gel
- Lavender essential oil (optional)
- Small bottle or bowl for mixing ingredients
- About 24 pads should be enough–can be cloth or disposable menstrual pads, cloth or disposable newborn diapers, or folded washcloths. These pads are for pain relief and may not hold all bleeding discharge. Place them inside your postpartum pad or Depends briefs.

Directions:

- Mix half witch hazel and half aloe vera gel in a bowl or bottle.
- Add 4-5 drops of lavender essential oil.
- Spray or spread onto pads
- Layer pads with aluminum foil to keep them from sticking together
- Put in a shallow bowl with the right curve to fit your bottom and then freeze
- Put in a freezer bag after they are frozen
- Let them thaw a few minutes before applying to your bottom.

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- Perineum/Sutures (stitches): The soreness in your bottom will be the worst in the first week. Use frozen witch hazel pads for the first 24-48 hours, then switch to warm sitz baths with Epsom salts and herbs. If you had a vagina or perineum repair after your birth, the sutures that were used are a synthetic material that usually dissolves in 2-3 weeks. The suture may look white and will dissolve faster and with less discomfort if you take a warm bath at least once a day every day. You can pre-make some Witch Hazel pads, too! See recipe above.

Feeding

Also see the whole section "**Breastfeeding and Feeding Your Baby"** for more information.

If you are breastfeeding, you should attempt to feed every two hours around the clock until your milk comes in, not to exceed three hours. Studies show that babies who nurse this often have less weight loss and less jaundice, a condition caused by excess bilirubin (explained in more detail below). In addition, babies who nurse more often have better temperature regulation and tend to be more satisfied. In the first 48-72 hours, your body is making its first milk called colostrum, which is made up of calorie-rich protein and antibodies to boost your baby's immune system. There is very little fat or carbohydrate in colostrum but it is exactly what babies need. You will notice that there is not a lot of colostrum and many clients feel as though their baby is not getting enough. Most babies get exactly what they need in the first few days before your milk comes in—their stomach is the size of a marble and the perfect size to fit 1-2 teaspoons of colostrum from each breast. But the more you feed your baby, the more colostrum your baby is taking in and the more satisfied your baby will be until your milk arrives.

If you are formula feeding, feed your baby 1-2 ounces for the first few feedings and then increase as the baby can take in more formula. Most babies should only take in 3-4 ounces per feeding in the first month. Newborns should only be fed pre-mixed liquid formula because it is sterile. They are not to have powdered formula until 1 month of age because their intestines are not colonized with bacteria and powdered formula is not sterile.

Engorgement

Milk is supply and demand. Therefore, engorgement is the over-supply of milk that your baby has been demanding for the past 3 days. Engorgement will usually only last for 1-2 days—it takes your body between 24-48 hours to adjust to your baby's feeding. So, when your baby slows down, your milk slows down in a day or two. When your baby has a growth spurt, it takes your milk a day or two to catch up. The best thing to do for engorgement is to nurse often to release the pressure. If your baby is having a difficult time latching on, it is best to express some of the milk from your breast either with your hand or a breast pump. You only need to express a little in order to soften up the areola around the nipple. Most babies have a difficult time latching on with engorgement only because they are not used to the way the breast feels once the breasts have become engorged. Try not to get frustrated or stressed. Your baby will pick up on those emotions and may become upset while nursing. Always get into a comfortable position, prop your arms and baby with pillows and a Boppy, and relax. Take your shirt off and let your baby get skin-to-skin with you to smell you and feel you. This will help you and your baby as you work together through the first couple weeks of breastfeeding.

You may stand in the shower to release some of the milk when you are engorged. Sometimes, just holding a warm washcloth against your breast will help release some milk. Cold green cabbage leaves will help as well—there is an enzyme in cabbage leaves that help reduce the soreness of engorged breasts and sore nipples. Also see the section "**Potential Breastfeeding Issues"** for more information.

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Sore Nipples

The two most important things to avoid nipple pain and injury are a) position and b) latch. Your baby should be facing your body as though you were dancing. You don't want your baby to have to turn their head to get to your breast—it will cause them to pull inadvertently, which can cause nipple injury. Also, make sure your baby's head is at the height of your breast. You always want to make sure that you bring the baby to you, not you to your baby. This is where propping the baby with pillows is very helpful.

Your baby's mouth should open like a fish, or like they are taking a bite of an apple. Their lips are pursed out and they should take in all of the nipple and as much of the areola into their mouth that can fit. Latch is of utmost importance. If your baby is only on the end of the nipple, then it can easily be injured by vigorous sucking. It is not uncommon to have some tenderness with the latch but after about 30-60 seconds, it should mostly ease off. If you have severe pain immediately with the baby latching on, then something is not right. Insert your finger into the baby's mouth to break the suction, reposition and re-latch the baby. Also see the section "**Potential Breastfeeding Issues"** for a lot more information on this one.

Nutrition

- Drink at least eight glasses of water each day, especially if you are breastfeeding.
- If breastfeeding, you should eat basically what you were in pregnancy as you burn up to 500 calories a day
- If not breastfeeding, you may resume your pre-pregnancy diet.
- Continue taking in good calcium - at least four servings of calcium-fortified foods per day.
- Eat a wide variety of fruits, vegetables, lean meats and whole grains. Your diet during breastfeeding is just as important as it was during pregnancy. Most babies don't have issues with what their mothers are eating but it is just trial and error.

Medications

- If you were given a prescription, follow the directions on the bottle.
- Continue your prenatal vitamins and any other supplements you have been taking unless instructed otherwise
- If you were taking an iron supplement during pregnancy including FerroFood or Floradix, continue at the dose you were taking until directed to change or stop
- You may take: Ibuprofen 800 mg every 8 hours.
- If ibuprofen alone is not giving you relief from cramping, you may take Ibuprofen 600mg every 6 yours and alternate that with Tylenol 1000mg every 6 hours. Do not take more than 4000mg of Tylenol in 24 hours.
- You may take: Colace 100 mg twice a day (stool softener)

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Emotional Changes

There is a wide range of emotions you may experience once you go home. You may feel so elated that you think you can't sleep. You may feel anxious. You may even feel a little sad as you realize the person who was inside of you for so long is no longer there—even though s/he is on the outside now, it is normal to miss the kicking and moving around. You may also cry for no reason and just feel "emotional". This is all normal for the first couple of weeks. Your hormones are changing drastically and rapidly and your family has just increased by one! So, don't be hard on yourself if you aren't feeling perfect in a couple of days. It is normal to:

- Have feelings of anxiety about caring for your new baby and family
- Have ups and downs
- Have difficulties coping with some things that didn't use to bother you (usually because of sleep deprivation)
- Have feelings of being overwhelmed, exhausted and out of your element. Be patient with yourself, this is a normal process of adjustment and you will get it with time.
    - **Not Normal: Feelings of depression and utter sadness, hopelessness and helplessness: you don't want to get out of bed in the morning; you don't want to take care of yourself, your baby or your other children; you don't want to eat anything or take part in normal daily activities; you want to hurt yourself, the baby or others.**

Postpartum Warning Signs

You need to call the midwives IMMEDIATELY if you have any of the following symptoms:

- **Fever over 101°F and/or chills and body aches**
- **Foul smelling vaginal discharge**
- **Pus or throbbing pain from stiches**
- **Throbbing pain near vaginal opening**
- **Strong uterine cramping or pain not relieved by pain medications**
- **Painful and/or red lump or red streak in one or both breasts with fever over 101°F, aches and/or chills**
- **Bleeding through a regular size pad in an hour or less**
- **Continuous clots from vagina**
- **Severe leg pain, red spot in calf or thigh, swelling, numbness or tingling in one foot or leg**
- **Feelings of hopelessness, helplessness or wanting to hurt you, your baby or your other children**

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Newborn Behavior and Care

You have been waiting for this bundle of joy for 9 months! Sometimes your little bundle of joy can turn into a bundle of frustration, sadness or exhaustion. The transition with a new baby, whether your first or your fourth, is always a difficult one. Remember, just because you have had your baby doesn't mean you can't call the midwives at any time or come in for an extra visit.

Crying

Newborns cry for a handful of reasons: they are hungry, tired, hot, cold, wet, dirty, gassy or lonely. Some babies cry and there may not be a reason. Maybe you have tried everything and your baby is still crying. Always try swaddling your baby tightly to mimic the womb. Babies have been in a very small space for a long time and coming into a cold world is often very alarming for them and can cause them sensory overload and disorganization, meaning they can't reverse the overload once it has begun. Babies often like background noise because they were used to that in the womb as well. Babies also liked to be held- it is ok to "wear" your baby or just hold your baby whenever you want. You cannot spoil a newborn; you can either meet their needs or not. If you get stressed and need a break, but your baby down for a few minutes and leave the room. NEVER SHAKE a baby. If you have tried everything and your baby is still crying, call the midwives and we will give suggestions.

Feeding

Most newborns sleep about 22 hours a day and are only barely awake for feeding. Most newborns are more alert and feed better at night and sleep more during the day. It usually takes a couple of weeks for baby's sleep to adjust but breastfeeding babies will nurse about every 2-3 hours all day and night so you may not see any longer sleep periods at night for a while. In the first three days after birth, you may need to stimulate and wake your baby up to feed. Babies are just as tired as their you are, as they worked hard to be born too. The best way to wake your baby and stimulate them is to undress your baby down to the diaper and place your baby skin to skin with you, either under your shirt or under blankets to keep the back warm. This allows you and your baby to feel one another, smell one another and to keep your baby warm. This closeness releases oxytocin, the hormone of love and a precursor to prolactin, the hormone that regulates breast milk. In fact, in the first 72 hours after birth, breastfeeding experts and researchers suggest that you keep your baby skin to skin as much as possible to encourage constant breastfeeding, bonding and an abundant milk supply. Skin to skin contact also regulates baby's heart rate and respirations, not just their body temperature.

Breastfed babies need to nurse every 2-3 hours (or on demand if they want to nurse more) around the clock until your milk comes in. You should not go longer than 3 hours between feedings. It is important that you nurse your baby at least 15-20 minutes per side. Sometimes babies have some mucous in their stomach from birth and are not as interested in feeding in the first 24 hours. They may even spit up or appear to be choking on it and you should place the baby on the side or belly and pat their back. This may feel scary the first time it happens but is totally normal. Not all babies want to nurse on both sides once the milk comes in but they should "finish" a breast before going to sleep or being switched to the other side. This is because the hind milk, the milk that has all the fat and calories that they need for growth and brain development, is the milk they have to work harder for—it is the milk that they get after the first few minutes of feeding. Once your baby has "emptied" your breast (breasts are never empty while breastfeeding- they are constantly making milk), you can switch to the other side if your baby is not satisfied. An "empty" breast feels soft again and the hard pockets (the milk ducts full with milk) have emptied their milk. It may not feel soft everywhere but it should be quite a bit softer than a full breast.

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Switching your baby too soon, or letting the baby feed 5 minutes per side will cause the baby to want to nurse more often as this is more like having a snack and can also cause colicky behavior. The fore milk (the milk they get at the beginning of a feeding) is mostly carbohydrate and gives the baby energy but it also causes gas and is metabolized very quickly. Nursing a few minutes per side will ensure that you will be nursing every hour or so. Most clients would like a little bit of a break!

Formula-fed babies should eat every 3-4 hours in general. Formula takes longer to break down than breastmilk so these babies don't always need to feed as often. But if your baby is showing signs of hunger (rooting, trying to suck on anything that gets near their mouth) then you should feed your baby.

Newborns and young babies should not be placed on a feeding schedule. Babies are growing rapidly and expending energy very rapidly. They use a great deal of energy just to stay warm as they adjust to extra-uterine life. If your baby is hungry, you should feed your baby.

Burping

Burp your baby in between breasts during a feeding. In the first couple of days before your milk comes in, the baby may not burp if s/he isn't taking in any air during the feeding. But once your milk arrives, you usually need to burp your baby once or twice per feeding. Formula fed babies should be burped once in the middle of the feeding and again at the end.

Cord

The umbilical cord is cut at birth and the remaining stump usually falls off within 7-14 days after birth. Studies no longer support the use of alcohol on the cord because is prolongs the detachment time. We recommend natural drying of the cord. Newborns can be put in the bath before the cord falls off, just keep the area clean and dry after the bath. The cord normally has a light odor, small amount of bleeding and small amount of yellowish discharge just prior to it falling off or immediately after. You may notice some brownish crusty discharge in the umbilicus for a few weeks after it falls off which is normal. Call your midwife if there is a quarter size area of redness of the skin around the cord, a large amount of yellow discharge, heavy bleeding at the site or an excessive foul odor at the cord site. Also call if your baby is lethargic, feeding poorly or has a fever which could be signs of infection.

Nasal Congestion

Most babies experience nasal stuffiness as they adjust to the outside environment. You will find a sample of saline drops in your discharge bag from the birth center. Apply a drop or two in one nostril at a time and this help soften the secretions. Your baby will either sneeze them out or you can use a NoseFrida "Snot Sucker" to suck it out. Using a humidifier in the room may help some too.

We do not recommend using a bulb syringe to suck out the mucous because, first of all, it is painful to your baby and secondly it can cause swelling of the nasal turbinates and make the problem worse. The bulb syringes can be a reservoir for bacteria, so if you decide to use one, be sure to clean it thoroughly and sterilize it or get a new one.

Eye Discharge

About 1 in 20 newborn babies will have a tear duct in one or both eyes that is not quite fully developed at birth. Within a few weeks to a few months of birth, the tear duct usually finishes developing and the problem goes away.

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Sometimes after a sleep the affected eye looks sticky or crusty and you can wipe away the discharge with a moist cloth. You should massage the tear duct of your baby by using gentle pressure with your finger on the outside of your baby's nose and then stroke downwards towards the corner of the nose. This should be repeated ten times a day. This can help to clear pooled tears in the blocked duct. It may also help the tear duct to develop. Most babies will respond to this massaging and then will not need any further treatment.

Sleeping

Newborns sleep 20-22 hours a day the first few weeks after birth. Feed babies more in the evening to help them sleep longer at night. Usually by one month of age, babies are starting to sleep more at night. Make sure your baby is dressed warm enough at night if sleeping in a crib or a co-sleeper. Do not place blankets over your baby. You should get swaddling blankets or sleep-sacks as placing loose blankets can increase the risk of SIDS (Sudden Infant Death Syndrome). If you co-sleep, make sure there are not extra pillows or blankets in your bed either. NEVER co-sleep with your baby if you have had any medication that makes you sleepy, alcohol or illicit drugs. NEVER let anyone co-sleep with your baby under these circumstances as well.

Clothing

The rule of thumb for dressing your baby is the same number of layers that you are in **PLUS** one layer. That is, if you are wearing a sweater and jeans, your baby needs the same plus a blanket. Babies can get cold stress very easily which causes them to use more energy and want to feed more often. You will both get more rest if your baby is warm enough, but not too warm. Heavy blankets or blankets made of synthetic material can cause a baby to overheat. If you are concerned, check your baby's temperature under the arm. It should be between 97.9-99.5 Fahrenheit. Always swaddle your baby in a crib and do not use loose blankets.

Diapering

Change your baby's diaper when it is soiled or wet. Many disposable diapers claim to have "12 hour dryness protection" or some such slogan. However, this does not mean that you should leave your baby in a wet diaper for hours on end. Wipe your baby's skin with a wet wipe or just a soft wet cloth after each pee and poop. Urine can break down their skin just as bad as poop can. It is a good habit to change your baby before or after every feeding. There are many disposable diapers that are more friendly for the environment. Some are biodegradable and some are flushable. We don't really know the effect of bleach on our baby's skin and genitals- most commercial diapers have been bleached. Choosing a diaper that is bleach, plastic and chemical free is best. There are many cloth diapers available and more and more parents are choosing this option. Rio Grande Diaper Service at (505) 877-6311 is a local diaper cleaning service. Parents in your birth class may have good ideas as well.

Newborn Stools and Voids

The baby's first stool (meconium) is black and tarry and will transition over the first week to yellowish seedy stools. You will be given a chart when you are discharged from the birth center that will help you determine if your baby's pees and poops are a normal amount and color. Below is a color chart that can help too. Babies may have some red or orange spots in their pee before your milk comes in. This is not blood but concentrated urine and is normal. It will resolve after your baby starts feeding more as your milk comes in.

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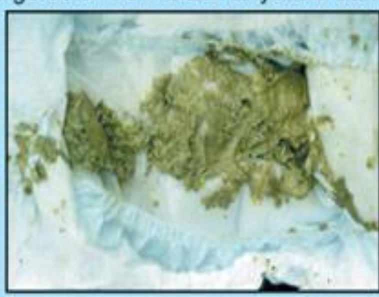
Diapers of the Breastfed Baby

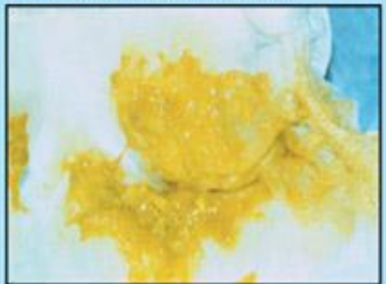
Looking at a baby's poop and pee can help you tell if your baby is getting enough to eat.

The baby's poop should change color from black to yellow during the first 5 days after birth.

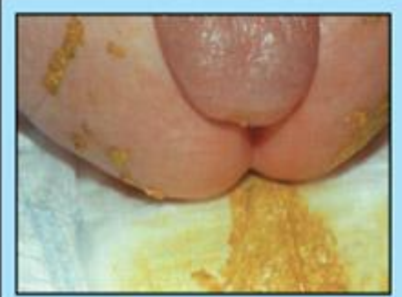
The baby's first poop is black and sticky.



The poop turns green by Day 3 or 4.

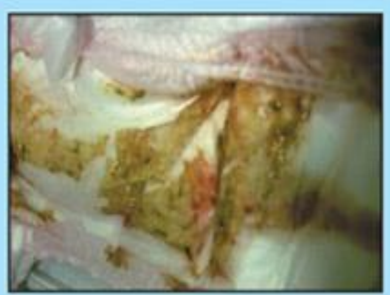


The poop should turn yellow by Day 4 or 5.



Poop can look seedy.

Poop can look watery.

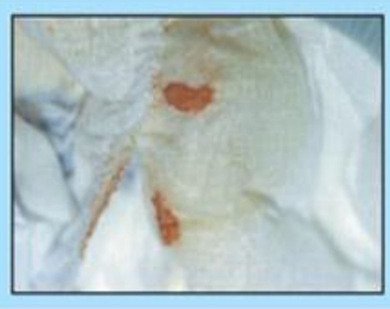


Illness, injury, or allergies can cause blood in poop. Call Doctor.

Babies make some large and some small poops every day.

Only count poops larger than this.

By Day 4, most breastfed babies make 3 or 4 poopy diapers every day.



On Day 1 or 2 some babies have orange or red pee.

By Day 3 or 4, breastfed babies should make 3 or 4 wet diapers with pee that looks like clear water.

A wet diaper is as heavy as 3 tablespoons of water.

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Postpartum and Newborn Follow-up

Insurance/Medicaid: Your baby's care is not included with your care, regardless of whether it is provided by midwives or a pediatrician. Your baby is a new person and the care is billed out separately. It is your responsibility to add your baby to your insurance or Medicaid. Most plans require that you add your baby within 30 days or claims will be denied. Be sure to ask for coverage from the time of birth. If you do not do this, you will be expected to pay the uncovered costs of care.

Baby's Healthcare Provider: Midwives at the birth center can care for your normal newborn baby for the first 28 days but you will need to choose a provider to take care of your baby after that or in case of problems. You will need to start thinking about a provider for your baby between 28 - 36 weeks of pregnancy and let us know who that person is by 36 weeks. (There is a list of providers in the section **"Pediatric Provider List."**)

Home Visit

Home visits between 24-36 hours of age are available to clients who live or can stay **within 30 minutes of the birth center** (see **"Home Visit Policy and Map"**). We no longer do visits on Kirtland Air Force Base. The midwives on call will let you know the day of the 24-36 hour visit if we are able to come to your home or if you will need to come to the center. If you birth in the hospital, one of the midwives will come see or call you during this time. This visit is about an hour so that we can examine you and your baby and assess weight, feeding, urination, bowel movements, jaundice, bleeding, nutrition, bonding and do the newborn heart and metabolic screening tests.

Applying for a Birth Certificate: Your midwife will fill out the vital records forms online to apply for the birth certificate at your birth. We encourage you to pick a name by your 3-day visit. The state requires us to submit the completed information by 10 days after the birth. If you do not know a name for your baby by then, we will assign a name of either "Baby Boy or Baby Girl" and you can change the name when you apply for a copy from the state. Any penalties assessed by the state for late filing (after 10 days) will be your responsibility.

If the parents are not married, the father's information may be included on the birth certificate but a letter of paternity has to be completed and notarized at the birth center and then sent to the state within 10 days of birth. If the paternity papers are not completed by the deadline, we are instructed by the state to turn in the paperwork without the father's name. To add the father's name, you will need to go to Santa Fe and pay a fee of about $10-20.

The midwife selects the option to apply for a social security number when filling out the vital records form. The Social Security Administration will contact you to apply for a number. The Vital Records office should send you information within about 1-6 months so that you can get a copy of the birth certificate which costs $10 per copy.

Newborn Metabolic Screen

New Mexico requires that all newborns be screened for all core and secondary conditions recommended by the College of Medical Genetics and the March of Dimes.

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The disorders, with their incidence rates, are listed below:

- *Cystic Fibrosis [1:3,500]*
- *Endocrine Conditions*
    - ***Congenital adrenal hyperplasia (CAH) + # [1:12,000]***
    - *Congenital hypothyroidism + [1:3,000]*
- *Hemoglobin Conditions*
    - *Sickle cell disease and other hemoglobinopathies + [1:5,000, 1:400 African Americans]*
- *Metabolic Conditions*
    - *Amino Acid Conditions*
        - *Homocystinuria + [1:100,000]*
        - *Hyerphenylalanemia, including phenylketonuria (PKU) [1:13,000]*
        - *Tryosinemia + [1:100,000]*
    - *Fatty Acid Oxidation Conditions*
        - *Carnitine uptake defect [1:50,000]*
        - *Carnitine palmitoyl transferase I deficiency (CPT I) + [rare, >1:300,000]*
        - *Carnitine palmitoyl transferase II deficiency (CPT II) [rare, >1:300,000]*
        - *Multiple acyl-CoA dehydrogenase deficiency (MADD) [rare, >1:300,000]*
        - *Short chain acyl-CoA dehydrogenase deficiency (SCAD) [1:43,000]*
        - ***Medium chain acyl-CoA dehydrogenase deficiency (MCAD) # [1:15,000]***
        - ***Long chain 3 hydroxyacyl-CoA dehydrogenase deficiency (LCHAD) + # [1:50,000]***
        - ***Very long chain acyl-CoA dehydrogenase deficiency (VLCAD) + # [1:31,000]***
    - *Organic Acid Conditions*
        - ***Beta-ketothiolase deficiency (BKD) # [rare, >1:300,000]***
        - *Glutaric acidemia, Type I (GA I) + [1:71,000]*
        - ***Isobutyryl CoA dehdrogensase deficiency (IBD) # [rare, >1:300,000]***
        - ***Isovaleric acidemia (IVA) + # [1:90,000]***
        - *Malonic aciduria [rare, >1:300,000]*
        - ***Maple syrup urine disease (MSUD) # [1:200,000]***
        - ***Methylomalonic acidemias (MMA/8 types) # [1:50,000]***
        - ***Propionic acidemia (PA) + # [>1:100,000]***
        - *3-Hydrox-3-methylglutaryl CoA lyase deficiency (HMG) + [rare, >1:300,000]*
        - *2-Methyl-3-hydroxybutyryl CoA dehydrogenase deficiency (MHBD) + [rare, >1:350,000]*
        - *2-Methylbutyryl CoA dehydrogenase deficiency (2MBC) + [rare, >1:300,000]*
        - *3-Methylcrotonyl CoA carboxylase deficiency (3MCC) [1:50,000]*
        - *3-Methylglutaconyl CoA hydratase deficiency (3MGH) [rare, >1:300,000]*
        - *Multiple carboxylase deficiency (MCD) [>1:60,000]*
    - *Urea Cycle Conditions*
        - *Arginase deficiency [1:300,000]*
        - ***Argininosuccinate lyase deficiency (ASA) # [1:70,000]***
        - ***Citrullinemia # [1:57,000]***
    - *Other Conditions*
        - *Biotinidase deficiency [1:60,000]*
        - ***Galactosemia # [1:60,000]***

+ The screening test will not detect 100 percent of affected infants.

 # Represents emergent conditions. Infants are at risk of illness or death in first 1-2 weeks of life.

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The purpose of the newborn screening is to identify infants at risk that require more definitive testing. Babies with these conditions appear normal at birth and may have no family history of the disorder. It is only with time that the conditions affect the baby's brain or physical development or causes other medical problems. By then, the damage may be permanent. Early diagnosis and treatment prevent serious health problems and most babies develop normally and lead healthy lives.

This is a two-part test collected from a small heel stick, where a few drops of blood are placed on a filter paper card and then mailed to a processing lab in Oregon. The first part is completed in the first 24-36 hours, and the second part must be done within 10-14 days of age. We strongly recommend doing this testing, but if anyone choses to decline, a consent form must be signed and sent to the state.

Tongue Tie (Ankyloglossia)/Lip Tie/Frenotomy Consent Info

What is Ankyloglossia (Tongue-Tie)?

The tongue is the only muscle in our body that has one end that moves freely, unattached to any other body structures. its other end is attached to eight other muscles. During the embryologic development, this muscle is initially attached to the floor of the mouth. This attachment usually partially disappears, and in most cases reduces naturally from the tip toward the base of the tongue. When this piece of tissue fails to disappear or reduce its attachment, it may restrict the ability of the tongue to function and have adequate mobility. When the frenulum (the band of tissue that connects the bottom of the tongue to the floor of the mouth) is too short and tight, it causes the movement of the tongue to be restricted. This condition is known as tongue-tie or "ankyloglossia." It is congenital (present at birth) and hereditary (often times, it has occurred in more than one family member). It is a relatively common finding in the newborn population (approximately 5%) and represents a significant proportion of breastfeeding problems. It is one of the most misdiagnosed and overlooked congenital abnormalities. A heart-shaped tongue tip when it's stuck out is a sure sign of a tongue tie.

What is Lip-Tie?

There is a frenulum between the lip and the gums, too. If it is too short or too tight on the upper (and sometimes lower) lip, it can interfere with a baby's ability to form a good latch and to suck. Lip ties can result in a shallow, pinching and painful latch that causes nipple damage. Sometimes the frenulum can wrap all the way around the gums and attach to the inside of the mouth –in fact, this is almost always a condition that people with gaps in their two upper front teeth have. If your baby's lips are blistered after eating, or if when you gently pull it toward their nose, their upper lip can't touch their nostrils, it may be a sign of a lip tie. Our midwives and lactation consultants can evaluate your baby's mouth and give you a referral for the pediatric dentist to further evaluate lip tie and make recommendations for revision.

Why should there be treatment of Tongue-Tie and/or Lip Tie?

Until recently there were few studies, recommendations, or consensus on what constitutes an abnormal lingual or labial attachment. That is changing, although traditional medical teaching has been that a tongue-tie is of little relevance and can be ignored; the facts now do not support that belief. A common myth that is often repeated is that the frenulum will stretch so we don't need to treat this condition. The reality is that a tongue-tie, by interfering with normal tongue mobility, can exert a harmful effect on many aspects of life. Problems which can be associated with a tongue-tie may cause difficulties that start from birth and may last a lifetime; fixing it now may save you a fortune on speech therapy, dental bills and braces later, too!

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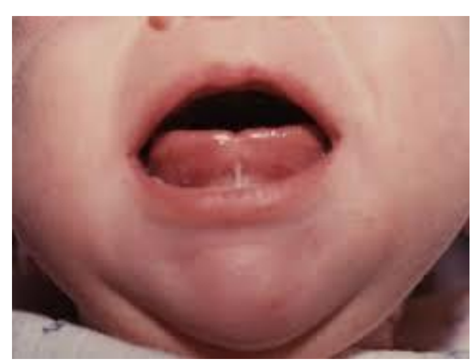
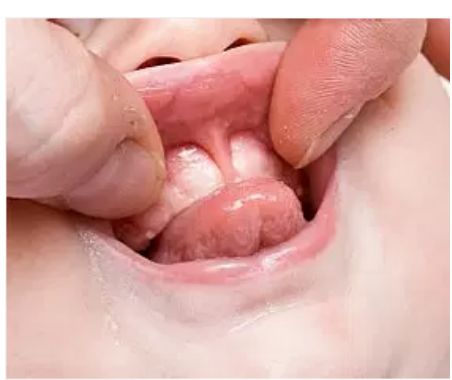
Problems resulting from tongue-tie for infant



- Colic and excessive gassiness
- Reflux (spitting up)
- Unable to sustain a latch, unable to develop a deep enough latch
- Difficulty with adequate milk intake/poor weight gain
- Falling asleep on the breast
- Extended nursing episodes
- Unable to hold a pacifier
- Early weaning from the breast

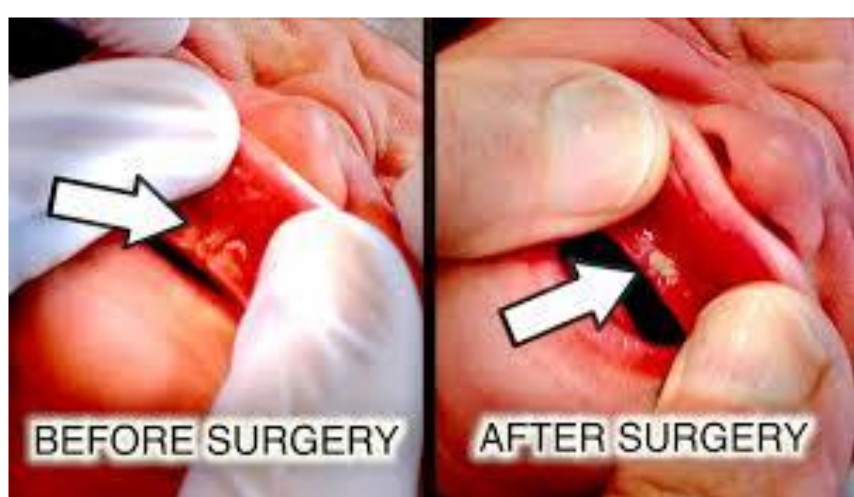
Problems resulting from tongue-tie for nursing



- Difficulty or inability to breastfeed
- Painful compression of nipples, bleeding, cracked and flattened nipples
- Mastitis, engorgement, thrush
- Vasospasm of the nipple
- Anxiety, stress & fatigue, feelings of guilt
- Postpartum depression
- Slow weight loss from pregnancy
- Low milk supply
- Early cessation of lactation

Treatment of tongue- and/ or lip-tie

Frenectomy/frenotomy has a low risk for infection or bleeding and does not usually require stitches, sedation, or numbing agents, although they may be available. The newborn is wrapped in a blanket or held by the parents for a few seconds while the frenulum is clipped. It takes a few seconds to clip the frenulum (about 2-8 mm) with small scissors, a scalpel, or a laser. There is usually only a tiny amount of bleeding.



After the treatment is completed, babies can immediately breastfeed, and many nursing parents have reported immediate pain relief, extended nursing, and improved infant sleep.

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Follow-up treatment is important!

If the frenulum isn't clipped until the baby is several weeks or months old, it may take longer for them to learn to suck normally. Sometimes suck training is needed to adapt to the new range of motion. Even though the anterior (front) tongue-tie has been released, there may still be some posterior (back) tongue-tie remaining, which may continue to affect breastfeeding. Some clients may need to use alternative feeding methods like the nipple shield, finger feeding, or the bottle if feeding continues to be painful. It is recommended to have further evaluation by a pediatric dentist for persistent breastfeeding problems. Once the tie is revised, our lactation consultants can help clients with any remaining breastfeeding issues.

We refer our clients to **Dr. Spencer Tasker or Dr. Stanley Hess** who are pediatric dentists in Albuquerque that do laser revision of the lip and tongue-ties. You might want to look up two of the well-known dentists who do research and publish on the topic: Dr. Lawrence Kotlow in Albany, New York and Dr. Bobby Ghaheri in Portland, Oregon. Check out their websites for extensive information.

Some of this information was gathered from www.bostontonguetie.com and ngdentalcenter.com

Three-Day Visit

This is a follow-up visit between 60-78 hours at the center to see how client and baby are doing. Your recovery, breastfeeding, jaundice and infant weight gain will be assessed as well as how the family is adjusting. Birth certificates and paternity papers need to be completed at this visit also.

Critical Congenital Heart Disease (CCHD) Screen

Congenital heart defects are the most common group of birth defects. Newborn screening using pulse oximetry can identify some infants with critical congenital heart defects which represent about 25% of all congenital heart defects. CCHDs are structural heart defects that often are associated with hypoxemia among infants during the newborn period and typically require some type of intervention – usually surgical – early in life. Without screening, some newborns with CCHDs might be missed because the signs of CCHD might not be evident before an infant is discharged from the birth center or hospital after birth. Infants with CCHDs are at risk for significant morbidity or mortality early in life because of closing of the ductus arteriosus or other physiologic changes. The targets of CCHD screening include 7 primary targets (hypoplastic left heart syndrome, pulmonary atresia with intact septum, tetralogy of Fallot, total anomalous pulmonary venous return, transposition of the great arteries, tricuspid atresia, and truncus arteriosus) and 5 secondary targets (coarctation of the aorta, double outlet right ventricle, Ebstein anomaly, interrupted aortic arch, and single ventricle). Pulse oximetry screening does not detect all CCHD, so it is possible for a baby with a negative screening result to still have CCHD or other congenital heart defects.

This is a state mandated screening that is done in the infant's first week of life and will be done at the 24–36-hour home visit. A pulse oximeter is placed on the right hand and either foot and is used to measure the percentage of hemoglobin in the blood that is saturated with oxygen. False positives are decreased if the infant is alert, and timing CCHD screening after 24 hours of age improves efficiency. Your baby would get a negative screen if the oxygen saturation levels are above 95% on both limbs and means you baby is unlikely to have a CCHD. A positive screening result occurs when the baby's oxygen saturation levels are below 95% on both limbs. In this case, we would recommend and help schedule an echocardiogram as soon as possible for your baby to evaluate the heart and the way the blood flows through it. This might require hospitalization depending on the severity of the defect.

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Newborn Jaundice

Jaundice is caused by an increased level of bilirubin in the blood. The increased bilirubin causes the infant's skin and whites of the eyes to look yellow. Bilirubin is created in the body during the normal recycling of old red blood cells. The liver helps break down bilirubin so that it can be removed from the body in the stool. However, babies have immature livers and are not able to process bilirubin as effectively as adults. Frequent feedings (up to 12 times a day) encourage frequent bowel movements, which helps remove bilirubin.

Jaundice is present to some degree in most newborns, and is called "physiological jaundice." It usually appears between day 2 and 3, peaks between days 3 and 5, and clears by 2 weeks. Physiological jaundice usually causes no problems and does not need any treatment.

Jaundice is more common in breastfed babies because they get colostrum in small amounts in the first few days before the milk comes in and have few stools that can get rid of the bilirubin. This happens more when a newborn does not get a good start to breastfeeding or has an improper latch which interferes with breastfeeding. It often will resolve itself with increased feedings and help from a lactation consultant to make sure the baby is indeed taking in adequate amounts. Rarely does a breastfed baby need any other type of treatment besides these for physiologic jaundice.

Sometimes, infants with significant jaundice have extreme tiredness and poor feeding. If your baby does not feed every 3-4 hours or you cannot keep your baby awake to feed well, *call the birth center (924-2229) or the midwife on call (944-5488) immediately* so we can assess the baby and draw blood if needed.

Mildly elevated bilirubin can be treated at home by placing your baby (with only a diaper on) in a bassinet next to a window in indirect sunlight. If your baby's bilirubin levels are elevated to a level that treatment is indicated, we can usually set up treatment at home with "ultraviolet lights or blankets". Some may require hospitalization and treatment with ultraviolet lights, called phototherapy. These lights work by helping to break down bilirubin in the skin. Excessive jaundice can cause a very serious condition called kernicterus which is a form of brain damage.

Two Week Visit

You will need to make an appointment for you and your baby to visit the birth center between 10 to 14 days of age to check your baby's growth and do the second part of the newborn metabolic screen. It is normal for your baby to lose some weight after birth but your baby normally regains this weight by two weeks of age. Breastfeeding and emotional adjustments will be assessed for you, and support given as needed.

Four Week Visit

This is baby's last visit at the birth center to check growth, breastfeeding and do a hearing screen. You will need to make an appointment at 2 months with your pediatric provider. You may sign a release of records at the center and we will send the baby's records to the provider or we can email you a copy of the records.

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Newborn Hearing Screen

Universal hearing screening programs have been implemented across the United States because hearing loss is one of the most common congenital anomalies, occurring in approximately 2-4 infants per 1000. The cause of hearing loss for many babies is not known, and hearing loss can go unnoticed for years. Early identification allows families to make decisions about their child's care that can affect speech, language, and social development.

There are two kinds of screening tests:

1. The Auditory brainstem response (ABR) test monitors brain wave activity in response to sound using electrodes that are placed on the baby's head and ears.
2. An otoacoustic emissions (OAE) test uses a small, very sensitive microphone inserted into the ear canal to monitor the faint sounds produced by the outer hair cells in response to stimulation by a series of sounds at different frequencies. ABR and OAE testing are painless and can be used for newborn babies and infants as well as older children and adults.
3. All infants born at the birth center will be screened for hearing loss using the OAE test between 2-4 weeks. If your baby does not pass this hearing screening by the 4-week visit, you will be referred to a local auditory screening office where they will do further testing. Usually, the babies pass the test but they may recommend repeat screening in a year. All babies born in the hospital will be tested with the ABR test prior to discharge. Even if your baby has passed their hearing screen at the birth center or hospital, these tests may not pick up all hearing loss including auditory neuropathies which are very rare. If you think that your baby can't hear, bring this to the attention of your pediatric provider immediately.

Six to Eight Week Visit

Your last postpartum visit. Assessing breastfeeding, emotional adjustment and physical recovery. Pap smears are done if indicated and we will discuss your plans for birth control.

Annual Exam

We recommend that you return annually for a well woman/healthcare visit. Preventative health including diet, exercise, breast exam, pap smear, birth control and a general health examination are done at this time. The midwives at Dar a Luz can provide your preventative care as well as problem visits and other concerns. We offer all forms of birth control including prescriptions, IUDs and referrals for sterilization. We are able to make referrals for ultrasounds and mammograms.

A baby will make love stronger, days shorter, nights longer, bankroll smaller,
home happier, clothes shabbier, the past forgotten,
and the future worth living for.

~ Unknown

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Postpartum Changes: Weeks 2 to 8

Please refer to the **"Discharge Instructions for You & Baby"** section for the first week after birth. You will also be given a separate postpartum discharge summary handout after the birth. This section refers to the postpartum changes you can expect during the first 8 weeks. Your body goes through many changes to return to a non-pregnant state. You and your family will be adjusting to a new family member. Your postpartum appointments are just as important as your prenatal visits. Call ***the birth center (924-2229) or the midwife on call (944-5488)*** if you are having problems.

Physical Changes

- You will have vaginal bleeding like a period for 1 to 2 weeks after your baby is born. The bleeding decreases over the next 3 to 4 weeks but can last up to 6 weeks. The vaginal discharge changes from red to brownish. Do not use tampons, douches or have sex until the bleeding stops.
- ***If you start bleeding more than 1 pad an hour, soaking a large pad in one hour, have extremely painful cramping, continuous blood clots or foul-smelling blood, call the birth center (924-2229) or the midwife on call (944-5488) immediately.***
- You will have soreness in your vaginal area for a week or more especially if you had stitches. The stitches should dissolve and usually do not have to be taken out. Taking a warm bath 2-3 times a day helps your stitches to heal faster and decreases the soreness. Once in a while the stitches do not completely dissolve and your midwife will need to remove parts of them.
- If you are having problems with hemorrhoids or constipation, you can use the same relief measures listed in the pregnancy discomforts section of this booklet.
- After birth, your uterus is about the size of a volleyball and can be felt at the level of your belly button. It should feel firm and you should give it a massage every couple of hours for the first couple of days. It is normal for you to feel cramping while breastfeeding and you can take ibuprofen 800 mg every 8 hours as needed. Your uterus returns to a normal size in about 6 weeks. Breastfeeding will make this happen faster.

Breastfeeding

- We strongly recommend and encourage breastfeeding for all infants and believe it is the best nutrition for human babies.
- The American Academy of Pediatricians recommends exclusive breastfeeding through six months of age and breastfeeding for the first year of life.
- Breast milk is the perfect food for your baby. It has the perfect amount of protein, fat and water. It changes to meet the demands of your baby's growth.
- Babies brains grow more quickly than any other part of their body and breast milk is designed to facilitate that growth.
- Breast milk is made up of foremilk which is full of carbohydrates and hindmilk which is rich in protein and fat, the most important nutrients for growth and development.
- It is very important to breastfeed your baby every 2-3 hours around the clock. Babies may nurse on only one side but usually need to nurse at least 15-20 minutes to get the hindmilk.
- Breastfed babies cannot be overfed. They are less likely to be obese.
- Breast milk is a supply and demand system: The more the baby nurses, the more milk you make.
- Good nutrition and hydration are essential for good milk supply.

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Nutrition

- Most clients lose about 12-17 pounds in the first week after the baby is born.
- Everyone loses some weight after birth. Breastfeeding may help you lose more weight than formula feeding.
- It is a good idea to take your prenatal vitamins as long as you are breastfeeding. Taking a vitamin daily is a good way to help get all the nutrients you need, and prenatal vitamins are fine to take when you are no longer pregnant too.
- Drink 8-10 glasses of water daily especially if you are breastfeeding. Milk supply is dependent on good nutrition and hydration.
- Eat high fiber foods like whole grains, fresh fruit and vegetables to prevent constipation.
- Breastfeeding may burn up to 500 calories/day, so it's important for you to continue good nutrition.
- Use the food group chart in the section "Nutrition and Healthy Lifestyles: Food Group Chart" to eat a healthy diet. This will help your body recover from pregnancy.

Exercise and Activities

- Try to rest or nap when your baby sleeps.
- Have family or friends help you at home so you can rest. For the first 1-2 weeks you should not be cleaning house, cooking long meals, doing lots of laundry, shopping, or having lots of company.
- Walking is good exercise for the first 6 weeks and then you can return to your normal exercises. You can start walking about a week after birth. If your bleeding increases, wait a few days and try again.
- If vaginal bleeding increases with any activity or exercise, decrease your exercise and activities.
- Kegel exercises help tighten the muscles of the birth canal. Strong muscles stop you from urinating when you cough or sneeze. Practice these up to 100 times a day by squeezing the muscles you would use to try to stop your urine flow.

Mother/Birthing Parent in Relation to Others

- Be sure to ask family and friends for help with the baby when you're tired or feel stressed.
- It is a good idea to spend time alone with your partner weekly. This is the perfect time for both of you to share your needs and fears.
- It is common for older siblings to become jealous and act younger than their age when you bring your new baby home. It will help to involve the siblings in the care of your baby. Be sure to spend special time with them only.
- Most clients' bodies are healed in four to six weeks after birth but you may not have a period. Remember that you can get pregnant again even before you have a normal period.
- You and your partner can decide when you want to have sex again but we recommend waiting for 6 weeks for the uterus to heal and suggest using a condom. You may want to explore other ways to feel close to your partner during this time. It is common to have decreased sexual desires due to hormonal changes, fatigue and lack of privacy. You may have discomfort during sex due to dryness. Use of lubricants may be helpful.

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Emotions

Many clients have the “baby blues” during the first 2 weeks after having a baby. This usually goes away within a few days or a week. You may experience some of the following symptoms:

- Mood swings
- Feel sad, anxious or overwhelmed
- Have crying spells
- Lose your appetite
- Have trouble sleeping

Depression and Anxiety During and After Pregnancy

Depression and anxiety are more than just feeling “anxious,” “blue,” or “down in the dumps” for a few days. Each is a serious illness that involves changes in the brain chemistry and structure.

Anxiety feels terrible, and includes a fear for the future. We all experience anxiety from time to time, but when it happens often, it can become a habit of both thoughts and physiological reactions. You might worry about the world around you, someone you love, or yourself. Anxiety can take on many forms, including social anxiety, panic, fear of crowded or enclosed spaces, fear/phobia of something specific, or general anxiety. Restlessness, fatigue, concentration issues, muscle tension, irritability, and sleep disturbance are all symptoms. Panic takes anxiety to a whole different level. It can present as an abrupt surge of intense fear, sometimes seemingly out of nowhere. Panic is a true fight-flight-freeze reaction, and can be terrifying. Symptoms include a pounding heart, sweating and shaking, shortness of breath, chest pain, nausea, feeling dizzy or lightheaded, feeling chilled or overheated, having numbness or tingling of the extremities, a sense of loss of reality (derealization) or a sense of loss of self (depersonalization), or fearing going crazy or even dying. All of this is a normal reaction to something that you perceive to be life-threatening; what assign to that category doesn’t always make rational sense. We share this information to normalize something that a number of our clients sometimes experience… and to let you know that, **if you’re experiencing anxiety and/or panic, you’re not alone, and that there is help available.** Reach out to a midwife or a mental health professional if you’re experiencing new or worsened anxiety and/or panic which disturbs your work or social life. Therapy alone is often helpful, and sometimes medication is needed regulate your emotional state to a more bearable level. It can happen at any time, but anxiety can be triggered by pregnancy and birth, or your feelings about these life events. See the sections “**Depression/Anxiety Warning Signs**” for ideas of what to look out for.

Depression. When sad feelings don’t go away, it can be mild to severe and will interfere with your day-to-day life and routines. About 13% of pregnant clients and new mothers/birthing parents have depression; sometimes dads and other parents are affected too. Depression is usually the result of a combination of factors. Stressful life events can trigger depression and hormonal factors unique to women and those giving birth may also contribute to depression. Females are at greater risk during puberty, pregnancy, postpartum and menopause. Depression after childbirth is called **postpartum depression** and can begin anytime within the first year after childbirth. The quick changes of hormones after birth and dropping levels of thyroid hormones can cause symptoms of depression. Lack of sleep, feeling overwhelmed with a new baby and doubting your ability to be a good parent can also play a role in postpartum depression. The stress from changes in work and home routines and grief over the loss of who you were before having a baby can be overwhelming.

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Some are more at risk for depression and anxiety during and after pregnancy. These risk factors include:

- A personal or family history of depression, anxiety, or another mental illness
- A lack of support from family and friends
- Anxiety or negative feelings about the pregnancy
- Problems with a previous pregnancy or birth
- Marriage or money problems
- Stressful life events – death of a loved one, caring for a family member, abuse, poverty
- Young age
- Substance abuse – alcohol, tobacco, drugs

Most depression gets better with counseling and some people also need medication. If you prefer to do self-paced therapy, you may benefit from "The Pregnancy and Postpartum Anxiety Workbook." You can buy it at www.amazon.com/Pregnancy-Postpartum-Anxiety-Workbook-Compulsions/dp/1572245891

There are a few things you can do to reduce your risks for depression. Here are some helpful tips:

- Rest as much as you can. Sleep when the baby is sleeping.
- Don't try to do too much or try to be perfect.
- Ask your partner, family and friends for help.
- Make time to go out, visit friends or spend time alone with your partner.
- Discuss your feeling with your partner, family and friends.
- Talk with other parents so you can learn from their experiences.
- Join a support group.
- Don't make any major life changes during pregnancy or right after giving birth that will cause more stress.

Untreated depression can hurt you and your baby. Some clients may eat poorly and not gain enough weight during pregnancy. Clients may have problems sleeping. It may increase the risk of problems during pregnancy or birth. Rates of preterm birth and low birth weight babies are higher in those with depression. Untreated postpartum depression and anxiety can affect your ability to parent. You may lack energy, have trouble focusing, and be unable to meet your child's needs. Depression can cause delays in language development, problems with mother-child bonding, behavioral problems and increased crying. If you are feeling depressed, please tell a loved one and ask for help caring for the baby. Partners and birthing parents/moms: read the section "**Depression/Anxiety Warning Signs**" and reach out if needed.

Support Groups for Mothers, Parents, Partners, and Families

At Dar a Luz, we care about every family and constantly strive to find ways to offer support! Most groups are FREE and open to the community. For group descriptions and current schedules, visit our website.

Here's a quick overview of the groups that might be offered.

- ❖ **Postpartum and Feeding Support Group**
- ❖ **Mindful Partnering, Mindful Parenting**
- ❖ **Postpartum Support Group for Moms and Birthing Parents**
- ❖ **Anxiety Support Group**
- ❖ **Pappy Hour and Piñon Pappies**
- ❖ **Reunion groups** - scheduled with birth class teachers. Reunite with your five-week class group.

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Depression/Anxiety Warning Signs

You or a family member needs to ***call the birth center (505) 924-2229 or the midwife on call (505) 944-5488*** if you have the following symptoms that last more than 2 weeks:

- Feeling restless or moody
- Feeling sad, hopeless, and overwhelmed
- Excessive worry about the baby or your ability to parent/mother
- Intrusive anxious thoughts about the worst-case scenarios
- Crying a lot
- Having no energy or motivation
- Eating too little or too much
- Sleeping too little or too much
- Having trouble focusing or making decisions
- Having memory problems
- Feeling worthless and guilty
- Losing interest or pleasure in activities you used to enjoy
- Withdrawing from friends and family
- Thoughts of harming yourself or your baby

Postpartum Warning Signs

You need to ***call the birth center (924-2229) or the midwife on call (944-5488)*** if you have any of the following symptoms:

- Fever over 101°F or chills and body aches
- Bad smelling vaginal discharge
- Strong abdominal or vaginal pain not helped by pain medicine
- Surgery incision that is open or has pus
- Severely painful, red or lumpy breasts lasting more than 24 hours
- Bleeding through a regular size pad every hour
- Severe leg pain that is worse when you stand or walk
- Painful red spot or streak in one or both breasts, fever over 101°F, chills or body aches

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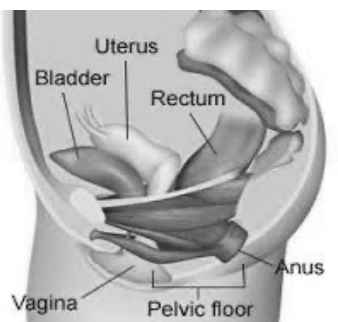
Postpartum Exercises

Pregnancy puts a huge strain, not just physically but emotionally on a new parent. During this early recovery period, you may have a negative body image and lack abdominal tone. To allow for your baby's growth during pregnancy your skin and stomach muscles have stretched and weakened. Your joints have loosened to facilitate passage of the baby's head through the pelvis. Don't get too discouraged as these will take time to return to their original state. Start these re-toning exercises about one week after birth or when you feel ready. It is also essential to use good body mechanics in your everyday activities, to protect the joints and ligaments until the muscles regain their former strength. Many new moms/parents find that walking after 2 weeks postpartum is a great way to start exercising and helps them get outdoors with their baby. At your last postpartum visit, the midwife will evaluate your diastasis and pelvic floor muscles. If these have not returned to normal, we will refer you to physical therapy for evaluation and treatment – but we endorse pelvic floor physical therapy for everyone!

Pelvic Floor Exercises – Kegels



Pregnancy, childbirth, surgery, aging, excessive straining from constipation or chronic coughing, and being overweight may weaken the pelvic floor muscles. Kegel exercises strengthen these muscles, which support the uterus, bladder, small intestine and rectum and can help prevent leakage of urine while sneezing, laughing or coughing (stress incontinence). Kegel exercises can be done anytime during pregnancy or after childbirth.

To identify your pelvic floor muscles, stop urination in midstream. If you succeed, you've got the right muscles. Think of tightening and pulling inward, not bearing down. Be careful not to flex the muscles in your abdomen, thighs or buttocks. Avoid holding your breath. Instead, breathe freely during the exercises. When beginning to strengthen the pelvic floor, you will want to perform two different types of Kegel exercises:

1. **Prolonged hold** - squeeze pelvic floor and hold for 10 seconds followed by a 20 second rest. This rest break is equally as important as the contraction. Perform 10 repetitions and do this 3 times a day.

2. **Quick hold** – squeeze the pelvic floor, hold the contraction for 5 seconds, and then relax for 5 seconds. Start with 3 sets of 10 working up to 10 sets as you get stronger.

Please note: pelvic floor physical therapists recommend evaluation before starting Kegel exercises, as you may actually benefit from relaxation exercises instead, depending on the issue(s) you're facing.

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Post Pregnancy Abdominal Routine - The Sahrmann Technique

Abdominal exercises designed by the physical therapist Shirley Sahrmann target the lower abdominals without putting too much stress on the post pregnancy abdomen and back that traditional sit-ups do. This sequence of exercises eliminates stress on the lower back and also the diastasis recti - a thinning and widening of the connective tissue between the recti muscles that occurs during pregnancy. The series of exercises gradually get harder and harder allowing your abdominals to strengthen and tone progressively. Try not to move through the exercises too quickly as you risk recruiting other muscle groups to aid in the movement and possibly cause injury.

Sahrmann Abdominal Rehabilitation Exercises

Before you can start Step One you need to master the **basic breath.** This will teach you how to isolate and control your abdominal muscles as you move your legs through a series of exercises.

1. Lie on your back with your arms at your side, knees bent and feet resting on the floor. Inhale and exhale a few times.
2. Don't flatten your back or tilt your pelvis, just let the natural curve in your back remain. Breathe in slowly and deeply.
3. Now breathe out and tighten your abdominal muscles, pulling your navel towards your spine. Remember to concentrate on contracting the muscles below your belly button and don't flatten your back.
4. When you are able to contract and relax your abdominal muscles without moving your back, you have learned to properly isolate the correct muscles. You can then try the next step

Step One

Figure 1

Figure 2

1. Lie on the floor with knees bent, feet resting on floor and arms at your side (see Figure 1).
2. Hold your abs in by doing your basic breath contraction. Keep breathing as you hold the muscles in and, keeping one leg bent, slowly slide the other leg out until it is straight with the floor and then slide back up to bent knee position (see Figure 2). Relax your abdomen.
3. Repeat the process for the other leg. Remember don't flatten you back and keep the curve relaxed.
4. When your abdominal muscles are contracted, it helps to stabilize your pelvis while your legs and lower ab muscles work. This prevents strain in your back muscles, and it trains your abdominal muscles to protect and support your spine. When you can comfortably do 20 legs slides on each side, you can move to the next step.

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Step Two

Figure 3

Figure 4

1. Lie on floor with knees bent, feet resting flat on the floor and arms at side.
2. Pull in on your tummy and hold, then raise one knee towards your chest (see Figure 3) and slowly straighten it out parallel to (about two to three inches above the floor) but not touching the floor (see Figure 4).
3. Return extended leg to starting position, knees bent, feet resting on floor and relax your tummy.
4. Repeat on opposite side, keeping one knee always bent as you extend the other leg. Work up to five repetitions on each side without stopping, building to 20 repetitions or more on each side.
5. Once you can do 20 reps on each leg you can move onto Step 3

Step Three

Figure 5

Figure 6

1. Lie on the floor with your knees bent and your arms at your side (see Figure 5).
2. Use your basic breathing as you bring your legs up one at a time toward your body with knees bent at a 90-degree angle.
3. Keep one leg bent as you slowly lower the other leg down to the floor and back up (see Figure 6). Repeat on the opposite side, working up to 20 times each leg.
4. If you can comfortably do 20 repetitions each leg of Step 3, you are ready to move on to Step 4

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Step Four

Figure 7

Figure 8

1. Do your basic breathing as you bring both legs up and bend knees to 90 degrees (see Figure 7).
2. Slowly extend one leg out parallel with the floor but not touching it (see Figure 8).
3. Bring the leg back and repeat with opposite leg. Work up to 10 repetitions each leg.
4. With each repetition, remember to keep breathing. Contract your abdomen as you move your leg, and don't let your back pop up. If the arch in your back keeps popping up during the exercise, it means you're not strong enough to progress to this level and need to go back to the previous exercise until you build greater strength.
5. You may try this exercise when you can do Step 4 20 times each leg while maintaining your abdominal contraction without your back arching

Step Five

Figure 9

Figure 10

1. Using your basic breathing, bring both legs to your chest one at a time.
2. Straighten both legs up at a 90-degree angle from your hip (see Figure 9).
3. Slowly lower your legs down together toward the floor (see Figure 10). Go only as far as it feels comfortable, and if you feel your back beginning to arch, bring your legs back up and lower them again only to the point where you notice your back arching. Work up to 20 repetitions.
4. If you notice back pain with this exercise, discontinue doing it and maintain at Step 4.
5. Step 5 may not be appropriate for clients who have low back pain.

With each exercise, remember to keep breathing, contract your abdominals as you move your leg and don't let your back pop up. If the arch in your back keeps popping up during the exercise, it means you're not strong enough to progress to this level, and you need to go back to the previous exercise until you build greater strength

Work through each stage nice and gradually making sure you can comfortably do the 20 reps per leg before moving on. It is a great progressive abdominal plan that can be easily added into your daily schedule and done from home.

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Birth Control

There are many forms of birth control available. Please refer to the chart below for information on most birth control methods. Typical failure rates are listed as the number out of 100 people who will become pregnant by the end of the year. If you are breastfeeding every 2-3 hours around the clock, you may not have a period for 3-6 months but you may not have a period as long as you are breastfeeding. Even though you do not have a period, you can still get pregnant. If you are formula feeding, you may have a period within a month after the baby is born. If you do not use birth control, you can get pregnant. Talk to your midwife to decide which method is best for you.

Birth Control Method	Typical Failure Rates	Use	Risks	Side Effects	Benefits
No Method	85%		Pregnancy, sexually transmitted infections		No hormones, no effect on fertility or lactation
Spermicides (cream, film)	29%	Vaginal use prior to sexual contact	Vaginal and urinary tract infections	Vaginal irritation, allergy	No hormones, no effect on fertility or lactation
Withdrawal	27%	Removal of penis from vagina before ejaculation	Sexually transmitted infections		No hormones, no effect on fertility or lactation
Fertility Based Methods Natural Family planning, periodic abstinence	25%	Record menstrual cycles monthly, check cervical mucous, take basal body temperature, no sex during fertile times	Difficult to practice, pregnancy, sexually transmitted infections	No sex during a large portion of each month	No hormones, no effect on fertility or lactation
Female condom	21%	Covers labia area and fits inside vagina	None known	May be noisy, less sensation	Protects against sexually transmitted infections
Diaphragm, cap, sponge	16%	Inserted into vagina prior to sexual contact	Vaginal and urinary tract infections, less effective in those who have had children, toxic shock syndrome is rare	Pelvic pressure, vaginal irritation, vaginal discharge if left in too long, allergy	No hormones, no effect on fertility or lactation
Male condom	15%	Apply to penis before sex	Severe allergic reaction to latex rarely happens	Less sensation, loss of spontaneity	Protects against sexually transmitted infections
Pills, Patch, Ring (estrogen and progestin methods)	8%	Take pills daily, apply patch weekly, insert ring monthly, will have monthly periods	Rare but possible risks include stroke, heart attack, blood clots, high blood pressure, depression, liver problems	Nausea, headaches, dizziness, spotting, weight gain, breast tenderness, may decrease milk supply	Decreases menstrual pain and bleeding, less PMS symptoms, protects from ovarian and uterine cancer
Minipill (progestin only)	8%	Take pills same time daily, monthly periods	May be less pills, patch or ring	Spotting or no menses, breast tenderness	Very low dose of hormones, same benefits as pills, minimal or no effect on lactation

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Birth Control Method	Typical Failure Rates	Use	Risks	Side Effects	Benefits
Depo-Provera® Injection	3%	Intramuscular injection every 12 weeks, no period after a year of use	Depression, allergic reactions, possible bone loss with long term use	Spotting and irregular bleeding for 3 to 6 months, weight gain, headaches, may take up to a year to get pregnant	Reduces risk of seizures, may protect against ovarian and uterine cancers, Minimal or no effect on lactation
Lactational amenorrhea	1.5%	May be effective for 3-6 months if **EXCLUSIVE** breastfeeding (no bottles or pumping) and no postpartum menses	Fertility returns before menses so may be at risk for pregnancy	Rare side effects include breast infection associated with breastfeeding	Good **TEMPORARY** method, excellent nutrition for infants under 6 months old
Nexplanon®	1%	Hormonal rod inserted under skin on arm; good for 3 years	Rarely infection at implant site, difficult removal, depression	Irregular bleeding most common reason to stop using method	Less menstrual bleeding and cramping
IUD (Paragard® copper T)	0.8%	Inserted in uterus, good for 10 years, monthly periods	Infection and uterine perforation when inserted, IUD may fall out	Menstrual cramping, spotting, increased bleeding	No hormones, no effect on fertility or lactation
IUD (Mirena® progestin releasing) (Skyla – lower dose progestin)	0.1%	Inserted in uterus, good for 5 years, light or no periods Sklya good for 3 years.	Infection and uterine perforation when inserted, IUD may fall out	Spotting and irregular bleeding for 3 to 6 months, no periods after one year with Mirena	Less menstrual bleeding and cramping, no effect on lactation
Tubal ligation (Female permanent sterilization)	1.0%	Outpatient Surgery	Bleeding, infection, anesthesia problems, damage to surrounding organs	Pain at surgical site, cramps, bleeding. Regret of doing procedure	Less concern about unwanted pregnancy, may increase sexual pleasure
Vasectomy (male permanent sterilization)	0.15%	Outpatient Surgery. Requires confirmation test. Effective in 3-6 months.	Infection, anesthesia problems	Pain at surgical site, psychological reactions, subsequent regret that the procedure was performed	Safer and cheaper than female sterilization, no effect on male sensation, performance or stamina
Emergency contraception (Plan B, or Paragard® copper T)	Lowers pregnancy risk by 75% with pills, 89% with mini pills and 99% with IUD	Take pills or insert IUD within 120 hours (5 days) after unprotected sex	Risks same as for pills and copper IUD	Nausea and vomiting with pills, menstrual cramping, spotting and increased bleeding with IUD	If emergency contraception pills fail, no harmful effects on pregnancy, IUD will provide 10 years of contraception
Abstinence (no sex)	0%	No vaginal, oral or anal sex	None	None	No hormones, no effect on fertility or lactation, prevents sexually transmitted infections

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Health Care for Your Baby

Your baby will be born soon! The midwives can care for healthy babies for the first 28 days but you need to have a pediatric provider selected by 36 weeks of pregnancy to care for your baby after the first month. Your baby should begin regular checkups starting at 2 months of age to make sure that he/she is healthy and developing normally, and to start vaccinations.

Immunizations

The birth center does not offer the Hepatitis B vaccine at this time; however, we are supportive of immunizations. We respect your right to choose whether to immunize your child and see our role as one of giving good evidence-based information so that you can make an informed decision. You may choose to start their immunizations at their first visit with the pediatric provider. We agree with the information posted on the After Hours Pediatrics website listed below:

> "*We believe that immunizations are the single most important medical intervention for children. They are as important in the United States as they are anywhere in the world. The modern program to immunize American children has done more to decrease illness and save lives than any other intervention in the last 50 years. Despite our success, though, only one illness (smallpox) has been eliminated through immunizations. Every other illness for which we immunize children remains a threat. These illnesses are held in check only because we continue to actively immunize our children.*
>
> *We strongly believe that the claims of an association between immunizations and autism are completely false. Several mechanisms by which immunizations might cause autism have been proposed. In each instance, further investigation has shown the proposed theory of causation to be false. Furthermore, no study has shown that children who are immunized are more likely to develop autism than those who are not. Thoughtful scientists and pediatricians have difficulty understanding why someone would even suggest that immunizations cause autism. Why use a completely false premise to discourage people from accessing the most important preventive health benefit available to children?*
>
> *As more and more parents choose not to immunize their children the risk to* ***your*** *child becomes even greater. Recent outbreaks in New Mexico of both measles and pertussis are reminders that the protective effect of 'herd immunity' is diminishing and the risk of serious preventable illness is increasing. As a result, it is even more important to immunize your child today than it would have been 15 years ago."*

The Children's Hospital of Philadelphia website gives reliable, well organized and easy to read information on each vaccine, vaccine safety and vaccine science. www.chop.edu/service/vaccine-education-center/home.html

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Below is the New Mexico Department of Health recommended immunization schedule and you can access more information at www.immunizenm.org. A reputable source for research on causes of autism is http://www.autismsciencefoundation.org/autismandvaccines.html.
Immunization hotline: (800) 232-4636.

Vaccines	Birth	1 mo.	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.
Hepatitis B	#1	#2			#3		
Rotavirus			#1	#2	#3		
Diphtheria/Tetanus/Pertussis (DTaP)			#1	#2	#3		#4
Haemophilus influenzae type b (Hib)			#1	#2	#3	#4	
Pneumococcal			#1	#2	#3	#4	
Polio			#1	#2	#3		
Influenza					Annual vaccination		
Measles/Mumps/Rubella (MMR)						#1	
Varicella (Chickenpox)						#1	
Hepatitis A						2 doses 6 month apart	

How Do You Choose a Pediatric Provider?

Some families prefer to go to their family doctor or nurse practitioner. Others choose to go to pediatricians. Convenience of location and hours may be important to you. Your health insurance may dictate where you can go. You may ask around to find out what other parents think about their child's provider. Here are some questions you may want to ask when you interview potential healthcare providers.

- Call the office and ask about the provider's background and training.
- It is a group or individual practice?
- Ask about office hours (including nights or weekends), making appointments for well and sick visits.
- Who handles emergency calls and where would your child be admitted to the hospital if needed?
- If you have routine questions, who handles those and when can you expect a return call?
- Do they perform circumcision if this is something you want for your child?
- What vaccinations do they recommend and are they supportive of alternative schedules?
- Are they supportive of breastfeeding? If so, what programs do they have to support breastfeeding?
- Do they give out formula samples and have formula advertising in the waiting room?
- What would they do if you were exclusively breastfeeding and your baby wasn't gaining enough weight?
- Do you feel like they are genuinely interested in your baby?
- Do they communicate clearly in terms you can understand?
- Do they listen to your concerns?
- Do you like them?

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Pediatric Provider List

Below is a list of practices providing pediatric care in the area. Contact a provider soon to find out if they are accepting new clients and can meet your needs.

After Hours Pediatrics

East Side
9201 Montgomery Blvd NE (505) 298-2505
Paseo Del Norte
5904 Holly Ave (505) 298-2505
Rio Rancho
1534 Unser Blvd SE (505) 298-2505
West Side
9210 Golf Course Rd NW (505) 298-2505

Bebe Care, Dr Beggs
4333 Pan American Fwy NE (505) 266-3835

Davita Medical Group Pediatrics (ABQHP)
Coors
2929 Coors Blvd NW, Suite 200 (505) 839-2300
Journal Center
5150 Journal Center Blvd NE (3rd Floor) (505) 262-3219
Rio Rancho
1721 Rio Rancho Blvd SE (505) 896-8600
Sunport
2901 Transport ST SE (2nd Floor) (505) 262-7594

Face to Face Pediatrics (Holistic virtual and in-home care)
Dionne Cozier Ross, MD www.facetofacepediatrics.com (505) 938-9571

Family Practice Doctors in the area giving high quality low volume care
Mark Unverzagt, MD
925 Coal Ave SW www.medicinedowntown.com (505) 246-1670
Jeff Miller, MD
3900 Eubank Blvd NE, Suite 18 www.jeffreymillermd.com (505) 292-1818
Melissa Garcia, MD
711 Encino Place NE Ste D (505) 224-7400
Scott Brown, MD
1817 Central Ave NW (505) 265-2244
Carmen Rodriguez, MD
500 San Mateo Blvd NE Ste B (505) 262-6500

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First Choice Community Healthcare

Alameda	
7704 – A 2nd ST NW	(505) 890-1458
Alamosa	
6900 Gonzales Rd. SW	(505) 831-2534
Belen	
120 S. 9th St., Belen	(505) 861-1013
Edgewood	
8 Medical Ctr Rd, Edgewood	(505) 281-3406
Los Lunas	
145 Don Pasqual NW	(505) 865-4618
North Valley	
1231 Candelaria Rd NW	(505) 345-3244
Rio Grande High School	
2300 Arenal Rd SW	(505) 873-0220 ext. 50086
South Broadway	
1401 William St SE.	(505) 768-5450
South Valley	
2001 N. Centro Familiar SW	(505) 873-7400

First Nations Community Healthsource

5608 Zuni Rd SE (505) 262-2481

High Desert Pediatrics

8650 Alameda Blvd NE, Suite 101E (505) 255-1866

Indian Health Service

801 Vassar Dr. NE (505) 248-7810

Presbyterian Pediatrics

Belen	
609 S. Christopher Rd	(505) 864-5454
Isleta	
3436 Isleta Blvd SW	(505) 462-7777
Northside	
5901 Harper NE	(505) 823-8282
Rio Rancho – High Resort	
4005 High Resort Blvd SE	(505) 462-6000
Rio Rancho	
3777 NM Highway 528 NE	(505) 404-2590
San Mateo	
401 San Mateo Blvd SE	(505) 462-7333

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Public Health Clinics – Immunizations only, no cost

Only available to non-Medicaid eligible patients and patients without private insurance. WIC services.

Belen	
617 Becker	(505) 864-7743
Bernalillo	
1500 Idalia Bldg B	(505) 867-2291
Estancia	
300 S 8th Street	(505) 384-2351
Los Lunas	
445 Camino del Rey	(505) 222-0940
Midtown	
2400 Wellesley Dr NE	(505) 841-4100
Moriarty	
1110 Rt 66	(505) 832-6782
North Valley	
7704 2nd Street NW	(505) 897-5700
Northeast Heights	
8120 La Mirada NE	(505) 332-4850
Santa Fe	
605 Letrado St	(505) 476-2607
Southeast Heights	
7525 Zuni SE	(505) 841-8928
Southwest Valley	
2001 Centro Familiar SW	(505) 873-7477
Westside	
6911 Taylor Ranch Rd NW Suite C-12	(505) 899-8574
UNM Hospital Ambulatory Care Center, Pediatrics Clinic, 3rd Floor	
2211 Lomas Blvd NE	(505) 272-2345

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UNM Family Practice and Community Medicine

Atrisco Heritage Center for Family and Community Health
10800 Dennis Chavez SW (505) 272-6009

Eubank Clinic
2130 Eubank Blvd NE (505) 925-2273

Family Health – 1209 Clinic
1209 University NE (505) 272-4400

Family Medicine Clinic
2400 Tucker NE (505) 272-1734

Northeast Heights Family Health
7801 Academy Blvd NE (505) 272-2700

North Valley Clinic
3401 4th ST NW (505) 994-5300

Southeast Heights on Central
8200 Central SE. (505) 272-5885

Southwest Mesa Center for Family and Community Health
301 Unser Blvd NW (505) 925-4126

UNM Family Health – Westside Clinic
4808 McMahon Blvd NW (505) 272-2900

Young Children's Health Center
306-A San Pablo SE (505) 272-9242

Los Alamos Pediatricians

Children's Clinic
3917 W Rd # 128 (505) 662-4234

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Resources

Adoption Assistance Agency	(505) 821-7779
Agora (Suicide Support Helpline)	(505) 277-3013
AIDS Hotline (CDC Information line)	(800) 232-4636
Amistad Crisis Shelter (teen temporary crisis center)	(505) 877-0371
Baby Net (referrals for medical and support services)	(800) 552-8195
Barrett House (meals, clothing for homeless women and children)	(505) 243-4887
Birth Certificates (Vital Records)	(866) 534-0051
Evidence Based Birth website	www.evidencebasedbirth.com
Head Start (education and family support services)	(866) 763-6481
Center for Reproductive Health (family planning, pregnancy options)	(505) 925-4455
Child Support Enforcement Division	(800) 288-7207
Trumbull Family Resource Center (Carseat Assistance)	(505) 256-2005
Domestic Violence Hotline/Shelter (S.A.F.E. House)	(800) 773-3645
ENLACE Comunitario (Domestic Violence/Sexual Assault survivor support)	(505) 246-8972
Joy Junction (family shelter)	(505) 877-6967
La Leche League (breast feeding support)	(505) 821-2511
Low-income Home Energy Assistance Program (LIHEAP)	(800) 283-4465
Milagro Program (substance abuse program for pregnant women)	(505) 463-8293
New Day Youth & Family Shelter (teen shelter)	(505) 938-1060
New Futures High School, 5400 Cutler Ave NE (for pregnant and teen moms)	(505) 883-5680

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New Mexico Solutions Center (505) 268-0701
(Medicaid inquiries/verification)

New Mexico Poison Control Center (800) 222-1222

Nurse Advice Lines

PresRN	(866) 221-9679
Molina Health Care 24-hour Nurse Advice Line	(888) 275-8750
Blue Cross Blue Shield Nurseline	(877) 213-2567
NM Health Connections CareConnect 24x7 Nurse Advice	(844) 308-2552
Tricare Nurse Hotline	(800) 874-2273

Paternity Testing by Mobile Medical Associates (costs $300-375) (505) 323-7999

Planned Parenthood (family planning, pregnancy options)

Central	(505) 265-3722
Candelaria	(505) 294-1577
San Mateo (surgical center)	(505) 265-9511
Rio Rancho	(505) 899-7900
Santa Fe	(505) 982-3684

Rape Crisis Center (505) 266-7711

Roadrunner Food Bank (505) 247-2052

Safer New Mexico Now (Car Seat Assistance) (505) 332-7707

Saint Joseph Community Health (505) 924-8000
(Home visiting program for first time parents)

Salvation Army (Family Assistance Program) (505) 881-4292

STD Clinic at Department of Health (DOH) (505) 841-4100

Storehouse (Children's clothing & food) (505) 842-6491

Storehouse West (Children's clothing & food) (505) 892-2077

WIC website: www.nmwic.org

WIC Offices at First Choice

Alamosa Center	(505) 831-4245
North Valley	(505) 345-8181
South Broadway	(505) 764-0271
South Valley	(505) 873-7416

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WIC Office at First Nations	(505) 262-2481
WIC Offices at Public Health	
Belen	(505) 864-7743
Los Lunas	(505) 222-0940
Moriarty	(505) 832-6782
Northeast Heights	(505) 332-4850
North Valley	(505) 897-5700
Rio Rancho, Bernalillo	(505) 867-2291
SE Heights (ABQ)	(505) 841-8928
Santa Fe	(505) 476-2607
Taylor Ranch, Westside	(505) 899-8574
Women's Housing Coalition (housing for single mothers)	(505) 884-8856
Youth Crisis Shelter (New Day)	(505) 938-1060

For more resources log on to www.mycommunitynm.org

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Glossary of Terms

Anemia - is a condition in which the body does not have enough healthy red blood cells. Red blood cells provide oxygen to body tissues. There are many types of anemia with the most common during pregnancy being iron deficient anemia. **Sickle cell anemia** is caused by sickle shaped cells that do not function properly.

Augmentation of labor – natural or artificial ways of making contractions stronger and closer together during labor. **Induction of labor –** natural or artificial ways of starting labor contractions.

Braxton-Hicks contractions or uterine tightening – The uterus is made up of muscle that is made to contract. It begins contracting early in pregnancy but is usually not felt until the 2nd or 3rd trimester of pregnancy. These are normal and can occur about 5-6 times a day.

Breech – refers to the fetal position when the baby's bottom is down in the pelvis instead of the baby's head. **Transverse** is when the baby is lying with the head and bottom at the sides of the uterus/abdomen. **Vertex** is the position of the baby when the head is down in the pelvis.

Cholecystitis - inflammation of the gallbladder that occurs most commonly because of an obstruction of the cystic duct from cholelithiasis (presence of bile sludge or gallstones). May require surgery to remove the blockage.

Chorioamnionitis – an inflammation of the fetal membranes (amnion and chorion) due to a bacterial infection. It typically results from bacteria ascending into the uterus from the vagina and is most often associated with prolonged rupture of membranes and labor.

Chronic hypertension – high blood pressure that exists over a long period of time, usually before pregnancy begins.

Congenital anomaly (**congenital abnormality**, **congenital malformation**, **birth defect**) - is a condition which is present at the time of birth which varies from the standard presentation. Some examples are heart defects, abdominal wall defects, extra toes or fingers, Downs Syndrome, kidney malformations and neural tube defects.

Cord prolapse – when a portion of the umbilical cord slips past the baby's head into the vagina and is trapped between the mother's pelvic bones and the baby's head. This can happen when the water breaks if the head is not down in the pelvis. This is an emergency because the oxygen supply to the baby is decreased or stopped.

Deep vein thrombosis (DVT) – when a blood clot forms in the legs or arms. A **pulmonary embolism (PE)** is a blood clot in the lung. It usually comes from smaller vessels in the leg, pelvis, arms, or heart.

Ectopic pregnancy – pregnancy that attaches in the fallopian tube (most common) or anywhere outside of the uterus. An ectopic pregnancy must be terminated either by medication or surgery.

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Fetal heart tones (FHT) –sounds that are heard during pregnancy usually with a doppler or a fetal monitor. **Accelerations** are when the fetal heart rate increases usually due to baby's movement. **Decelerations** are when the heart rate drops- they can be normal or abnormal. **Reassuring fetal heart tones** are when the fetal heart rate is a normal rate and has periodic accelerations and normal beat-to-beat variability in the rate. **Non-reassuring fetal heart tones** are when the rate is abnormally high or low, concerning decelerations are present or if there is little beat-to-beat variability in the rate.

Fetal demise – death of the fetus while in the uterus.

Fetal Kick Count - counting the fetal movements during a specified time period.

Gestational age - the length of time, usually weeks, the fetus has been growing in the uterus.

Gestational diabetes - is a condition characterized by high blood sugar (glucose) levels that is first recognized during pregnancy. The condition occurs in approximately 4% of all pregnancies.

Hemorrhage – bleeding from the uterus or a laceration of more than 500 mL of blood during or after birth.

Hydatiform mole - A relatively rare mass or tumor that can form within the uterus at the beginning of a pregnancy. The cause of hydatidiform mole is unknown. Some hydatidiform moles may become cancerous.

Hyperemesis gravidarum - extreme, persistent nausea and vomiting during pregnancy that may lead to dehydration. This can lead to weight loss, lightheadedness or fainting.

Hypoglycemia of the newborn - low blood sugar (glucose) in the first few days after birth.

Hypothyroidism – a condition in which the thyroid gland does not make enough hormone. When the thyroid gland makes too much hormone it is called **hyperthyroidism.**

Incompetent cervix – is a medical condition in which the cervix begins to dilate (widen) and efface (thin) before the pregnancy has reached term. Cervical incompetence may cause miscarriage or preterm birth during the second and third trimesters.

Intrauterine growth restriction (IUGR) - is a fetal weight that is below the 10th percentile for gestational age as determined by an ultrasound. This can also be called **small for gestational age (SGA)** or fetal growth restriction. **Large for gestational age (LGA)** is a term used to describe babies who are born weighing more than the 90th percentile for their gestational age, meaning that they weigh more than 90 percent of all babies of the same gestational age.

Jaundice – yellowing of the skin due to rising bilirubin levels in the blood. Some jaundice is normal in the first one to two weeks of life of the baby. **Hyperbilirubinemia** is when there are abnormally high levels of bilirubin in the blood. Sometimes the levels are high enough that the baby needs treatment with ultraviolet light therapy.

Laceration – a separation of the vaginal, labial or perineal tissues during birth. **First-degree** lacerations are minor and usually do not require any repair. Some **second-degree** lacerations may require numbing with a local anesthetic and stiches. **Third- and fourth-degree** lacerations involve the rectal capsule and/or the rectal muscle and may require a doctor to repair them.

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Last menstrual period (LMP) – the date of the first day of bleeding of the last menstrual period.

Loop electrosurgical excision procedure (LEEP) - uses a thin, low-voltage electrified wire loop to cut out abnormal tissue from the cervix that has been diagnosed with a colposcopy (magnified look at the cervix for an abnormal pap smear).

Low-lying placenta - is when the edge of the placenta is less than 2 cm away from the cervical opening. This is common in early pregnancy (before 20 weeks) and usually resolves by 28 weeks.

Meconium – this is the poop that is inside the intestines when the baby is born. It is dark greenish black and has a tarry consistency.

Miscarriage or spontaneous abortion – when a pregnancy spontaneously ends before the embryo or fetus is incapable of surviving independently.

Oligohydramnios / Polyhydramnios – Oligohydramnios is not enough amniotic fluid around the baby and polyhydramnios is too much fluid around the baby.

Placenta previa refers to the position of the placenta when it is covering the opening of the cervix. If the placenta remains over the opening at 37 weeks of pregnancy, a cesarean section is needed for the baby to be born.

Postpartum – refers to the time after the baby is born, usually considered the first six weeks.

Pregnancy induced hypertension (PIH) - high blood pressure that starts during pregnancy. It is more common in the first pregnancy and often starts in the last weeks of pregnancy. **Pre-eclampsia** is a group of symptoms that includes high blood pressure, abnormal liver functions tests and elevated protein in the urine. **Eclampsia** is more severe pre-eclampsia with seizures. **High blood pressure, elevated liver enzymes and low platelets (HELLP)** is a group of symptoms that can be associated with pre-eclampsia and is more severe.

Preterm labor (PTL) – refers to labor that starts before 37 weeks.

Pyleonephritis – infection of the kidneys. Symptoms include fever, flank and backpain, nausea and vomiting. May need hospitalization for intravenous antibiotic therapy.

Resuscitation – assisting the baby or mother with breathing and/or heart function. This may be as minimal as giving oxygen and stimulating the baby or as involved as giving positive pressure breathing with a mask/bag/valve device and chest compressions. Some may know this as cardiopulmonary resuscitation (CPR).

Rh – there are two types of Rh (positive and negative) that are associated with a blood type. (example: O negative). An **antibody screen** is a blood test done to determine if a blood type has been sensitized to by another blood type. **Sensitization** is when the body makes antibodies against another blood type when different types mix. This can happen during pregnancy and birth when the mother has an Rh negative type and the baby has an Rh positive type.

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Spontaneous rupture of membranes (SROM) – is when the membranes of the bag around the baby spontaneously start leaking. This can be a big gush of fluid or a slow leak. **Artificial rupture of membranes (AROM)** is when a small plastic crochet-like hook is used to prick a hole in the bag of waters to stimulate labor and to assess the color of the amniotic fluid. **Premature rupture of membranes (PROM)** is when the membranes of the bag of water around the baby start leaking after 37 weeks but before the onset of labor. **Preterm premature rupture of membranes (PPROM**) is rupture of membranes prior to 37 weeks' gestation.

Systemic lupus erythematosus (SLE) or lupus - is an autoimmune disease in which a person's immune system attacks various organs or cells of the body, causing damage and dysfunction.

Transient tachypnea of the newborn (TTN) - is a respiratory disorder usually seen shortly after delivery in full or near-term babies. It is short-lived (usually less than 24 hours) and is characterized by abnormally rapid breathing (most normal newborns take 40 - 60 breaths per minute).

Ultrasound (sonogram) - A prenatal test that uses high-frequency sound waves, inaudible to the human ear, that are transmitted through the abdomen via a device called a transducer to look at the inside of the abdomen. With prenatal ultrasound, the echoes are recorded and transformed into video or photographic images of your baby.

Urinary tract infection (UTI) – infection of the urinary tract (bladder or urethra) that causes burning, urination urgency and painful urination.

Uterine rupture – separation of the uterine wall that leaves a hole in the uterus. Usually is associated with the separation of a scar after a cesarean section.

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Visit Diary

Appt. Date	Appt. Time	Weeks Pregnant	Weight	Baby Heart Rate	Comments

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