



Dar a Luz

BIRTH & HEALTH CENTER

505-924-BABY

www.daraluzbirthcenter.org

Birthing Your Baby

Please bring this booklet to each visit.

24/7 Midwife On Call: 505-944-5488



Emergency Backup Numbers:

505-273-5583 or 505-273-5584

www.facebook.com/pages/Dar-a-Luz-Birth-Health-Center

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

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Welcome to Dar a Luz Birth & Health Center!

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

Over the next few months of your pregnancy, 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 book will be an important resource for you, your partner and your family. Although there are many things that we discuss at your prenatal visits, this book is designed to supplement those visits as well as other resources that you are using. We encourage you to read every section of this book and keep a list of questions. Bring the book and your questions to every visit.

At Dar a Luz, we believe that pregnancy and birth are normal life events. Most women will have very normal and comfortable pregnancies with few issues if any at all. Some women will have slight deviations from normal but will still be able to receive our care. And there will be a few women that have some issue in their pregnancy that will require them to transfer their care to a hospital-based practice. This educational tool is designed to help you understand what is normal, what is not normal and when to call us. If there is something going on in your pregnancy that is not addressed, please do not hesitate to call us. Our relationship is that of a partnership—we 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!

Warmly,

A handwritten signature in black ink that reads "A. Eaves, CNM". The signature is written in a cursive, flowing style.

Abigail Lanin Eaves, CNM
Executive Director
Certified Nurse-Midwife

Message from Abigail: How our Midwife Practice Works

Dar a Luz is a group practice. At this time, we have 6 midwives who share 5 full-time positions. Three of our midwives are considered full-time clinical and cover just a few more clinic and call shifts. The other three midwives are about three-quarters time clinical and two of them, Abigail and Melanie, are also the executive and clinical directors, respectively. 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 who you'd like. 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 women 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/births in that time period) and a back-up call midwife who is just that: back-up for the first call; she is usually covering other clinical duties but will attend labor/birth if there is more than one client or if the first call midwife needs assistance. Midwives rotate every 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 going into clinic and also for midwives' personal time.

It is important to be aware and understand that because there are 6 different midwives, there are 6 different styles and 6 different personalities. We pride ourselves on being a diverse group of women with very different backgrounds and lifestyles- this brings a lot to the table and makes us a stronger practice. But because we are all different, there will likely be some personalities that aren't as agreeable to you as others in the practice. This would be true in any group practice. We ask you to be open and accepting of all the different personalities as we are of you, our clients. If you have a visit with a midwife that you weren't particularly fond of, you don't need to see her again in clinic. But you may not ask to not have her at your birth. If you feel you have been mistreated, please contact Shelley our office manager immediately. If you feel that you absolutely cannot have a certain midwife at your birth, then you will need to transfer your care.

In addition, please also understand that the midwife clinic schedule is a complicated and fluid schedule. No appointments are set in stone. Ever. Please understand this. There are many reasons we might need to change your appointment: 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; we have a mom/baby dyad that need to be scheduled for a time sensitive visit (we will adjust the schedule for you too); 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 there is 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!

Lastly, we really need you to give us a working MOBILE telephone number (we send appointment reminders by text; we do NOT call). We call and text from the main Dar a Luz phone line. 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 woman, 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 mother 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,

A handwritten signature in black ink that reads "A. Eaves, CNM". The signature is written in a cursive, flowing style.

Abigail Lanin Eaves, CNM
Executive Director
Certified Nurse-Midwife

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 mothers and babies 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 the state while the national average is about 10%.



Las Parteras, 1938



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.

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. So now after over 30 years, Dar a Luz is the only freestanding nurse-midwife operated birthing center to open in Albuquerque since the closing of Southwest Maternity Center. The freestanding birth center in Taos, was open for over 25 years and 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. As well, midwifery is no stranger in Albuquerque- over half of the babies born 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.

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”.

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 maternity 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 6 years to get a law passed to require licensure for birth centers

in the state and then helped write the regulations for freestanding birth centers. This is an important milestone for our state and birth centers to increase access to family centered care in birth centers!

Building

The center is located on an acre of property in the North Valley at 7708 4th ST NW. You will find convenient parking. There is a private garden for family and staff. The building is approximately 3,000 square feet and includes two birthing suites, education and meeting spaces, a lending library, a snack area, two visiting rooms, a lab, a storage room with laundry facilities and office space with retail area.

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. 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 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.

Requirements for Continuation of Care

- **All first time parents must take childbirth classes including a 5-week session, breastfeeding, newborn and car seat 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. Exceptions will 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 class or part of a series.
- **All parents who 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.
- **All families who have not taken the Intervention & Transfer class previously are required to take the class** to prepare them for the possibility of a transfer to the hospital. Those who have attended this class have had better transfer experiences.
- **All clients will be tested for our routine prenatal labs** including routine prenatal labs and labs or testing to rule out gestational diabetes and group B strep.
- **All clients will be required to get an ultrasound** to determine the location of the placenta and to rule out any major problems in the fetus that would require additional care after birth.

Home visits between 24-36 hours after birth are available to clients who live or can stay **within 30 minutes of the birth center (See map below)**. We do not include Kirtland Air Force base in our home visit area 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 midwives will come see you at the hospital during this time.



Birth Center Staff: See the Dar a Luz Website for current bios and pictures of all of our staff!!

Certified Nurse Midwives (CNM)

CNMs are Registered Nurses who have earned a Masters Degree with two additional years of training in midwifery. We provide prenatal, birth, postpartum and breastfeeding care to women and care for newborns for the first 28 days of life. CNMs are licensed to practice independently and can prescribe medications. Midwives are probably best known for “being with women” through pregnancy and birth. If there are problems, we work closely with consultant doctors. CNMs can also provide care for your annual women’s health needs including birth control, pap smears and some primary care issues.

Registered Nurse (RN) Birth Assistant & Lactation Consultants

A Registered Nurse has 2-4 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, quality assurance checks, statistics reporting, support groups, childbirth education classes and lactation consultations. She 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.

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. 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, please let the staff know.



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, 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, Physician Consultant

"I am trained in family medicine and obstetrics with a primary focus on working with pregnant women 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 women desiring natural childbirth. I also work with pregnant women 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 all women don'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 maternity care and contraception. I have three boys and my spouse, Rebecca, is a nurse-midwife. Our recreation includes international travel, scuba diving and gardening."

"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

HOW TO CONTACT DAR A LUZ STAFF MEMBERS

Office Hours:

We are open from 9:00 am - 5:00 pm Monday through Thursday for appointments.

We are open 9:00 am – 1:00 pm on Friday for administrative duties and urgent visits.

PHONE 505-924-BABY (2229)

FAX 505-554-3673

Midwife on Call 505-944-5488

EMERGENCIES: CALL 911

LABOR CALLS:

CALL THE MIDWIFE ON CALL 944-5488. PLEASE LEAVE A MESSAGE AND CALLS WILL BE RETURNED WITHIN 15 MINUTES.

URGENT CLINICAL ISSUES:

CALL THE MIDWIFE ON CALL 944-5488. CALLS WILL BE ADDRESSED THE SAME DAY.

NON-URGENT CLINICAL ISSUES:

CALL THE OFFICE 924-2229 AND TALK TO NURSE (EXTENSION #5). IF THE NURSE CAN NOT ANSWER YOUR QUESTION, SHE WILL TALK TO THE MIDWIFE IN CLINIC. CALLS WILL BE RETURNED IN 24-48 HRS

EMAIL ONLY FOR NON-URGENT ISSUES:

Abigail Eaves CNM, Executive Director
Melanie Yanke CNM, Clinical Director
Susan Moore Daniels CNM, Midwife
Yelena Baras CNM, Midwife
Sarah Weinstein CNM, Midwife
Donyelle Miller CNM, Midwife
Shelley Black, CHT, Office Manager
Tracy Cooper, Receptionist
Stephanie Sanchez, RN, IBCLC Lactation Counselor
Robin Hayter, IBCLC Lactation Counselor
Carly Nowicki, RN
Jenna Montano, RN
Savannah Holloway, RN
Cherro Hamadamin, RN
Kimberlee Boreson-Marsema, Support Group Facilitator
Amity Johnson, Childbirth Educator
Laura Wood, Blissborn Hypnosis Birth Class Instructor
Nancy Anthony, Certified Car Safety Instructor
Erica Deerinwater, Billing Specialist

Abigail@daraluzbirthcenter.org
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Jenna@daraluzbirthcenter.org
Savannah@daraluzbirthcenter.org
Cherro@daraluzbirthcenter.org
Kimberlee@daraluzbirthcenter.org
Amity@daraluzbirthcenter.org
Laura@daraluzbirthcenter.org
Nancy@daraluzbirthcenter.org
Erica@daraluzbirthcenter.org

Social Networks: Facebook (Dar a Luz Birth & Health Center)

Client Grievances

All complaints about any aspect of Dar a Luz Birth & Health Center services should be brought to the Executive Director, Abigail Eaves, CNM. She will personally respond within five (5) business days.

Welcome to your online health record resource thru the Client 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, request corrections and appointments, send messages to the birth center staff and complete medical history forms online. For urgent questions regarding your information, contact the office at 505-924-2229. **If you have any problems logging into the portal, please contact Erica directly at 505-908-3251. She is available at this number by phone or text! Or you may email her at erica@daraluzbirthcenter.org**

We appreciate you accessing the portal because it is considered a part of the meaningful use of our electronic health record and each time you log in to the portal or send messages, we receive credit towards our yearly government incentives for using electronic records. This can be in the 10's of thousands of dollars each year and we depend on these funds to keep your cost of care lower. We need more than 5% of our clients to access the portal to view their health information. We also need 5% of our clients to message a midwife for **NON-URGENT ISSUES**. It does not count if you message Tracy or the nurses.

The first time you access your account, please message the midwife you saw last to let her know that the messaging is working correctly. Think of accessing the client portal as a donation to the center.

Thank you,
Dar a Luz Staff



How do I log in to the Client Portal?

Please find your username and temporary password in the information sheet provided to you. 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: <https://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”.

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:** The Client 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.
 - **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 with the number of new messages.
 - **Messages:** Send and receive secure messages from the receptionist (Tracy Cooper), nurses (Stephanie, Cherro, Jenna, Carly and Savannah) and your midwives (Abigail, Melanie, Susan, Yelena, Sarah and Donni). **ATTENTION: DO NOT SEND EMERGENCY MESSAGES THROUGH THE PORTAL!! PLEASE USE THE AFTER HOURS 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 FAQ’s listed below on how to use the different functions.



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 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: <http://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 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.*
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.**

Advance Directive for Health Care / Durable Power of Attorney

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 want BEFORE you are not able to speak for yourself. The Advance Directive can be used by your spokesperson, to tell others what you would want regarding medical care.

A Durable Power of Attorney for Health Care Decisions is a document that gives the person you choose the authority to make the choices listed in your Advance Directive for you if you are unable to make them yourself.

It is hard to think about these things when we are well. 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 this. You must sign and date the form. You are not required to have your document witnessed, but it may help to do this in case your advance directive is ever challenged. You can change it at any time.

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 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**; abide by all birth center rules and safety regulations; and be mindful of noise levels, privacy and number of visitors and nonsmoking policy on the premises.
10. You have the **responsibility to keep appointments** and if you cannot keep your appointments 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.



Dar a Luz Birth & Health Center

Notice of Privacy Practices - 2017

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.

Summary of Notice of Privacy Practices Information

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
- 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

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.

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 go ahead and 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.

Our Uses and Disclosures

How do we typically use or share your health information?

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

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.

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.

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.

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

Do research

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

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 law.

Respond to organ and tissue donation requests

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

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.

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

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.

Other Instructions for Notice

- Effective Date of this Notice – April 15, 2017
- Privacy Officer: Shelley Black, contact her at shelley@daraluzbirthcenter.org, 505-924-2229, Ext 1

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](tel:855-427-5674). File an insurance complaint here: <http://www.osi.state.nm.us/consumer-assistance/forms/managed-healthcare.html>



Safety of Birth Center Care

Many women wonder if a birth center would be safe for their pregnancy and birth. Many studies have shown that birth centers are as safe as or safer than hospitals for carefully selected “low-risk” women. When women were cared for by Certified Nurse Midwives (CNM) in a freestanding birth center with transfers to collaborative CNM/physician practices, they used significantly less resources, had fewer interventions, fewer operative deliveries and higher breastfeeding rates with equally good neonatal outcomes when compared to a matched group of women cared for by physicians in the hospital. Women cared for at birth centers consistently have higher maternal satisfaction rates. The most recent study showing these outcomes is:

Outcomes of Care in Birth Centers: Demonstration of a Durable Model. By S. Stapelton, C. Osborne, & J. Illuzzi. Published in the Journal of Midwifery & Women’s Health, Volume 58, No. 1. January/February 2013. This is available online free of charge.

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 well 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 mom and baby. This allows for prevention or early recognition of problems that may require a consultation or transfer.

What to Expect From Birth Center Care

- You can expect individualized care from the midwives.
- You can participate in your care and discuss your choices.
- More time in your appointments to have your questions answered.
- Appointments every 4-8 weeks until 28 weeks, every 2-4 weeks until 36 weeks and 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.

"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

Who Can Receive Care at the Birth Center?

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):

- More than one previous cesarean section
- Eclampsia
- Uterine rupture
- Previous Rh sensitization
- Gestation of more than 28 weeks with no prenatal care
- Heart disease
- Chronic hypertension
- Symptomatic congenital heart defects
- Severe heart murmur
- Deep vein thrombosis (DVT) requiring anticoagulant therapy
- Pulmonary embolus
- Asthma not well controlled
- Diabetes on medication
- Hyperthyroidism or uncontrolled hypothyroidism
- Systemic Lupus Erythematosus (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 marijuana
- Clients designated by CNM as inappropriate for birth center care



Reasons for Consultation

Occasionally problems arise that the CNM will consult about with the 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.

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 < 35 weeks
- Previous birth weight <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
- At CNM discretion

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
- At CNM discretion

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
- At CNM discretion

Reasons For Transfer

Most women go through pregnancy and birth without any major problems, however about 10-15% of women will develop conditions that need the next level of care which could require a transfer to a midwife or doctor that 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
- 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)
- Oligohydramnios, inadequate fluid around baby
- Polyhydramnios, too much fluid around the baby, at 37 weeks
- 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

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:

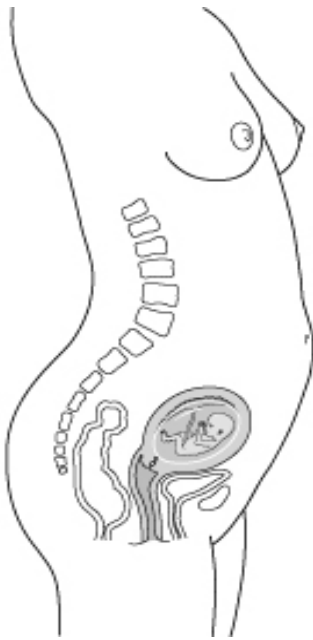
- Apgar score of less than 7 at 5 minutes
- Unable to maintain temperature at 2 hours of age
- Severe or worsening respiratory distress
- Resuscitation requiring chest compression
- Congenital anomaly requiring immediate acute care
- Immediate jaundice
- Exaggerated tremors or any seizure activity
-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



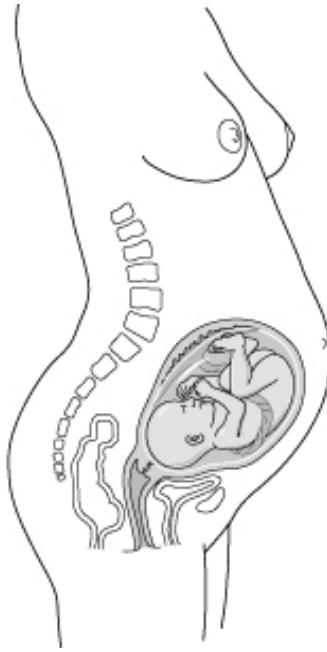
***“Birth is the sudden opening of a window,
through which you look out upon a stupendous prospect.
For what has happened? A miracle.
You have exchanged nothing for the possibility of everything.”***

~ William MacNeile Dixon

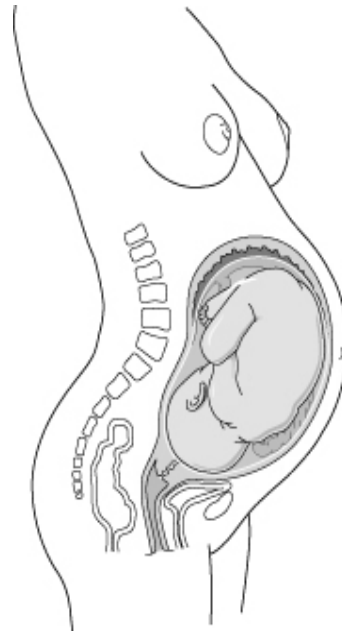
Stages of Pregnancy



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. Each woman feels different in pregnancy. Each pregnancy is different. You may have some of these common changes:

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

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 women to go into labor 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



Fetal Growth: Conception to Birth

Fetal growth happens so fast and is amazing! View these pictures online <http://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
- 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 can feel movement
- Many women 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

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



Emotional Adjustments

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

Fears are common in pregnancy and most women feel extremely vulnerable. Fears of death for yourself and your baby come up to the surface. Your body seems out of your control and is changing rapidly, which can be frightening. This makes some women feel more dependent and more demanding. During pregnancy women are searching for new support and direction in imagining their new role as a mother and the unknown life changes before them. Although each woman has unique emotions, there are some feelings that are common to everyone.

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

- Being upset or ambivalent about being pregnant. Some women 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 mother and acceptance of pregnancy by your partner.
- Some women are overjoyed especially if they have had a hard time becoming pregnant. They may not believe it is actually true and look for every little sign that they 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 the woman feels good and has 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 mother. This may bring up conflict and guilt or make your relationship even better. You may feel like you need to prove yourself as a mother. 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 women. 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 her 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 and interests.
- Anticipating the loss of attention after birth.
- Some depression, increased dependency from loved ones, and introversion are common.

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 for your stomach muscles, use a pregnancy belt or cradle (ask for a prescription), or rest and take warm baths. You may take regular strength Tylenol® (acetaminophen).
- When getting out of bed, turn to your side and use your arms to push your body up to avoid twisting or sitting straight up.
- ***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 37 weeks. This could be a sign of preterm labor.***

Back and Pelvic Pain

More than 50% of women 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.
- Some women find pregnancy belts helpful. Ask for a prescription.
- ***Call 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 women 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 when you hear yourself wheeze, feel like you cannot breathe, or are coughing up blood.***

Carpal Tunnel Syndrome - Numbness of the Hands

Some women 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. Some women find some relief by wearing a wrist splint. Ask your midwife about a prescription for a splint.

Constipation and 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. **See page 45** for stomach flu information.

- For relief of constipation, eat high fiber foods (bran or fiber cereal, prunes, fresh fruits, vegetables).
- 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 helps 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.
- ***Call if you have bleeding from your rectum, severe cramping or more than six stools in 24 hours.***

Cravings

Most women notice changes in their 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.

Some women 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.

Dizziness and Fatigue (feeling tired)

Most women 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

Women commonly 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 anytime before, during or after pregnancy.

Dreams and nightmares are not to be taken literally. They are most likely a representation of fears and anxieties about childbirth, motherhood 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.

Heartburn

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.
- Zypan® (natural digestion aide - sold at the birth center). 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), Zantac® (ranitidine), Pepcid AC® (famotidine), or Tagamet® (cimetidine).
- 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 women require prescription strength medications.***

Headaches

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.
- To prevent headaches eat small meals every 2-3 hours, rest, take a walk in the fresh air, and drink at least 10 glasses (8 oz) of water per day (2-3 liters or 80 ounces).
- 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).
- ***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 or standing for long periods of time, constipation and pressure from the growing uterus. Some women are just more likely to get them too.

- For relief, eat foods with lots of fiber.
- 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 women require prescription strength medications.***

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.***

Nasal Congestion – Allergies and Colds

Nasal congestion may be due to allergies or colds. Acupuncture and taking bee pollen may lessen allergies. The best defense against colds is reducing your risk for getting one by washing your hands often, getting enough sleep, eating a healthy diet, regular exercise, reducing stress and avoiding contact with sick family or friends.

Colds:

- Use a humidifier or breath warm humid air. Try hot and cold packs to the sinus area.
- Try saline solution nose spray or neti pots. Gargle with salt water, or drink warm water with honey and lemon.
- Get lots of rest. Drink 10 glasses (8 oz) of water per day (2-3 liters or 80 ounces).
- See medicines you can take on **page 45**.
- ***If you have a fever over 101° F and feel achy, congested or have a cough, call the midwife.***

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.

Skin Changes

Some women, especially those with darker skin and hair colors, notice an irregular brownish discoloration on their forehead, nose, cheeks or neck (cholasma) during pregnancy. Some women 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, coca butter or Bio Oil® to help soothe them.

Sleep Disorders / Insomnia

Poor sleep patterns are common in pregnancy and postpartum. See more information under “Sleep” on **page 73**. 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:

- Chamomile tea or linden tea
- Doxylamine (Unisom)
- Diphenhydramine (Benadryl) or diphenhydramine and acetaminophen (Tylenol PM)

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

Swelling of Hands, Legs, 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.***

Increased Urination

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.

- For relief, drink more water during the day, less at night and avoid caffeine and sweet foods.
- To help prevent infection, wipe from front to back, and urinate after sex.
- You may drink unsweetened cranberry juice or taking a cranberry supplement twice a day.
- ***If you have painful urination, 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.***

Vaginal Discharge

An increase in milky white vaginal discharge (leukorrhea) while pregnant is normal and is caused by an increase in hormones.

- If you have an itchy, thick white and clumpy discharge, this could be a yeast infection. You can call the midwife 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, 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 and you would need to call the midwife.***

Uterine Tightenings

Uterine tightenings or “Braxton-Hicks contractions” are common during pregnancy and begin in the first few months but are 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 tightenings 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.***

Vomiting and Nausea

It is very common to have nausea in the first 3 months of pregnancy. Often, this will stop by 12 to 14 weeks of pregnancy. Some women 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.
- Avoid vitamins and iron supplements until you feel better, but keep taking folic acid (try taking it 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, then 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.
- Try Dramamine® (dimenhydrinate) 1-2 tabs every 4-6 hours. Maximum 8 tabs daily.
- Zofran® (ondanestron) is a prescription drug that may help. Call the midwife for this.
- ***Call if you cannot keep food or liquid down, have blood in the vomit or cannot stop vomiting for 24 hours. Some women may require prescription strength medications to control nausea and vomiting.***



EARLY PREGNANCY WARNING SIGNS

Call the birth center at 924-2229 Monday thru Thursday from 9 to 5 and Friday 9 to 12 or call the midwife on call at 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.*

“Think of stretch marks as pregnancy service stripes.”

~Joyce Armor

Medications for Colds & Flu / Stomach Viruses / Allergies / Pain

Colds and flu during pregnancy are often more severe due to the weakened immune state in pregnancy. Consider getting the seasonal flu vaccine and practicing these things to reduce your risk of getting sick:

- wash your hands often
- get enough sleep (7-8 hours nightly)
- eat a healthy diet
- avoid close contact with sick family or friends
- exercise regularly
- reduce stress

For colds / flu:

- Get plenty of rest. Sleep with head elevated if congested.
- Drink a lot of fluids
- Gargle with warm salt water for a sore throat or cough
- Avoid dairy because it thickens mucous secretions.
- Saline nasal drops for loosening nasal mucus. Try rinsing nasal passages with a neti pot.
- 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.
- These over-the-counter medicines are probably safe in pregnancy especially after the first trimester.
 - ✓ Sudafed® (pseudoephedrine) 30 to 60 mg every 6 hours as needed during the day. This is a nasal decongestant and drying agent, so drink lots of water. Do not take if you have high blood pressure.
 - ✓ Robitussin® (guaifenesin) 1 to 2 teaspoons every 4 to 6 hours as needed during the day. This helps you cough up the mucus easier.
 - ✓ Robitussin DM® (guaifenesin with dextromethorphan) 1 to 2 teaspoons every 4 to 6 hours as needed at night. This keeps you from coughing as much.
 - ✓ Sore throat - throat lozenges, cough drops, Chloraseptic® Spray, Cepacol®
 - ✓ NyQuil® (doxylamine) take as directed.

For stomach virus (vomiting and/or diarrhea):

The stomach flu, or gastroenteritis, can be caused by a number of different viruses that attack your gastrointestinal system. You can get these viruses from inadequately prepared food or conditions with poor hygiene. 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.
 - Bananas: Bananas are easy to digest and can replace the potassium you lose from vomiting and diarrhea.
 - Rice: Brown rice has too much fiber, but white rice is easier on the stomach and provides energy from carbs.
 - Applesauce: Applesauce can provide an energy boost due to the carbs and sugars, and also contains pectin, which can help with diarrhea.
 - Toast: Avoid whole-wheat bread, as fiber can be difficult on the digestive system. White bread is processed and easier to digest.

For allergies:

- ✓ Chlor-Trimeton® (chlorpheniramine) 4 mg every 4 to 6 hours as needed.
- ✓ Benadryl® (diphenhydramine) as directed or use Benadryl® cream for itchy skin
- ✓ Zyrtec Allergy® (cetirizine) 1 tab daily.
- ✓ Claritin® (loratadine) 10 mg once a day.

For headaches or pain:

- ✓ Tylenol® (acetaminophen) 325 to 650 mg every 4 to 6 hours. Do not take more than 4000 mg per day.
- ✓ 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.

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. As a result, 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 and how safe the product may be. Reliable information about the product may be hard to find, which makes researching these products' effectiveness more challenging.

Herbs to Avoid 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 information on alternative medicines and herbs go to:

<http://www.americanpregnancy.org/pregnancyhealth/naturalherbsvitamins.html>



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.

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 cardamon, 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: <https://www.naha.org/explore-aromatherapy/safety/>

Essential oils to Avoid throughout Pregnancy, Labor, and while Breastfeeding

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

Use of essential oils in labor should only be used in small amounts and locally applied, not used with a diffuser. Consider how irritating the fragrances could be 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.

Vaccinations in Pregnancy

Rh D Immune Globulin (Rhogam® or Rophylac®): Rh D Immune Globulin (Rophylac®) 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 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 her Rh-positive fetus. These are the risks if prophylaxis is not used:

- 13% to 14% of Rh-negative expectant mothers 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 an Rh-negative mother is carrying an Rh-positive fetus. As many as 75% of all pregnant women 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 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 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 to death in utero or shortly after delivery. Examples 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 can not completely process the bilirubin, which was metabolized by the placenta and the mother before birth.
- 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
 - mental retardation
 - bleeding in the lungs
 - death

TREATMENT:

Rh D immune globulin (Rophylac) has been safely used for over 30 years and there are no reported adverse fetal effects. The action of Rophylac 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 an Rh-positive child, it has a success rate of greater than 99%. Women should also be given the mini-dose if they have early pregnancy miscarriage or heavy bleeding before antibody production begins and the woman 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, the 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 WOMAN 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.

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 924-2229 or the midwife on call at 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; or
- 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.

- **Seasonal Flu Vaccine:** The flu shot (inactivated vaccine) given during pregnancy has been shown to protect both the mother and her baby (up to 6 months old) from flu. (The nasal spray vaccine should not be given to women who are pregnant.) Flu is more likely to cause severe illness in pregnant women than in women who are not pregnant. 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 woman with flu also has a greater chance for serious problems for her unborn baby, including miscarriage or preterm birth. We offer the preservative free (no thimerisol, mercury) flu vaccine for any women 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.
 - 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.
 - We offer a daily immune support supplement called Immuplex.
- **Tetanus, Diphtheria, Pertussis (Tdap) Vaccine:** Pertussis (whooping cough) is at epidemic levels due to decreased immunity in adults. All women should be given the Tdap booster with each pregnancy or immediately postpartum to protect their babies from pertussis. Infants get some protection from pertussis (whooping cough) in early life and before beginning the primary DTaP series from maternal antibodies that are transferred across the placenta and in colostrum. They are also protected by a cocooning effect when all the caregivers around the baby have been vaccinated. Tetanus and diphtheria-toxoid containing vaccines administered during pregnancy have not been shown to be teratogenic and do not contain thimerosal (mercury). See more detailed information below. Ask your midwife about getting the booster.



Pertussis or Whooping Cough

What is Pertussis?

Pertussis 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.

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.

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:

In 2014, 32,971 cases of pertussis were reported in the United States; 3,330 of those cases were in infants younger than 6 months of age — 8 of those infants died while there were only 5 deaths in the rest of the population. Studies have shown that when the source of pertussis was identified, mothers were responsible for 30–40% of infant cases.

In New Mexico, rates of pertussis are above the national average at 17.7 cases per 100,000 persons. The latest data reported in 2013 showed 472 cases. Infants less than 6 months of age made up 7.0% of cases and a third of those were hospitalized while 57% of the cases occurred in the 11 to 65 year old group and only 2% were hospitalized. Los Alamos County had the highest rate in the state at 117.1. Bernalillo County was 28.7 while rates in the surrounding counties include Torrance 73.3, Valencia 16.9, Cibola 3.7, Sandoval 12.8 and Santa Fe 51.9.

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 post partum." Optimally, women should receive Tdap between 27 and 36 weeks' 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:

All pregnant women should receive a dose of the Tdap vaccine between 27-36 weeks of gestation, even if she has received the vaccine previously. If a woman does not get the vaccine during pregnancy, she should receive it immediately postpartum.

Safety of Tdap for Mother 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 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.

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, a woman vaccinated with Tdap vaccine during pregnancy will also herself be protected at time of delivery and will be less likely to transmit pertussis to her newborn infant.**

By vaccinating a woman with Tdap during pregnancy her 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.

Breastfeeding after Tdap Vaccination:

Breastfeeding is not a contraindication for receiving Tdap vaccine. Tdap vaccine can and should be given to women 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, by breastfeeding, mothers can pass antibodies they've made in response to the Tdap shot on to their 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 January 25, 2015. <http://www.cdc.gov/vaccines/vpd-vac/pertussis/tdap-pregnancy-hcp.htm> retrieved on June 2, 2016.



Routine Screenings at Each Visit

- **Urine sample:** You will need to give a urine sample at each visit. 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 **page 80** for the weight gain guide.
- **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 2cm 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.

Tests During Pregnancy

First Trimester 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 given Rhogam® or Rhophylac® [Rh_o (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 Screening:** These tests are optional. There are early blood, ultrasound, chorionic villus sampling and amniocentesis screens you can choose that detect some but not all genetic defects. See discussion on **page 63**.
- **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:** If you have a history of diabetes in your family, have a pre-pregnant BMI ≥ 30 or have had gestational diabetes in the past, the hemoglobin A1c blood test will be done at your first visit to determine your glucose levels for the past 3 months. A random glucose will also be done.

- **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. If you prefer free anonymous testing, call the Public Health Department in Albuquerque at 841-4100.
- **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 immune 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. Women who follow a vegan/vegetarian diet are most at risk. Women who have a B12 deficiency that does not respond to treatment are not eligible to use Nitrous Oxide in labor.
- **Vitamin D:** This is a blood test to check if you are low in Vitamin D. Low levels of Vitamin D can affect your immune response and may be linked to high blood pressure during pregnancy. You produce Vitamin D when your skin is exposed to the sun or get it through supplements and fortified foods.

Second Trimester Tests:

- **Genetic Screening:** These tests are optional. There are blood and ultrasound screening tests you can choose that detect some but not all genetic defects. See discussion on **page 63**.
- **Hematocrit:** 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.
- **Blood Type:** This test is repeated if you are Rh negative and we strongly recommend Rhogam® or Rhophylac® [Rh_o (D) Immune Globulin], 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 24-28 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 diet counseling and to monitor fetal growth. You may continue your care at the birth center as long as you control the diabetes with diet and exercise. 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 hr GTT or referral to diet counseling.

INSTRUCTIONS FOR 1-HOUR GTT

1. Eat protein the day of your test.
2. Do not eat any sweet foods the day of your test (NO SUGAR OR FRUIT!!!!)
3. Do not eat anything 2 hours before 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.
4. 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).
5. 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.

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 (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. Tel the nurse what time you finished drinking the glucola so we can draw your blood at 1 and 2 hours later.

Third Trimester Tests:

- **Group B Step (GBS) screen:** All birth women must be screened for GBS. This is a vaginal and rectal culture that is done at 35 to 37 weeks to check for the GBS bacteria. We strongly recommend treatment under the Centers for Disease Control (CDC) guidelines for prevention of newborn GBS infection. See next page for details.
- **Hematocrit:** This blood test is done at 36 weeks to recheck for anemia and to see if the iron supplements you have been taking are helping.

Group B Streptococcus (GBS) Screening

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

The Centers for Disease Control recommends routine screening for GBS in all pregnant women by taking a culture from the vaginal and rectal area around 35-37 weeks of pregnancy. The results are usually available in one to two days. Those women that test positive for GBS are said to be “colonized”. A mother can pass GBS to her baby during birth if she is colonized but most babies do not contract GBS. However, GBS can be serious and affects about 1 in every 2,000 babies in the United States. About 5% of infected babies will die from GBS disease.

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 to 6 hours until delivery. This is usually Penicillin or a different antibiotic if you are allergic to Penicillin. CDC recommends that women 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 or 8 hours before delivery depending on the antibiotic. 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.

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 women 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 that 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 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 if you missed that here is a great post that reviews the current research and suggestions for pregnancy, birth and early mothering at:

<http://midwifethinking.com/2014/01/15/the-human-microbiome-considerations-for-pregnancy-birth-and-early-mothering/> updated January 2015

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 her 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.

Suggestions for pregnancy:

- Eat fermented foods like kombucha, kefir, yogurt, kimchi and sauerkraut
- Take probiotics to 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

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 pregnant women showed lower colonization counts and women 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 women test positive for GBS and antibiotics are used in labor, mom and baby should be started on probiotics shortly after birth. Baby should stay on the probiotics for 6-12 months.

Probiotics containing *L. reuteri* DSM 17938 (commercially available in BioGaia ProTectis – sold at Dar a Luz) have been shown 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.

A 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. 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.

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, mother and baby should consider 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 mom and 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

***"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

Prenatal Genetic Screening

While most babies are born healthy, even young healthy parents with no family history of genetic defects can have a baby with a birth defect or serious medical problem. You may want to have tests, which can tell you about your chances to have a baby with certain birth defects or certain genetic conditions. This section informs you about some conditions that can be found with screening.

Trisomy 21 - Down Syndrome

- This leads to learning problems (mental retardation), health problems, and sometimes birth defects.
- Children with Down Syndrome are usually able to do many things that other children can. They do need extra medical care and help with learning. Children do not usually die from Down Syndrome.
- Persons with Down syndrome are living longer than ever before. Although many children have physical and mental limitations, they can live independent and productive lives well into adulthood.
- Rates of an embryo having Down syndrome at 10 weeks of pregnancy range from 1 in 1,064 pregnancies at age 25, 1 in 240 pregnancies at age 35 and 1 in 19 pregnancies at age 45.

Trisomy 13 – Patau Syndrome

- There is extra DNA on chromosome 13 that occurs in either the sperm or the egg that forms the fetus.
- Trisomy 13 occurs in about 1 out of every 10,000 newborns. Most cases are not inherited.
- There can be multiple defects and about 80% of these children die in the first year.

Trisomy 18 – Edward Syndrome

- The syndrome occurs when there is extra DNA on chromosome 18.
- This is a serious combination of birth defects and brain damage.
- Trisomy 18 occurs in 1 out of every 2500 pregnancies in the United States and 1 in 6000 live births.
- Most babies with Trisomy 18 die before birth or soon after. Those that live are severely disabled.

Neural Tube Defects (NTDs)

- This happens very early in pregnancy. If the neural tube does not form normally, this leads to birth defects of spinal cord (spina bifida) and/or brain (anencephaly).
- Some NTDs can be fixed by surgery after birth. Even with surgery, many children with NTDs have physical disabilities and/or learning problems. Some NTDs are so serious that babies die from them.
- NTDs affect about 3000 births a year in the United States.
- Taking folic acid 400 mcg daily can help prevent NTDs.

Cystic Fibrosis (CF)

- This is a serious childhood disease that leads to many lung infections and growth problems.
- CF does not affect learning ability.
- CF can be treated, but not cured. CF may shorten a person's life.
- CF occurs in 1 out of 3,400 births. Most babies with CF are born to people with no family history of CF.
- Both parents have to be CF carriers in order for a child to have CF.
- The chance of being a carrier depends on your family history and ethnic background.
- A blood test that can be done now will find most, but not all, CF carriers.
- All babies born in New Mexico are screened at birth for CF.

If you have a close relative with a birth defect, genetic disease or mental disability, you might want to talk to a genetic counselor about your risks and testing options. Ask your midwife about your options.

Screening Tests

Screening tests are safe and pose no risk to the baby and are less expensive than diagnostic 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. Risk increases with a family history of genetic defects and gradually increases with the age of the mother. Women over 35 years of age may be offered additional testing options. Most women with “low risk” screening test results have healthy babies. Many women with “high risk” results also have healthy babies. However, women with “high risk” results will be offered genetic counseling and diagnostic tests.

There are several types of screening tests that screen for Down Syndrome, trisomy 18, trisomy 13:

- **Cell-free fetal DNA testing** is a new screening test for high-risk women (35 years old or more at delivery, abnormal first or second trimester screen, ultrasound abnormalities, or history of a previous child with abnormalities) that indicates if a woman is at increased risk of having a fetus with Down syndrome (trisomy 21), trisomy 18 and trisomy 13. The test measures the relative amount of free fetal DNA (from placental sources) in the mother's blood and is done by drawing maternal blood after 10 weeks gestation. Results are available in about 2 weeks. Cell-free fetal DNA testing is thought to detect up to 99% of all Down syndrome pregnancies and greater than 98% of all trisomy 18 pregnancies. It detects about 65% of all trisomy 13 pregnancies. There is a false positive (abnormal result in an unaffected baby) rate of 1%.
- **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 an 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.

Diagnostic Tests

Diagnostic tests will tell you for sure if a baby has certain birth defects. They are not as safe as screening tests and may pose some risk for miscarriage. These tests are also more expensive than screening tests. Diagnostic tests are usually recommended for women who have risk factors for genetic defects or have a screening test with elevated risk for defects. If you think you might want a diagnostic test, talk to your midwife about scheduling a genetic consultation.

There are several types of diagnostic tests:

- **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 birth defects and 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 mental 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.
- **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 mental disabilities and most heart defects. There is a 1 in 500 chance for miscarriage with this procedure and although it is less than 1% chance, it is worth considering.



Ultrasounds During Pregnancy

What is a fetal ultrasound or sonogram?

It 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 2013 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.

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. Use of spectral Doppler imaging 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 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 as clinically appropriate when technically feasible.

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 <http://www.aium.org/resources/guidelines/obstetric.pdf> on 12/01/17.

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.
- 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.
- Women who are advanced maternal age (over 35 years) are offered more frequent surveillance due to increased risks of stillbirth in pregnancy. Risks for stillbirth increase more at 38-42 weeks of pregnancy for all age groups. Healthy women have lower risks than women with complications.

Advanced Maternal Age (AMA)

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. More recently in resource-rich countries there has been an increased trend of women delaying pregnancy into their 30's and 40's. Different studies may define AMA as ≥ 40 or very advanced maternal age as ≥ 45 . Availability of assisted reproductive technologies has also extended women's reproductive years into their 50's.

Benefits

Benefits to having children at an older age include parents that are potentially more financially stable and emotionally mature than they were at a younger age. There may also be reductions in breast and ovarian cancer related to pregnancy when compared to women of a similar age with fewer or no pregnancies.

Early Pregnancy Risks

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

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 women who choose to have more screening or who wish to speak to a genetic counselor.
- We require a detailed anatomy scan for all women 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 women.
- 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 women at higher risk for pre-term birth. We educate all of our clients on the warning signs for pre-term labor.

Late Pregnancy Risks

There is a risk of stillbirth in all pregnancies and that risk increases with maternal age and is strongest after 36 weeks gestation. Women ≥ 40 years of age have the same risk of stillbirth at 39 weeks of gestation as women in their mid-20s have at 41 weeks of gestation. Women having their first baby are at higher risk for stillbirth than women who have had children before. Black women have the highest risk in all ages and in all categories. Overall, the risk of stillbirth at term for all women is less 1%. See the chart below for risk of stillbirth according to age and pregnancy.

Chances of stillbirth after 37 weeks of pregnancy

Age at birth	First Baby	Subsequent Babies
Age < 35	1 in 270	1 in 775
Age 35-39	1 in 156	1 in 502
Age > 40	1 in 116	1 in 304

Third Trimester Considerations

There are no large good quality research studies that have examined the effectiveness of routine fetal testing during late pregnancy in women age 35 and older and there is no consensus on what interval of testing to recommend. However, it is commonly recommended to start weekly fetal testing at 36 weeks and offer induction of labor at 39 weeks and women over 40 years are generally discouraged from going past 40 weeks of gestation. Certainly, taking into consideration risk factors, such as age, the number of pregnancies, fetal growth, IVF, gestational diabetes, high blood pressure, obesity, socioeconomic status, race and previous pregnancy complications may be used to develop an individualized plan for fetal testing in late pregnancy.

To address the risks related to stillbirth, we ask our clients to consider the following maternal and fetal surveillance options:

- Continue fetal kick counts twice daily (10 movements in a 2 hour period) until birth.
- Offer ultrasound to check on baby's growth and amniotic fluid level between 36 to 39 weeks.
- Consider weekly fetal monitoring with ultrasound called a biophysical profile (BPP) and/or fetal heart rate monitoring called a non-stress test (NST) starting at 36-39 weeks. BPP plus NST is considered the gold standard and predictive of fetal well-being for 72 hours.
- For women ≥ 35 years with additional risk factors, consider weekly BPP beginning at 36 weeks and induction of labor by 41 weeks.
- For women ≥ 40 years, consider weekly BPP beginning at 36 weeks and induction of labor at 40 weeks of gestation.
- All women transfer for induction of labor at the hospital by 42 weeks.

Our midwives are available to discuss the risks and benefits 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.

Info from Up-to-date, April 2017, Management of pregnancy in women of advance maternal age by Ruth C Fretts.

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 the activity of the baby.
- 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.

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.

Dental Care

Taking good care of your teeth and gums during pregnancy is very important for a healthy pregnancy. About 25-75% of pregnant women 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

Preventative 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! Mothers that 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 her 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 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. Check out the flyers for Baby Boot Camp with coupons for free classes during pregnancy and postpartum.

Yoga

Yoga can be very beneficial for pregnant women — 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 your instructor know that you are pregnant if you are not taking a class designed for pregnant women. Prenatal, hatha and restorative yogas are the best choices for pregnant women. 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 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.

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, energy is restored 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 women 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
- 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 **page 41** for over the counter sleep remedies that may be helpful for insomnia.

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, working with chemicals or need a letter for your employer, ask your midwife.

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 in pregnancy. 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.

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, many women have a decreased desire for sex, partly due to physical changes. They may feel a need for more love and loving without sex. During the second trimester of pregnancy, most women feel more erotic and experience an increased libido and sexual satisfaction. They feel better physically, are more relaxed, and are seeking more attention from their partners. During the last part of pregnancy, sexual desires can decrease; women have reported feeling big, awkward, ugly and uncomfortable. Women need frequent reassurance from their partner and honest sharing of feelings between them to feel supported and loved. Explore alternative methods for intimacy which can be useful after pregnancy too.

***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~

What to Avoid During Pregnancy

- Drugs, 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 or have someone else clean it daily
- Activities or sports that could cause you to fall or hit your abdomen
- Biking and hiking above 10,000 feet altitude
- Limit time in saunas and hot tubs to 10 minutes or less
- Eating undercooked meats and fish (See food safety during pregnancy on **page 90**)

Drugs, Alcohol and Smoking

Drugs: Pregnant women who use drugs like heroin, opioids, methamphetamines (meth), cocaine or marijuana are at risk for having babies with physical and mental problems or drug dependence. When mothers are using opiate drugs such as heroin, Percocet® (oxycodone), Lortab® or Vidocin® (hydrocodone) or others on a frequent or daily basis, their babies may need to stay in the hospital longer to be watched for drug withdrawal. This may also be true of women who are using other medically prescribed medicines as treatment for dependency such as methadone or Subutex® (buprenorphine). Let your midwife know if you are taking drugs. Women 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.

Alcohol: We don't know how much alcohol can harm the baby. 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 drink alcohol. Special help is available.

Smoking: Smoking while pregnant raises the risk of spontaneous abortion, placenta problems, premature rupture of membranes, low birth-weight babies, stillbirth and newborn death. Women 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.

Second hand smoke: This is also harmful for you and the baby. Babies who are around people who smoke 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 your midwife know or call 1 800-QUIT NOW.

E-Cigarettes: Vapers may feel safe using e-cigarettes but research has not proven them to be safe. 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. Pregnant and breastfeeding women, 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 that include physical, financial, verbal, emotional and sexual abuse. This may start or become worse while you are pregnant. Physical abuse can lead to a miscarriage (a spontaneous abortion). Pregnant women 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, please tell your midwife or call the services listed below for help.

- Safe House 247-4219
- ENLACE Comunitario 246-8972
- NM Domestic Violence Hotline 1-800-773-3645
- Women's Community Association Shelter 247-4219
- New Mexico Coalition Against Domestic Violence 800-799-SAFE (7233)

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. There are many things you can do to keep both of you 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 car pooling. 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.
- Move seat back as far as possible.



Travel Advice

Later in pregnancy, extra body weight makes it hard for blood to flow through your body and may make you swell more. 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.

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.

Some airlines may 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. 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, 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.

"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

**What we know:**

- Zika is spread mostly by the bite of an infected Aedes species mosquito (Ae. aegypti and Ae. albopictus). These mosquitoes bite more during the day but may be out at night. These are the same mosquitoes that spread dengue and chikungunya viruses.
- Zika can be passed through sex, even if the infected person does not have symptoms at the time.
- Local mosquito-borne Zika virus transmission has been reported in the continental United States and the Albuquerque and areas south of here are in the possible range of the mosquito.
- A pregnant woman can pass Zika virus to her fetus during pregnancy or around the time of birth. Zika is a cause of microcephaly and other severe fetal brain defects.
- To date, there are no reports of infants getting Zika virus through breastfeeding. Because of the benefits of breastfeeding, mothers are encouraged to breastfeed even in areas where Zika virus is found

What we do not know:

- If there's a safe time during your pregnancy to travel to an area with Zika.
- How likely it is that Zika infection will affect your pregnancy.
- If your baby will have birth defects if you are infected while pregnant.

Symptoms of Zika:

Many people infected with Zika virus won't have symptoms or will only have mild symptoms that may last several days to a week. People usually don't get sick enough to go to the hospital, and they very rarely die of Zika. For this reason, many people might not realize they have been infected. The most common symptoms of Zika are:

- Fever
- Rash
- Joint pain
- Conjunctivitis (red eyes)
- Some have muscle pain and headache too

Pregnant women should get a blood test to confirm Zika:

- Within 2-12 weeks after the last date of possible exposure
- Development of symptoms
- Live in or have recently traveled to an area with Zika
- Had sex (oral, vaginal, or anal sex or the sharing of sex toys) without a condom with a person who lives in or traveled to an area with Zika, even if you do not have symptoms.
- Zika virus usually remains in the blood of an infected person for about a week.
- Once a person has been infected, he or she is likely to be protected from future infections.

Treatment:

- There is no specific medicine or vaccine for Zika virus.
- Treat the symptoms.
- Get plenty of rest.
- Drink fluids to prevent dehydration.
- Take acetaminophen (Tylenol®) to reduce fever and pain. Do not take aspirin or ibuprofen.
- If you are pregnant, you can care for someone with Zika if you follow these steps.

- Do not touch blood or body fluids or surfaces with these fluids on them with exposed skin.
- Wash hands with soap and water immediately after providing care.
- Immediately remove and wash clothes if they get blood or body fluids on them. Use laundry detergent and water temperature specified on the garment label. Using bleach is not necessary.
- Clean the sick person's environment daily using household cleaners.
- Immediately clean surfaces that have blood or other body fluids on them using household cleaners or and disinfectants.

Prevention:

The best way to prevent Zika and other viruses spread through mosquito bites is to take steps to prevent mosquito bites. If you are pregnant, strictly follow these steps:

- Wear long-sleeved shirts and long pants.
- Stay in places with air conditioning and use window and door screens to keep mosquitoes outside.
- Use Environmental Protection Agency (EPA)-registered insect repellents with one of the following active ingredients:
 - DEET
 - picaridin
 - IR3535
 - oil of lemon eucalyptus (OLE), or para-menthane-diol (PMD).
- When used as directed, EPA-registered insect repellents are proven safe and effective, even for pregnant and breastfeeding women.
- Treat clothing with permethrin or purchase permethrin-treated items.
- The effectiveness of non-EPA registered insect repellents, including some natural repellents, is not known.

Protect your Children:

- Always follow instructions when applying insect repellent to children.
- Do not use insect repellent on babies younger than 2 months of age.
- Dress your child in clothing that covers arms and legs, or cover crib, stroller, and baby carrier with mosquito netting.
- Do not apply insect repellent onto a child's hands, eyes, mouth, and cut or irritated skin.
- Spray insect repellent onto your hands and then apply to a child's face.
- Do not use products containing oil of lemon eucalyptus (OLE) or para-menthane- diol (PMD) on children under 3 years of age.

Mosquito proof your home:

- Use screens on windows and doors. Repair holes in screens to keep mosquitoes outside.
- Use air conditioning when available.
- Keep mosquitoes from laying eggs in and near standing water.
- Once a week, empty and scrub, turn over, cover, or throw out items that hold water, such as tires, buckets, planters, toys, pools, birdbaths, flowerpots, or trash containers.

Nutrition and Healthy Life-styles

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 women 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. Most providers just avoid this conversation because they do not want to upset women. Many women are self conscious about their weight and may have struggled with weight throughout their lives.

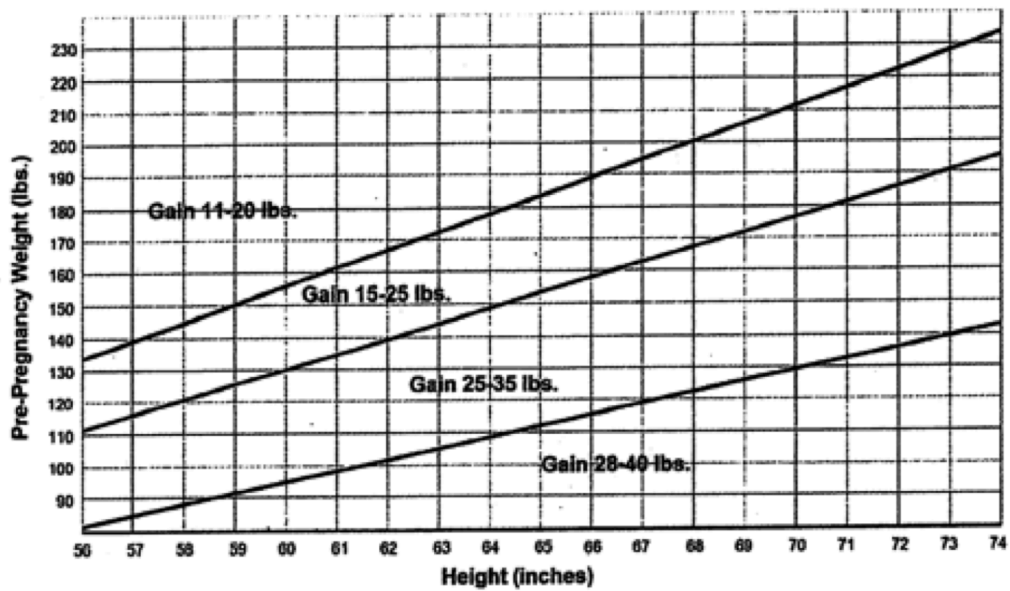
Studies show that weight gain within the Institute of Medicine (IOM) recommended ranges is associated with the best outcomes for both mother and baby. Weight gains outside these ranges are associated with twice as many poor pregnancy outcomes. Weight gain below the IOM ranges is associated with pre-term birth and low birth weight babies. Gains above the IOM ranges increase the risk of complications in pregnancy including macrosomia (baby 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. These women may need closer surveillance to monitor fetal growth and placenta function. We recommend following the IOM guidelines for weight gain in obesity for the best outcomes.

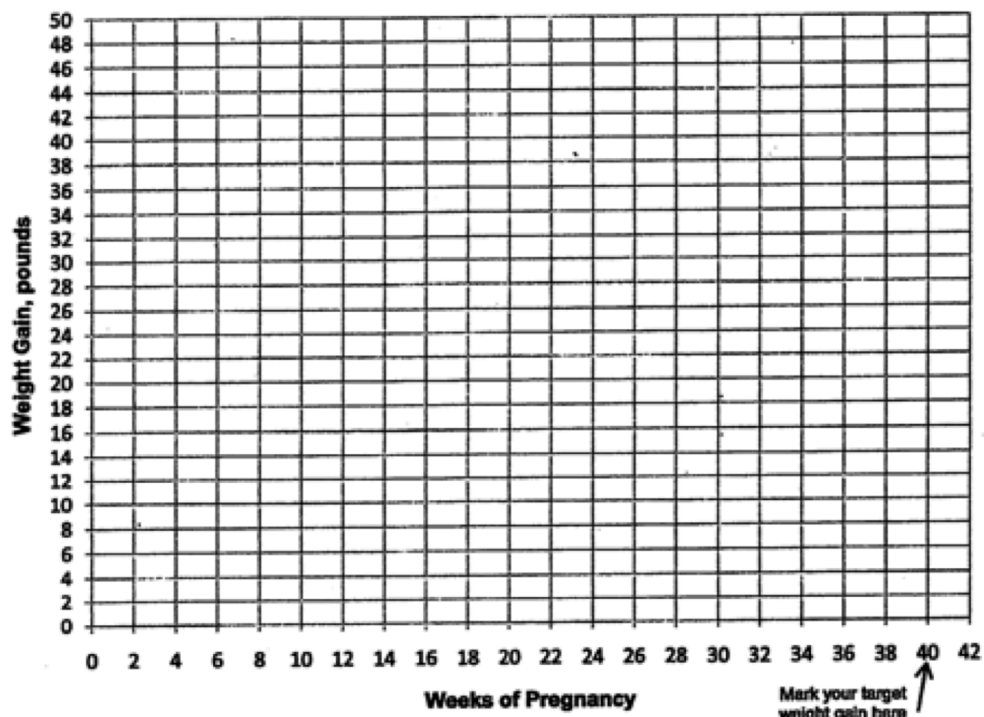
Although weight gain in pregnancy is an important tool to assess the baby's growth, we are most interested in helping women and families make healthy life-style choices during their pregnancy that will hopefully become a permanent part of their lives.

Where do those pounds go?	Institute of Medicine (IOM) Weight gain guide												
6.5-8.5 lbs Baby 2-3 lbs Placenta 2-5 lbs Uterus 2-3 lbs Breast tissue 2-3 lbs Amniotic fluid 4 lbs Blood 5-9 lbs Fat stores needed for birth & breastfeeding	<table><tr><td>BMI <18.5</td><td>Under weight</td><td>28-40 lbs = 12.5-18 kg</td></tr><tr><td>BMI 18.5-24.9</td><td>Normal weight</td><td>25-35 lbs = 11.5-16 kg</td></tr><tr><td>BMI 25-29.9</td><td>Over weight</td><td>15-25 lbs = 7-11.5 kg</td></tr><tr><td>BMI ≥ 30</td><td>Obese</td><td>11-20 lbs = 5-9 kg</td></tr></table> <p>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.</p>	BMI <18.5	Under weight	28-40 lbs = 12.5-18 kg	BMI 18.5-24.9	Normal weight	25-35 lbs = 11.5-16 kg	BMI 25-29.9	Over weight	15-25 lbs = 7-11.5 kg	BMI ≥ 30	Obese	11-20 lbs = 5-9 kg
BMI <18.5	Under weight	28-40 lbs = 12.5-18 kg											
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BMI 25-29.9	Over weight	15-25 lbs = 7-11.5 kg											
BMI ≥ 30	Obese	11-20 lbs = 5-9 kg											

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 (page 82) and your midwife can go over this with you or refer you to a nutritionist for further counseling.



My target weight gain is _____ pounds.



Healthy Life-style 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 <http://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:** Try to stick to a diet full 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 $\frac{1}{4}$ to $\frac{1}{2}$ 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 on **page 85** 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 are not 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.
 - 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 discussion on page 87)

Food Level Guideline








Use these food levels to help you evaluate your diet. Level 1 has the lowest fat and carbs while 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 now. When you cook from scratch and use high quality foods some of the foods listed can be healthier than the level you find them in. 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, mackerel, sardines) * #	Olive oil *	Sweet potatoes +
Bran +	Fish freshwater * #	Olives *	Tea, green or black
Broccoli + #	Flaxseed *	Onions +	Tofu + #
Brussels sprouts +	Garlic, fresh +	Pears, with skin +	Tomato sauce, no sugar +
Cabbage +	Granola, raw, no sugar + * #	Peas + #	Tomatoes +
Carrots +	Kale + #	Peppers +	Vinegar
Cauliflower + #	Lettuce, romaine, green or red leaf +	Plantains +	Water
Celery +		Prunes +	Yams +
Cereal, whole grain + * #		Radishes +	Yogurt, nonfat, no sugar + #

Level 2:			
Apples, skinless + Bananas + Blueberries + Bread, whole grain + Cantaloupe + Cheese, nonfat # Chicken, skinless white meat # Coffee, black or cappuccino w/nonfat milk + # Corn + Cottage cheese, low-fat * #	Cream cheese, nonfat # Duck, free-range * # Granola or energy bar + Eggplant + Fish, farmed # Grapes + Hummus + * # Juice, fresh squeezed, w/pulp, no sugar + Kiwifruit+ Mangoes + Meal replacement bar + * #	Melon, honeydew + Milk, 1% + * # Nuts, raw + * # Ostrich * # Pancakes, buckwheat + # Papayas + Peaches + Pineapple + Plums + Raisins + Ricotta cheese, nonfat # Soy nuts + * #	Soy sauce + Squid # String beans + # Sunflower seeds + * # Tortillas, whole wheat + * # Turkey breast # Vegetable juice + # Veggie Burger + * # Venison, free-range * # Watermelon + Yogurt, no sugar + * # Zucchini +
Level 3:			
A1 Steak Sauce + Angel food cake + Applesauce + Bagels + Beef, eye of round * # Beef, London * # Beef, top round * # Canola oil * Cheese, low-fat * # Chicken, dark meat * # Chicken sandwich, broiled + * # Chicken taco, baked + * # Clams #	Coffee, cappuccino w/ whole milk + * # Crab # Cream cheese, low-fat * # Eggs, whole * # French fries, baked + Fruit, dried + Graham crackers + Granola + * Honey + Jam or marmalade + Jerky, turkey # Juice from concentrate +	Ketchup + Lamb, lean * # Lettuce, iceberg + Lobster # Mayonnaise * Milk, 2% + * # Muesli + * Oatmeal, flavored + Oysters # Pancakes + Pasta, plain + Peanut butter, raw * # Popcorn, plain +	Pork tenderloin * # Potatoes, baked or boiled + Pretzels + Refried beans, low-fat + * # Rice cakes + Rice, white + Sauerkraut + Soup, canned broth + * Steak, lean * # Sweet-and-sour sauce + * Wine, red + Yogurt, frozen, nonfat + #
Level 4:			
Animal crackers + Beef, filet mignon * # Beef, lean ground * # Beef, sirloin * # Beef stroganoff * # Beer + Bread, refined flour + Buffalo * # Butter * Caesar salad, w/ chicken + * # Canadian bacon * # Cheese (including bleu and goat) * Chili + * # Chinese food + * # Chips, low-fat, baked + Coconut *	Coffee, iced mocha latte w/ nonfat milk + # Coffee, latte w/ whole milk + * # Coffee cake + * Crackers + Grilled cheese sandwich + * Ham * # Hot dogs, turkey * # Ice cream, sugar-free or fat-free + Jell-O + Juice, sweetened + Lamb chops * # Lasagna, w/meat * # Macaroni and cheese + * Margarine * Meat loaf * #	Mexican food + * # Milk, whole + * # Muffins + * Nuts, salted or roasted * Peanut butter, no raw + * Pepper, stuffed * Pizza, meatless or Hawaiian style + * # Popcorn, w/ salt and butter + * Pork chop* # Potato salad or macaroni salad + * Pudding, w/ low fat milk + * Reuben sandwich * # Sherbet + Shrimp # Sloppy Joe, lean beef/turkey * #	Soft drinks, diet Soup, canned creamy + * Spaghetti w/ meatballs + * # Sub sandwich + * # Taco salad w/ chicken + * # Tortilla, refined flour or corn + * Tuna salad or chicken salad * # Vegetable oil * Wine, white + Yogurt, frozen + * #
Level 5:			
Alcohol, hard liquor Bacon * # Baked beans + * # Beef, ground, regular * # Beef taco, fried * # Breakfast sandwich, fast food * # Cakes + Candy + Cereal, sugared + Chicken a la King * #	Chicken, buffalo wings or nuggets * # Chicken or fish sandwich fried * # Chips, potato or corn + * Chocolate + * Coffee, mocha, macchiato, ice blended, frappe, triple caramel vanilla, buzz bomb, etc + * Cookies + * Cream cheese *	Creamed veggies + * Creamer, nondairy * Doughnuts + * French fries + * Gravy * Hamburger, fast food * # Hot dogs * # Ice cream + * Jerky, beef, pork, venison # Juice, sugar added + Lobster Newburg * #	Nachos + * Onion rings + * Pastries + * Pies + * Potato skins, fried + * Potpie * # Refried beans, w/ lard + * Salad dressing, creamy * Sausage * # Soft drinks, sugared + Tater tots + * Toaster pastries + *

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

Food Groups	Pregnancy Recommend.	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 more 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.

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						

Vitamins and Supplements

There is a huge difference between synthetic supplements (the vitamin and mineral pills that you buy at a health food store, grocery store, or drug store) 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 called nutraceuticals. They are made by chemical/pharmaceutical companies and 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 lower but they are of much higher quality and potency resulting in better absorption.

We strongly recommend whole food supplements for all our clients and we have selected the whole food supplements from Standard Process for purchase at the birth center. Cyrofood, Tuna Omega 3 oil, Folic acid/B12 and Immuplex are the prenatal supplements we recommend. Talk to your midwife about which supplements would be best for you.

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, supplementation is recommended. Also, women with B12 deficiencies cannot use nitrous oxide in labor. Folic Acid/B12 is a Standard Process whole food supplement that is available at the birth center.

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. Calcium lactate and Cataplex F are Standard Process whole food calcium supplements available at the birth center. 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.

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 cold liver oil. It is fortified in some foods including milk, some juice products, some breads, yogurts and cheeses. You need at least 1000 IU of Vitamin D3 daily and 4000 IU daily if you have low blood levels. Supplements come in liquid or pill form and Cataplex D is the Standard Process Vitamin D supplement available at the birth center.

Maternal vitamin D levels affect the newborn levels. Human milk typically contains about 25 IU or less of vitamin D per liter but lactating women 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. Women who are deficient will not provide enough vitamin D for their baby's needs. We recommend supplementing the mother 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. Tuna Omega-3 oil is a Standard Process whole food supplement available at the birth center.

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 at the birth center 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.

Iron: Women 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. Women with anemia will need to eat iron rich foods and may also need to take an iron supplement. There are several synthetic iron supplements (ferrous sulfate) and several whole food supplements (Floradix and FerroFood). 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)

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)

When taking iron, take it with water or juice and at a different time than your prenatal vitamins. Do not drink milk for at least 1 hour before or after you take iron. Milk and dairy products do not let your body absorb iron. 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 skillet 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 Clams, shrimp Cooked oysters, mussels Heart, kidneys Goose, pheasant, deer, elk Dried seaweed Tofu, soybeans	Beef or lamb Dried beans, lentils Dried dates, apricots, figs Dark meat chicken or turkey Fortified cereals Blackstrap molasses Seeds – sesame, pumpkin	Spinach, dark leafy greens Peas, green beans, broccoli Sweet potato, potato Pumpkin Rice, whole grains Egg yolks Nuts – cashew, pine



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: <http://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.

Food Safety During Pregnancy

Health risk	Where it's found	How to prevent illness
Listeria This is a bacteria 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.

"By far the most common craving for pregnant women is not to be pregnant."

~ Phyllis Diller

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 moms 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. Exceptions will 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 class or part of a series.

****** If you are not sure which class you would like best, we offer an “Introduction to Dar a Luz” class that gives you an opportunity to meet all the educators and hear about their classes and our resources. They can help you sign up for all the classes you are required to take. Most clients find this class very helpful. ******

CLASS CHECKLIST:

***** Classes must be completed by 37 weeks of pregnancy*****

***** Partners are encouraged to attend all classes*****

First-Time Mother	
Required <ul style="list-style-type: none"> ✓ Dar a Luz Series or Blissborn (5 classes) ✓ Breastfeeding 101 ✓ Newborns Head to Toe ✓ Car seat Clinic ✓ Interventions & Transfers 	Strongly Recommended <ul style="list-style-type: none"> ✓ Introduction to Dar a Luz ✓ Pumping Basics ✓ Newborns Beyond the Basics ✓ Infant CPR
Mothers Who HAVE BIRTHED Before but NOT at Dar a Luz	
Required <ul style="list-style-type: none"> ✓ Condensed Class ✓ Interventions & Transfers 	Strongly Recommended <ul style="list-style-type: none"> ✓ Introduction to Dar a Luz ✓ Dar a Luz Series or Blissborn – 5 classes ✓ Breastfeeding 101 ✓ Pumping Basics ✓ Newborns Head to Toe ✓ Newborns Beyond the Basics ✓ Car seat Clinic ✓ Infant CPR
Mothers Who HAVE Birthed at Dar a Luz	
Required <ul style="list-style-type: none"> ✓ Intervention & Transfers – if not taken previously 	Strongly Recommended <ul style="list-style-type: none"> ✓ Condensed Class ✓ Interventions & Transfers

Dar a Luz Birth Class Series (5 classes) is anything but boring or lecture-based. Tailored to the needs of the individuals within each series group, 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! These classes are available to clients who are not receiving their care at the birth center for a fee of \$300.

The Dar a Luz Condensed Class (4 hours) covers the ins and outs of having your baby at the birth center. We discuss the differences between hospitals births and birth center births, while incorporating some fun things like birth visualization. The class covers the basics of labor and birth and gives you ideas for pain coping techniques.

Blissborn Birth Hypnosis® classes (5 classes) give you the tools to practice birth hypnosis. This helps you to use the natural state of hypnotic focus to make birth easier, safer, and more blissful. You will learn to shift from normal awareness to heightened body and mind awareness. You will practice instant triggering of deep physical and mental relaxation anytime, anywhere. This process creates natural anesthesia with the power of your mind. You will be guided to release old negative ideas about what childbirth might be, and reprogramming your subconscious with wonderful new expectations. Perhaps most importantly, this helps you to learn how to control your own body and mind so that you can create the birth experience you desire. (If you're wondering about hypnosis, please go to our website at www.BlissbornOnline.com to download a free 10-minute relaxation.) Blissborn founder Laura Wood teaches here at Dar a Luz. Studies have shown that the Blissborn technique shortens labor, reduces pain, decreases interventions, decreases postpartum depression and Blissborn babies are noticeably calmer too.

Breastfeeding 101

Throw out everything you've ever heard about breastfeeding being difficult or painful and come learn the evidence-based strategies that activate your instincts in breastfeeding and baby care. Find out how amazing your newborn will be in this breastfeeding class which focuses on the early weeks of breastfeeding and learn how to let your BABY teach YOU to breastfeed! Find out how to watch for and prevent difficulties like sore nipples and low milk supply and what to do if they arise. Explore strategies for returning to work or school after the baby is born and ask all your questions about pumping, engorgement, and whether or not you can drink that glass of wine with dinner again. This comprehensive breastfeeding basics class is recommended to all parents.

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. Explore your thoughts on issues like co-sleeping, cloth diapering, baby-wearing and circumcision, and learn coping strategies and resources for difficult or sleepless nights. Learn about normal newborn behavior and appearances and what to do if something doesn't seem right. 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.

Car Seat Clinic

This is a clinic held once a month by Nancy Anthony who is a certified car safety instructor. You will learn which car seat is right for your baby and how to install it. Recommended for all parents.

Interventions and Transfer Class – REQUIRE EVERYONE TO TAKE IT 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 am not worried about that.” The midwives hear the experiences of women after transfer and some are very positive; others report back that they feel some level of trauma around their experience. We hear from mothers 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 woman’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.

We at Dar a Luz 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 moms 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. Our midwives have put together a class to address your fears and answer your questions surrounding interventions and transfers. In May 2014, we started a partnership with New Life Doula Collective to be on call 24/7 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 until you have your baby. 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. Then the midwives will present our transfer statistics and discuss interventions at the birth center and hospital. We have also started a birth trauma support group to help women process their birth experiences. Since starting this program, those families that attend this class 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 women from 2011 to 2016 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 or prolonged rupture of membranes)
- Postpartum 2% (most likely for a mom 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, uncontrollable postpartum hemorrhage, baby not tolerating labor, newborn resuscitation)

The Good News is that MOST WOMEN DO NOT GET TRANSFERRED!!

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

Parenting Classes

Parenting classes meet periodically and cover a variety of topics related to raising young families including, cloth diapering, baby wearing, baby sleep basics, infant CPR, infant massage, mom/baby yoga, intimacy in pregnancy and postpartum, attachment parenting and others. These classes are designed to address interests for both pregnant families and those that have young babies and children. They are taught by a variety of instructors including professionals and community members. Dar a Luz does not endorse or accept responsibility for the content presented in classes taught by community members. We expect families to do their own research on the topics presented. Expect to learn something relevant to your busy, changing life! Parenting classes are open to the entire community. Some classes are free and some have a fee. Check our website for a schedule and register online.

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!

Birth 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:

- 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



Doula Care

You will receive one-on-one care by a midwife that you know during labor and birth at Dar a Luz. However, you may choose to have any other support person or persons present for your labor and birth. This could include your partner, family, friend or a doula. Check out the doulas who have left business cards at the birth center.



A birth doula refers to a supportive companion who is professionally trained to provide labor support and help the woman have a safe and satisfying childbirth experience however she may define that. They do not perform any clinical tasks. A doula provides physical, emotional and information support to women 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 who want to play an active support role.

Doula Support for Hospital Transfer

In May 2014, Dar a Luz partnered 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 packages to choose from including prenatal, labor and postpartum support. You can also choose to have them encapsulate your placenta for around \$200-300. If you would rather to do it yourself, you can rent the Dar a Luz kit with everything you need for \$100. Dar a Luz does not share any of the cost of private hire services.

New Life Birth Services, also hosts the Mother's Circle: Mom and baby yoga group at Dar a Luz. There is a fee for this class. Please check the website for a current schedule of classes.

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.

Preterm Labor

Premature or preterm birth is the birth of a baby before 37 weeks of pregnancy. Women with preterm labor before 34-35 weeks will need hospital care to try to stop their labor and 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 have a greater risk for health problems for the first 2 years of life.

About half of the preterm births happen in women 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 (anytime 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 944-5488.***

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 women 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 his/her own pattern of movements.

You are encouraged to start counting your baby's movements twice a day beginning at 28 weeks of pregnancy. Please choose 2 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. 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 (924-2229) or
the midwife on call (944-5488).**

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

DATE	TIME STARTED	MOVEMENTS FELT	TIME STOPPED	COMMENTS
02-24-18	8: 30 pm	/// // /// //	8:45 pm (15 minutes)	

BIRTH PREFERENCES DOCUMENTS

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 below in the section **Birth Preferences: Your Care at Dar a Luz**.

We encourage you to create a Birth Preferences Document specific to a hospital transfer situation. See the common preferences and some guidelines, in the section **Birth Preferences: Your Care at the Hospital When Transferred**

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 you know 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 2-3 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 the mom
- True Informed Consent/Informed Decline regarding the use of eye ointment and Vitamin K shots. We do not offer Hepatitis B vaccination
- Choices regarding your placenta, including our disposal or 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 home visit

We would also like to let you know our preferences regarding the following:

For example:

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

Birth Preferences: Your Care at the Hospital When Transferred

We hope your birth experience happens entirely at Dar a Luz. It is sometimes necessary for some of our moms and babies to transfer their care to a hospital setting before, during, or after labor and birth. Dar a Luz statistical averages of all women continuing care from 2011-2017: Birthed at DAL- 68%. During pregnancy transfers -18%. Prior to labor transfers - 4%. During labor transfers - 11%. Postpartum transfers - 1%. Newborn transfers - 2%. Emergency transfers - 0.4%. Total vaginal birth rate between DAL and hospital is 90%. Cesarean section rate is 10%. 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!
- 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 mother 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.

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 the mom's 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 the mom's 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 mom asks.
- The use of hypnosis (includes dim lights, soft music, quiet, playing a CD, refraining from speaking to the mom 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 types of medications and procedures to induce and augment labor and when to use them. (Cooks catheter for 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.
- When circumstances allow (non-emergent), ask about "gentle cesarean births" designed to promote breastfeeding, mother-infant bonding and to enhance the experience of the woman 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 but dropping the drape
 - Delayed cord clamping for healthy newborns
 - Skin-to-skin care for newborns

Choices after the birth

- Placing the baby on the mom's 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.
- Option to take the placenta home.
- 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 the baby's routine examinations in the mom's presence, or in the 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 and pacifiers). Access to lactation consultations as needed and providing a pump to express colostrum and breastmilk for baby if mom and 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, 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 mom 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.

What to Expect When 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 Intervention and Transfer 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. When 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 to achieve our number one goal of a healthy mom and baby and secondly that you are able to have a vaginal birth. It may take up to 30 minutes or so to arrange the transfer and get your records completed. For non-emergent transfers, you will follow your midwife in your personal car to the hospital. She goes with you to help answer questions and make the transfer as smooth as possible and will stay a short time (usually 1-2 hours) until you are settled in. We usually transfer to UNM for care by Dr. Larry Leeman and the family practice residents but we do work with all of the area hospitals and we will go to the hospital of your choice. You will have the option to hire the doulas to continue your labor support at the hospital. If there is an emergency, you will be transferred by ambulance to the UNM Hospital. Your midwife will usually come visit you in the hospital after your birth but does not do a home visit after discharge. You need to have the hearing and newborn metabolic screen done on your baby before you leave the hospital. We are happy to continue care for you and your baby at 2-3 days after birth. Please call 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 Practice 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 for over 7 years now and they are supportive of women and their desire to be informed and have the least intervention possible for a healthy mom and baby.

Your care at UNMH usually includes the following:

During labor and birth:

- Compassionate, respectful care from Dr. Leeman and his 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).
- Continuous electronic fetal monitoring of baby’s heart rate and may include internal uterine pressure monitors or fetal scalp electrodes to monitor baby’s heart rate. Options for wireless and waterproof monitoring are available when moving around.
- Providers obtaining permission to conduct vaginal exams when deemed necessary.
- Freedom of movement depending on your choices for pain management.
- Eating may be limited but drinking fluids is usually encouraged. Most women have IV fluids too.
- Pain relief options: movement, water immersion, 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 healthy 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 mother'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 you taking it home.
- Circumcision will be done if desired prior to discharge.
- Newborn 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 mom can be awake during the birth.
- When circumstances allow (non-emergent), UNM does "gentle cesarean births" designed to promote breastfeeding, mother-infant bonding and to enhance the experience of the woman 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 but dropping the drape
 - Delayed cord clamping for healthy newborns
 - Skin-to-skin care for newborns

NICU care:

- Other parent can go to the NICU with the baby. Mom can see baby when she is 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.



EXAMPLE ONLY – Create your own list of preferences reflecting your hopes and values

Birth Preferences of (your names here)

We are aware that our situation may require interventions, and we appreciate your expertise. Although our circumstances have changed as long as mom and baby are doing well, we request the following:

General philosophy

- 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 mom, 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 mother's partner, _____, is authorized to speak, act, and make decisions on the mom's and the baby's behalf, and to go with the baby wherever he/she is 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 drops 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. He/she will stay with the baby. Please allow the baby and the mom to bond as much as possible. Please reunite the mom and the baby 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.
- 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 505 924-2229 or the midwife on call at 505-944-5488 for appointment.
_____(date & time)

Mother's signature _____ Partner's signature _____

Transfer Checklist:

- ✓ Hospital bag
 - Labor support supplies and snacks
 - Clothes and personal toiletries for mom 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
- ✓ Birth preferences document
- ✓ Bring the “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 desired
 - Breastfeeding tips and reminders
- ✓ Remember:
 - Call the midwife on call (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 sign for the door when you do not want to be disturbed or need more privacy
 - Call the midwife on call when you are discharged (505-944-5488)
- ✓ Followup 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 baby hat and onsie.
 - You can put your baby’s name and birth date up on the sign when you come back for a visit.

Additional Notes:

Attention: Your insurance plan may not cover all hospitals in the area and 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 at the hospital:

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.

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)? Copay _____ Deductible _____ Coins _____

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 his/her own Deductible? _____ Coinsurance? _____ Copay? _____

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

Post Term Pregnancy

Post term pregnancy is defined as a pregnancy lasting longer than 42 weeks with accurate dating. Recent studies show, only about 3% of pregnancies will go over 42 weeks. The risk of having a post term pregnancy is increased in first pregnancies, a prior post term pregnancy, obesity, carrying a male fetus and genetic factors.

WHY IS THIS IMPORTANT?

The risks of maternal and fetal complications and perinatal mortality (stillbirth and early neonatal death) increase the longer a pregnancy continues past 40 weeks. A newer term, **postdates**, refers to pregnancies between 40-42 weeks.

FETAL AND NEONATAL RISKS

Fetal risks include complications from fetal post-maturity syndrome (growth restriction due to poor placental function), meconium aspiration (respiratory distress, fast breathing rate and pneumonia) and fetal macrosomia (a baby weighing over 9 pounds 14 ounces). 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 mom's pubic bone). These could require a cesarean section for delivery or result in injury to the baby with vaginal birth.

Perinatal mortality increases in postdates pregnancies. In 1999, a British study showed the risk of stillbirth was 1 in 926 at 40 weeks' gestation, 1 in 826 at 41 weeks, 1 in 769 at 42 weeks, and 1 in 633 at 43 weeks. Another study quoted 2-3 deaths per 1000 pregnancies at 40 weeks versus 4-7 deaths per 1000 at 42 weeks. Low risk pregnancies with normal antenatal testing starting twice weekly at 41 weeks have been shown to have a rate of 1-2 deaths per 1000 at 42 weeks. A British study in 2007 found that there were no increases in stillbirth rates after 41 weeks for women who have had a baby before and therefore no benefit for induction at 41 weeks.

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 than women who have had children before and the rate of complications increases from 40 to 42 weeks in all of these. Rates of vacuum delivery at 42 weeks were 20.2%, perineal injury was 12% at 41 weeks, and uterine infection was 7.7% at 41 weeks. The rates for cesarean section increase from 9.5% at 40 weeks, 12.6% at 41 weeks and 14.9% at 42 weeks according to Caughey & Bishop, 2006.

MANAGEMENT OPTIONS

Women should be counseled about the risks of induction versus expectant management. Studies show that there are reduced risks with the following management of the pregnancy from 40-42 weeks in low risk women.

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 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. Birth centers offer non-medical inductions using natural cervical ripening methods, foley bulb, 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 women and healthy babies.
3. 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 women. 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 women 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. First time mothers, obesity and advanced maternal age increases the chances of failure of induction.

4. If a woman declines induction of labor at 41 weeks, twice weekly antenatal testing (BPP/AFI and NST at 41 weeks and NST at 41 ½ weeks) should start 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.
5. Induction of labor at 42 weeks should be scheduled if the woman does not go into spontaneous labor. Women with risk factors will be given individual counseling about their risks and may benefit from induction prior to 41 weeks.

DAR A LUZ MANAGEMENT OPTIONS

The midwives will discuss your individual risks if you go past your due date and will work with you to develop a plan. Most of our mothers go into labor spontaneously or with the help of non-medical induction at the birth center. Very few mothers (3 out of 100) need to go to the hospital for an induction at 42 weeks.

We recommend a limited ultrasound called a biophysical profile (BPP) at or a few days before 41 weeks and a NST at the birth center. If labor has not started by 41 weeks 3 days, we would repeat the NST at the birth center and discuss options for non-medical methods of induction like mechanical dilatation of the cervix with a foley balloon, castor oil and nipple stimulation with a breast pump. 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 by 42 weeks, you will 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.



Alternative non-medical methods for cervical ripening and/or induction of labor

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. Keep in mind that any methods used to stimulate labor are **Interventions** and may increase risks for complications.

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 women. 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 women who have previously had a baby. Some of these methods may be recommended by the midwives to ripen the cervix once you reach your due date, if you are past 41 weeks of pregnancy or if your water breaks and labor has not started in 4-8 hours. 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 women.
- **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 women and is more effective with a favorable cervix. There was no increase risk of cesarean section or meconium stained fluid. There were no instances of uterine hyperstimulation.
- **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
- **Accupuncture** 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 as a method of induction of labor has been poorly researched. 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.
- **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. Only take this with the direction of your midwife.
 - We suggest starting early in the day. Drink 2 ounces castor oil in a milk shake or blended with ice cream or frozen yogurt. Stay home all day and expect abdominal cramping, diarrhea and nausea or vomiting. Expect the first bowel movement in 2-6 hours and eat after that. Increase your fluid intake to prevent dehydration. May repeat the same dose in 4 hours if no regular contractions have been stimulated.



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 WOMEN:

- Call ANYTIME you are concerned.
- Call ANYTIME if you are GBS POSITIVE and your water breaks or you think it might be leaking.
- Call ANYTIME your water breaks or you think you might be leaking amniotic fluid. If you are not contracting and are GBS NEGATIVE, we will recommend that you try and go back to sleep and call again after 8:00 am to make a plan for evaluation.
- Call DURING THE DAY if you think you might be in labor. At night, we request that you call when you think you are ready to come in. We need to rest as much as possible to be the best midwife for you in labor! It is often very difficult to go back to sleep when we get a “heads up”.
- 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).

FOR FIRST TIME MOTHERS:

- If you are GBS NEGATIVE: call when contractions are about **2-3 minutes apart**, strong, are felt over your entire uterus (not just low cramping), 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 not broken, call when the contractions are about every 3-5 minutes for about an hour and getting stronger.

FOR SUBSEQUENT PREGNANCIES:

- When contractions are about **3-5 minutes apart**, strong, are felt over your entire uterus (not just low cramping), you are unable to walk/talk/do anything else during contractions, and they **last about 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 second and subsequent labors can move quickly once active labor is reached. Listen to your body.
- If you are GBS POSITIVE, and your water has not broken, call when the contractions are regular and are about every 5-7 minutes.

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

Labor Coping Methods

Women 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 during labor
- Use birthing balls
- Change positions often. Sit, squat, lie down or stand
- Take a warm bath or shower once labor is active (not too early)
- Get a back massage
- Take deep breaths and relax or use hypnosis
- Listen to music
- Have a person you trust with you all the time

Hydrotherapy and Water Birth: 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 women requesting this option for both hospital and out-of-hospital births is occurring. Hydrotherapy can also decrease blood pressure, conserve energy, reduce the need for pain medications and/or other interventions, reduces perineal tearing, cesarean section and is rated very highly for mothers while being a more gentle way for a baby to be born. The midwives at the birth center are trained in water birth and can talk to you more about this option.

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: Nitrous oxide (laughing gas) is blended to deliver 50% inhaled nitrous oxide (N₂O) and 50% oxygen (O₂) 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. 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 women. The birth center started offering nitrous oxide for laboring women in February 2013 and about 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 reducing effects of nitrous oxide vary but most women who have used it were satisfied with the effects.

Some of the **benefits** of using Nitrous Oxide include:

- It is self-administered and the woman controls how much she wants
- It takes the edge off the pain and decreases anxiety
- Women remain awake and alert with the ability to move around
- There is no effect on the mother'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
- There is no effect on baby's breathing, heart rate or Apgar scores
- Babies are alert and responsive
- There is no increase in meconium stained amniotic fluid

Side effects of nitrous may include nausea and vomiting, dizziness, restlessness and anxiety. A woman is not a good candidate for using nitrous if she cannot hold the nitrous mask for herself or has a documented vitamin B12 deficiency.



Intravenous ("IV") Medications: The birth center has these medicines available to help dull the pain 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. Since the IV medicines can make you and your baby sleepy, you are given less medicine close to the time of actual birth of your baby.

Epidural Block: If you need more pain relief or rest and desire an epidural, you would be transferred 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.
- 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 women 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 in 20,000 cases).

Effects of the epidural block on labor care

- Women 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.
- Women are **more likely to need Pitocin®** (oxytocin) in the IV to make their labor contractions stronger.
- Women are **more likely to push longer** (1-2 hours longer) to get their baby out.
- Women 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.
- Women who use epidurals do not appear to be more likely to need a cesarean section or develop long-term back pain.
- Using an epidural does not increase infection in mothers and babies but **might make your temperature go up**. Sometimes your baby might have to stay in the hospital longer due to this fever.

***“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

Water Immersion During Labor and Birth

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 either non-existent or very rare.

Many organizations that support women in birth including the American College of Nurse Midwives (ACNM), Water birth 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 women 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 of newborns.

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, women 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 1.0% in the water birth sample. The total rate of any respiratory issues was 1.6% in the babies born in water and 2.0% 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 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 women 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 mothers 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 mothers have experienced the benefits of immersion in water for labor and birth.

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 an un-medicated mother 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 women.

- **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 woman and/or neonate could acquire an atypical infection. There have been reported cases of legionaries 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, women should get out of the water for further evaluation.
- **Mortality.** As with conventional birth, the potential exists for death of the woman 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 WATER BIRTH:

- Single baby in head down position at time of labor
- Gestation of 37 – 42 weeks
- Normal fetal heart rate without any decelerations

WHEN IS WATER BIRTH 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 woman 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 woman'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 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 water birth.
- All low risk mothers are eligible for water birth. No exclusions for GBS positive or meconium stained fluid.
- Moms 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.
- Women may use self-administered nitrous oxide in the tub.
- Maternal vital signs are assessed every 1-2 hours and 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 insure the tubs and any equipment used in the tub are either disposed of or thoroughly cleaned after every use to prevent infection.

Positions for Labor and Birth

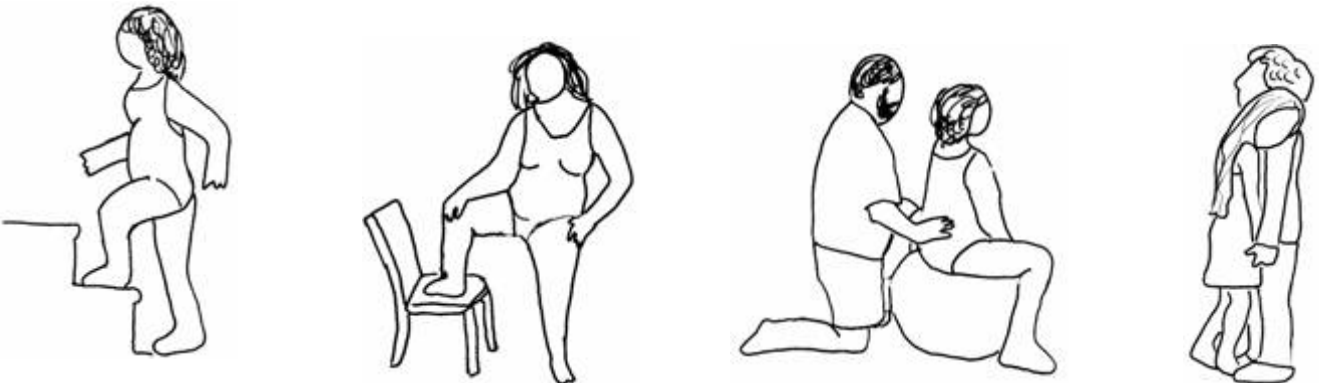
Exercises: Tailor Sit, Tailor Press, and Pelvic Tilts:



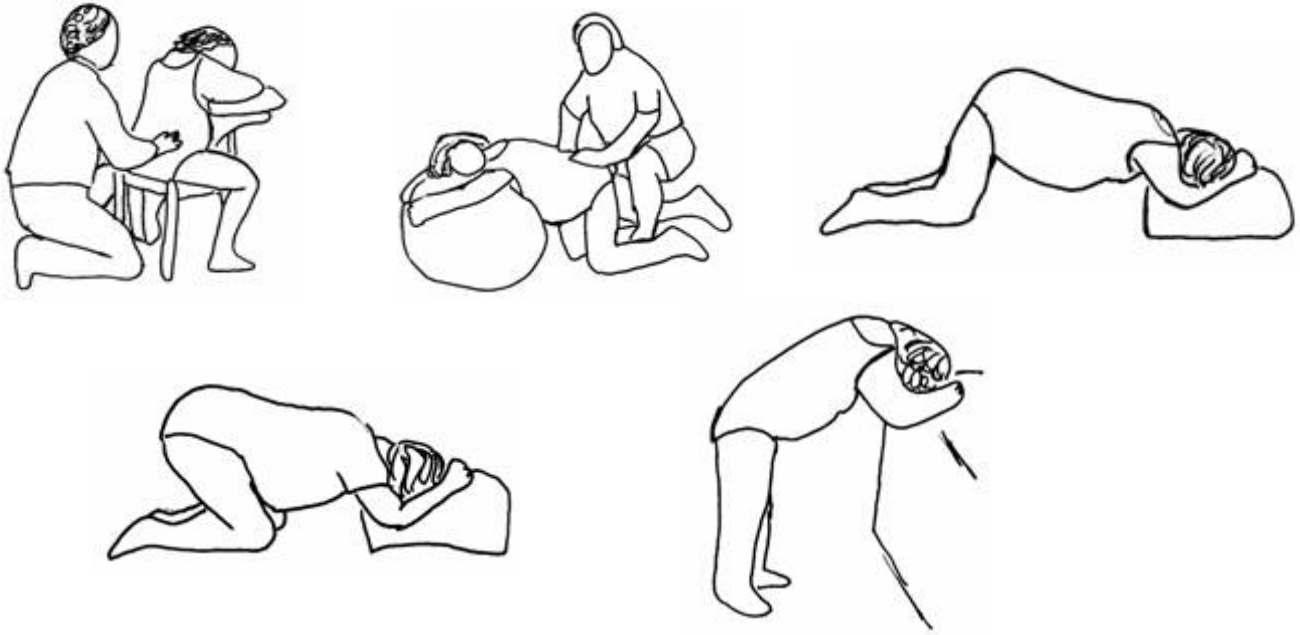
Positions for Resting During Labor



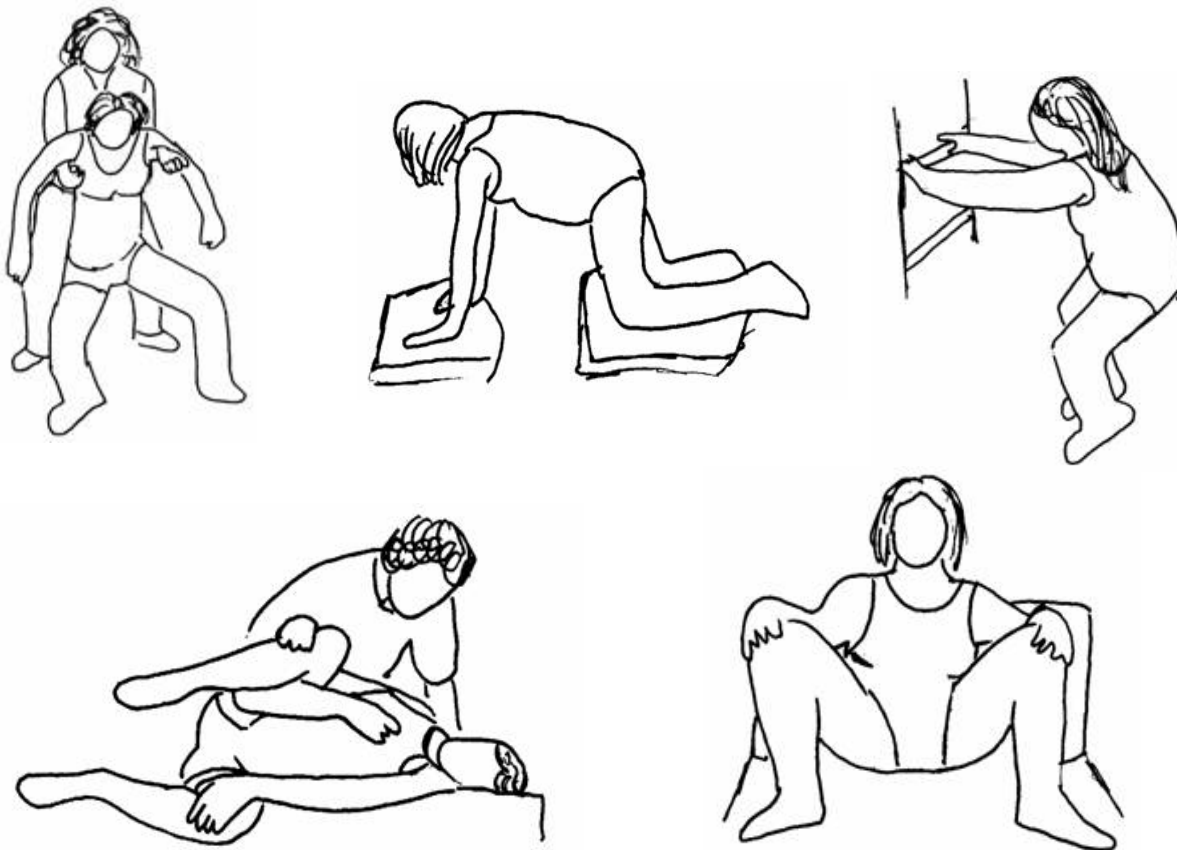
Positions for Being Active During Labor



Positions for Back Labor



Positions for Birth



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, water birth 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.

What to bring to the Birth Center

- Your favorite protein and high calorie snacks and high calorie drinks for mom in labor (fruit, juices, soft drinks, jello, power bars, honey, milk shakes, etc.) Do not bring low calorie drinks – you need the energy for labor!
- Food for the rest of your family
- Clothes for labor and to wear home. Partners need swimwear if they want to get in the tub or shower.
- Shoes to walk around in the gardens (flip-flops are not good in the mulch)
- The birth center provides mesh panties, peri-bottle (to dilute your urine stream with warm water if there are any tears or stitches) and pads while you are at the center. You will need large pads at home.
- Music on iPod or phone, camera, video recorder
- No candles please (we have flameless candles that we can provide for your use)
- 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 hat and onesie
- Cooler for taking the placenta home

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 need to break 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.

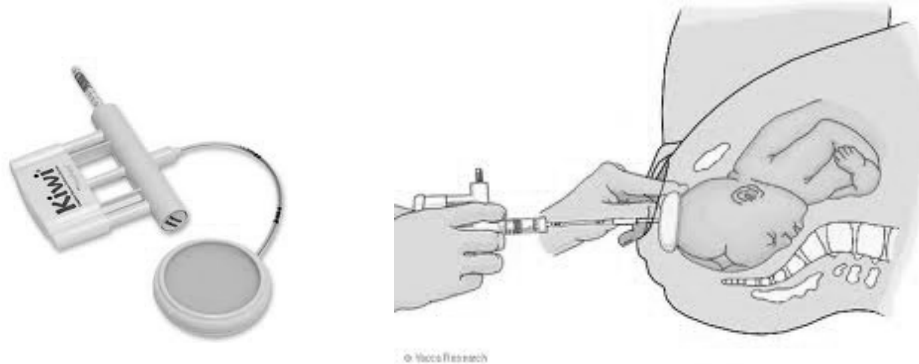
Birth of Your Baby: The majority of all babies are born vaginally and traditionally that rate is about 90% in birth centers. We encourage you to birth your baby where you feel comfortable, whether that is in the water, bed or somewhere in the room. A midwife and a birth assistant will be with you at your birth.

Repair of Tears or Episiotomy: Most women have minor or no separations of the tissues in the vaginal area when the baby passes through. Some tears may need a repair 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 distress or maternal exhaustion. When needed, your midwife will use a local anesthetic and stitches to close the tear or cut.



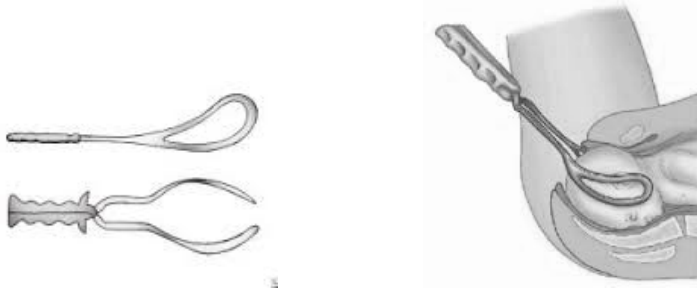
Vacuum Delivery:

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 mother pushes to help the baby come out.



Forcep Delivery:

Forcep assisted births are only done in the hospital. Sometimes forceps may be needed 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 mother pushes. The doctor will describe the risks to you and your baby if you need this help.



Cesarean Sections:

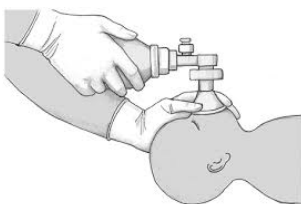
Cesarean sections are only done in the hospital. Sometimes a C-section is needed because of problems with the mother or the baby. At the hospitals, labor and delivery staff are ready 24 hours a day to do C-Sections if needed. Most cesarean births are done with spinal anesthesia so mom can be awake during the birth. When circumstances allow (non-emergent), some hospitals are offering "gentle cesarean births" designed to promote breastfeeding, mother-infant bonding and to enhance the experience of the woman 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 but dropping the drape
- Delayed cord clamping for healthy newborns
- Skin-to-skin care for newborns

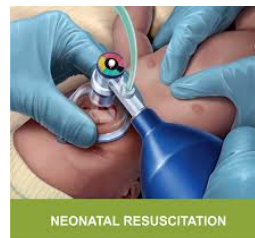
Newborn Resuscitation:

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 cut and 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. It is rare that a baby needs more help transitioning than this but if the baby continues to have signs of respiratory distress we would be talking to you about transferring the baby to the hospital for further evaluation and support that we can not provide at the birth center.



Very few babies need a full resuscitation but if the baby's heart rate drops below 60 despite a full minute of effective breathing with the bag and mask we would start chest compressions and call 911. Babies usually respond to these measures before the EMS arrives but these babies need special post resuscitation care and the baby would be transferred to the hospital. Usually the partner or a staff member can ride in the ambulance and the mom would be discharged early once she is stable to join her baby at the hospital. We realize this is scary and are including this information to help you be better prepared.

Unexpected Home or Car Birth

Labor can be shorter than you expect. This can be true for first time mothers but happens more frequently for mothers who have had a baby before. Your cervix changes faster after the first birth and you may find the contractions getting 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 will take this into consideration when making a plan with you about when to call for signs of labor. It is safer for you to come in a little earlier and be sure that you make it to the birth center than to birth unexpectedly at home or in the car. Just remember that when an unexpected birth happens, it is usually fast and the baby cries right away and everyone is fine!

The midwives will cover what to do in this situation during the Intervention & Transfer 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 if you are at home or in the car
- The midwife will assess your situation and make a plan with you. She will 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 mom
 - 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 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 minutes to come out but can be up to 30 minutes.
- Usually by this point, the EMTs are there or you are at the birth center.

If you have called 911, the EMT's will evaluate the mother and baby and will usually 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 mother is bleeding or baby is not breathing normally, we advise you to go to the hospital. Please request to go to UNM and the midwife will meet you in Labor & Delivery for evaluation. If the baby is crying and pink and the mother is 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 mother and repair of lacerations as needed. If the baby is doing well, then mom 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 mom or baby has been admitted to the hospital after an unexpected home birth.

If you are en route to the birth center when the baby is born, please let the midwife know or honk your horn when you arrive so that we can meet you at the car. Mom and baby will stay for the normal postpartum and newborn recovery depending on the situation.

Breastfeeding

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.

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.

Breastfeeding laws protect your right to breastfeed.



Federal and New Mexico state laws protect a mother's right to breastfeed her 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 her for this time.

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, leukemia and Sudden Infant Death Syndrome

For Mom:

- 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 cancer, 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 he/she is skin to skin. (Partners can do this too!) Repeated skin to skin contact helps your baby to develop and increases your milk supply.

Colostrum: Colostrum is the first milk your breasts will produce and it is very high in protein. This is the perfect milk for your baby. It helps 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.

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, 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 of colostrum. By day three, your baby's stomach stretches more and holds less than one ounce per feeding. By day 10, your baby's stomach has stretched to the size of a ping-pong ball. It holds about two- 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 moms and babies 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 also come visit you at home 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 (924-2229) or the midwife on call (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.
- Formula feeding and artificial nipples 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 and restlessness.

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.
- 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.
- You will need BPA-free plastic or glass breast milk bottles or milk storage bags (not regular freezer bags) to store pumped milk.
- You may want to get some Quick Clean micro-steam bags to clean your pump parts (microwave bags 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.

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 are now covering breast pumps under the Affordable Care Act and the midwives can write a prescription for you to get a pump. Bring it with you to the class. We also keep Medela breast pump 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?

- 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 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 is 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.

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,

they are 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.

What do I store breast milk in? Glass or hard BPA-free plastic bottles or breast milk freezer bags. Make sure to label with date expressed. Studies show that adherence to container is about equal between glass and BPA-free plastic. Only use bags specifically made for breast milk and consider putting them in another container to avoid puncture.

How long can I store breast milk in refrigerator or freezer? You can store breast milk for up to 8 days in the refrigerator, but ideally no more than 3. You can transfer from the fridge to freezer any time during the 8 days, but if you are not planning to use within a couple of days place in freezer as soon as possible. Do not store in the door of the fridge or freezer. Breast milk can be stored in the freezer for 6 months and deep freeze for 12 months but less than 3 months is ideal. The nutritional needs of a baby change over time and freezing milk does destroy some of the antibodies and vitamin C in the milk so consider only freezing if needed.

Breast milk Storage Guidelines (For Healthy Term Babies)					
Type of breast milk	Room, table, counter	Cooler with ice packs	Refrigerator	Refrigerator freezer with separate door	Chest or upright deep freezer
Freshly expressed breast milk	6-8 hours up to 77°F (25°C)	24 hours at 5-39°F (-15-4°C)	5 days at 39°F (4°C)	3-6 months at 0°F (-18°C)	6-12 months at -4°F (-20°C)
Thawed breast milk (previously frozen)	Do not store	Do not Store	24 hours	Never refreeze thawed milk	Never refreeze thawed milk

How do I thaw frozen breast milk? Place in fridge overnight to thaw or run under cool water gradually increasing temperature. Thawed milk needs be used within 24 hours. Do not refreeze thawed milk.

How do I heat breast milk? Run under warm (not hot) water or place in a bowl of warm water replacing water periodically. Never microwave or boil breast milk as this destroys antibodies in the milk and can cause hot spots in milk. You can offer milk cold to older babies.

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
La Leche League Helpline (505) 821-2511 or (877) 452-5324 outside of Albuquerque
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

MILK DEPOT

Dar a Luz is the first location in New Mexico to offer services to women who want to donate their milk to the Mother's Milk Bank in Denver, Colorado. First, you have to contact the milk bank and go through their screening process. When you are approved, we can draw your blood at the birth center and ship your donated milk to the milk bank. Our hours for milk drop off and blood draws are Wednesdays from 9:30 am to 1 pm.

Mother's Milk Bank: Phone: (303) 839-6782 **Fax:** (303) 839-6783 <http://rmchildren.org/mothers-milk-bank/>

***“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

Supplemental Feeding

Dar a Luz supports a woman's right to make choices in all areas of her life including how she feeds her 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 a woman may choose to supplement her baby with her own pumped milk, pasteurized or 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)
- A baby who is too sleepy to nurse due to jaundice
- A baby who has a painful latch causing nipple damage
- A baby who is not vigorous at the breast which can be due to low 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
- Not being able to make enough milk due to hypoplasia of the breast (decreased breast tissue)
- Just needing a break or letting someone else feed the baby so mom 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.

Supplemental Feeding with Donor Breast Milk

What is Donor Breast Milk?

Human milk donated from lactating mothers to provide nutrients and protective health benefits to infants that are not biologically their own. Women have been providing breast milk to infants that are not their own biological children for thousands of years. Before the advent of commercial formulas, wet nursing was the only way that infants could survive if their mother was unable to breastfeed. As the number of wet nurses declined at the turn of the 20th Century, doctors looked for other ways to provide milk to sick children. In 1911, the first U.S. donor milk bank was founded.

Not all Donor Breast Milk is Equal.

There are a wide range of milks available from milk processed at a milk bank that meets the highest standards of safety; informally shared milk on social media; to informally sold milk on the internet which is the most risky and may be the poorest quality.

Indications for use of Donor Breast Milk:

Prematurity, allergies, feeding/formula intolerance, inadequate milk supply, immunologic deficiencies, postoperative nutrition, and inborn errors of metabolism.

Benefits of Donor Breast Milk:

- Human breast milk provides nutrition, digestive enzymes, immunologic factors, growth factors, and other bioactive factors that may be especially beneficial to preterm infants.
- It also decreases incidence and/or severity of infectious diseases including bacterial meningitis, bacteremia, diarrhea, respiratory tract infection, necrotizing enterocolitis, otitis media, urinary tract infection, and late-onset sepsis in preterm infants.
- Formula use in preterm and low birth weight infants increases the risk of feeding intolerance and an association with necrotizing enterocolitis and late-onset sepsis with formula use.

- American Academy of Pediatrics research supports that breastfed infants have significantly lower rates of infections of the ear, respiratory and gastrointestinal tracts, asthma, dermatitis, obesity, celiac disease, diabetes, leukemia and SIDS.

Risks for Using Donor Breast Milk:

The FDA and American Academy of Pediatrics recommend using milk processed at a milk bank that meets strict standards to ensure the safety of the milk.

No organizations endorse the use of informally shared breast milk. There is no regulation of it and there has been little research at this time comparing the risks of banked human milk versus informally shared human milk for babies in this country. There is no official place for mothers to report negative experiences they have had while engaging in informal milk sharing. It is a complex issue and one that deserves careful examination by anyone considering any kind of milk sharing.

Risks of informally shared breast milk:

- Exposure to infection - HIV, Hepatitis B, Hepatitis C, syphilis, HTLV - human T cell lymphotropic virus.
- Exposure to harmful herbs, medications, drugs, alcohol, nicotine.
- Possible bacterial contaminants in milk due to unsafe handling of the milk.

Types of Donor Breast Milk

Donor Milk Banking:

Milk that has been collected from volunteer breastfeeding women 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 \$6/ounce or more 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 her milk supply and produce milk in excess of her own baby's needs
- ✓ Be willing to donate a minimum total of 150 ounces throughout her time as a donor
- ✓ Not have any medical condition that prohibits her from giving blood
- ✓ Be in excellent health without any 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 marijuana 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 and products containing fenugreek or other herbs are NOT 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 carry out careful milk collection and storage methods
- ✓ Be willing to undergo blood testing
- ✓ Be less than 18 months postpartum when collecting the milk

Informal Donor Breast Milk Sharing:

Selling of Informal Donor Breast Milk:

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.

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 insure 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). 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*. 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 158 degree Centigrade 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.

Dar a Luz Donor Breast Milk:

Dar a Luz Birth & Health Center is supportive of all women in their feeding choices for their babies; however, it does NOT condone buying informally shared breast milk on the internet. Dar a Luz agrees with the research that milk bank processed milk is the safest option.

Dar a Luz keeps a small supply of pasteurized donor milk from the Denver Milk Bank that can be purchased at the center by calling the office. It is approximately \$24 for a 4 oz frozen bottle. If your baby is admitted to NICU and needs supplemental feedings, you can only supplement with pasteurized donor milk or formula.

Dar a Luz also stores informal donor breast milk from approved Denver Milk Bank donors and clients of Dar a Luz who have been screen prenatally for HIV I&II, Hepatitis B & C and Syphilis. Although Dar a Luz does not endorse the informal sharing of donor breast milk or assume any liability for its use, the milk is available free of charge to clients who are making an informed choice to use the informally shared milk.

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. There is a very informative post about the ingredients in formulas at: <http://foodbabe.com/2013/05/28/how-to-find-the-safest-organic-infant-formula/>. You might also ask your pediatric provider if he/she has any recommendations. There are different types of formulas from regular to organic and those made from cows 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 some 4 to 8-ounce bottles (safe plastics or glass) and nipples. Usually about 10 bottles are needed if you are only supplementing.
- Some women 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 syringe fed or spoon-fed 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.



Preparing For Baby

By the time you reach 37 weeks, you will want to have things ready at home for your baby's arrival. You will need the following:



Bassinets, Co-Sleepers, Cradles: In 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: <http://www.cpsc.gov/cpscpub/pubs/5030.html>. 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.

Clothing: Newborn's clothing is fairly basic. 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.

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. One of our moms is passionate about cloth diapers and very knowledgeable. Watch for one of her workshops at the birth center on meetup.com for more detailed information and examples of all the diapers. She has also donated some cloth diapers to be used at the center for your baby before you go home so you can try them out. We also have a few diapers at the center for you to look at and an information sheet.

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 potty 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 <http://www.fluffloveuniversity.com/>

Rio Grande Diaper Service [\(505\) 877-6311](tel:5058776311)

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 story telling, 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.

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? The only way to assess that is to take a pause, and slow down. -Karen Strange

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.

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 interruptions 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.

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

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 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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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 and has developed eight principles.

Eight Principles of Parenting

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 <http://www.attachmentparenting.org/>
- Abby Bordner (Santa Fe) <http://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 mothers about their experiences. YouTube has lots of how to videos.

Additional resources:

- Babywearing NM (website and Facebook group) <http://www.babywearingnm.org/>
- Baby Wearing International <https://babywearinginternational.org>

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 his or her 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 his or her 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 his or her 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 his or her 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

The following website has more information on how to safely bed share with your baby:
<http://cosleeping.nd.edu/safe-co-sleeping-guidelines/>

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. First, 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 around 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 <https://www.happiestbaby.com> These include: 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
- 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 <https://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 she circumcised her 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.

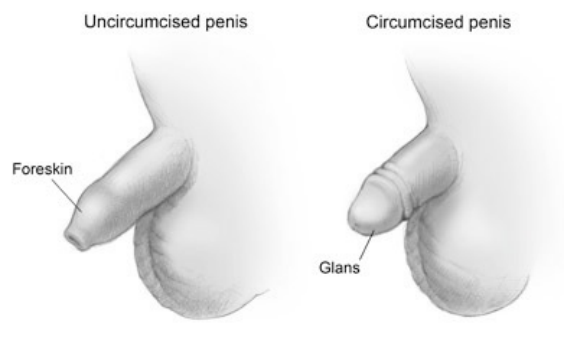
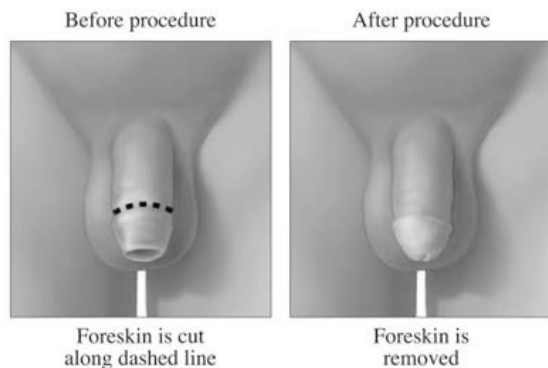
In 1999, the American Association of Pediatrics (AAP) was neutral on circumcision but in 2012 they changed their position to favor circumcision and issued this position statement:

"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 1 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 <http://pediatrics.aappublications.org/content/130/3/585>

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 the preputial orifice so the glans can be visualized;
3. Bluntly free 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. Amputation of the foreskin. (American Association of Pediatrics, 1999)

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.

Not To Circumcise or To Circumcise: 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 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:

- 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 than 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 physicians each have an ethical duty to the child to attempt to secure the child’s best interest and well-being.” The birth center supports an individual’s right to choose what is done to their body and does not perform circumcision. Parents need to arrange this to be done by their pediatric provider.

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 his/her 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%.

“Babies are such a nice way to start people.”

~ Don Herald

Shaken Baby Syndrome – New 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 | ■ Cerebral palsy |
| ■ Paralysis | ■ Blindness |
| ■ Deafness | ■ Seizures/Epilepsy |
| ■ Learning disabilities | ■ Behavioral disorders |
| ■ Developmental delays | ■ 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.

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!

WHILE WE'RE OUT...

The _____ Family Babysitter Notes

We will be at: _____

Cell #: _____

We should be home around: _____

In case of emergency

Address: _____

If you can't reach us, call _____ at _____

Remember

- | | |
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House Rules

- | | |
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| _____ | _____ |

WHAT TO DO WITH A CRYING BABY

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 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 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. The baby is safe in the crib. Be sure to check on the baby every 5-10 minutes.

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.

Comfort the baby:

6. Wrap the baby snugly in a light blanket. (This is called swaddling.)
7. Give the baby a lukewarm bath. Stay with the baby the whole time.
8. Massage the baby gently on the back, arms, or legs.
9. Sing softly. People all over the world sing lullabies to crying babies.
10. Calm the baby with soft words like "it's OK." (This can help comfort both you and the baby.)
11. Hum in a low tone against the baby's head.

Distract your baby:

12. Run a vacuum cleaner or dishwasher to make "white noise." This may take the baby's mind off crying.
13. Rock with the baby in a rocking chair. This may relax you both.
14. Push the baby in a stroller.
15. Put the baby in a baby swing for a slow, rocking motion.
16. Place the baby underneath a lighted mobile.
17. Dance slowly while holding the baby... and relax!

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 mothers, 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 of around \$125 with a 20 year cost ranging from \$2000 to \$4500). 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 more gentle 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.

The first 2 hours are called the "Golden Hours" and we encouraged 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 monitor his/her 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: New Mexico state law requires that erythromycin antibiotic ointment be placed in the newborn's eyes immediately after 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. This is done to protect the baby from 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.

Preventive treatment with 0.5% erythromycin ophthalmic ointment is considered 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. During your prenatal care, we routinely test the mother for gonorrhea and chlamydia so that you will know your status and can determine your baby's risk. You will be given the opportunity to discuss the benefits and harms of this treatment and will sign a consent to accept or decline treatment. If you want the antibiotic ointment (erythromycin) in your baby's eyes, it will be done at least 2 hours after birth.

Vitamin K: Newborns have low levels of vitamin K and low levels of vitamin K dependent clotting factors. This deficiency intensifies before they begin making 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 1-9 mcg vs. 53-66 mcg in formula) putting them at increased risk for "Vitamin K deficiency bleeding". Serious hemorrhagic complications can occur and are preventable with vitamin K intramuscular prophylaxis.

Early vitamin K deficiency bleeding usually occurs between birth and the first week of life. The chances of early bleeding range from 0.25 to 1.7 cases per 100 births. Bleeding may present in one or more areas with oozing from the umbilicus, cephalhematoma, intestinal tract, skin bruising, nose and mouth, bleeding from the circumcision and injection sites and inside the abdomen or chest. Risk factors for early onset include breastfeeding exclusively, the mother taking medications for seizures (phenytoin, phenobarbital, carbamazepine, or primidone), blood thinning agents (coumadin, aspirin) or antibiotics (especially cephalosporins).

Late onset can occur between 2 to 6 months of life in 4.4 to 7.2 per 100,000 births. Bleeding commonly occurs in the brain. Risks for late onset include infants who are exclusively breastfed who have received no vitamin K or inadequate oral vitamin K prophylaxis. There are no cases reported with intramuscular vitamin K use. Also infants who have intestinal malabsorption defects (cystic fibrosis, celiac disease, chronic diarrhea, hepatitis, cholestatic jaundice) are at risk.

SAFETY

One study in 1990 attempted to show an association between intramuscular vitamin K administration and increased incidence of childhood leukemia and cancer but many additional studies since then have refuted this claim and found no association between the two. 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.

TREATMENT

The American Academy of Pediatrics (AAP) has recommended vitamin K for prophylaxis since 1961 and today it is the standard of care. 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". The injectable form has a long history of preventing both early and late onset "vitamin K deficiency bleeding" in the newborn with no reported

cases of bleeding. The AAP recommends the injectable vitamin K because it gives the best protection to newborns with proven safety.

Oral administration of vitamin K 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 1.2 to 1.8 per 100,000 births. Babies receiving incomplete oral vitamin K are at higher risk with rates of 2 to 4 per 100,000. In countries that have increased the use of oral vitamin K there has been an increase of reported bleeding cases compared to injectable use. 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
- 2mg oral vitamin K after first feeding and then 2 mg within first week followed by 25 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. 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 the mother take 5mg/day oral supplementation to further protect from late onset bleeding.

“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

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 his/her temperature in a normal range and breathing and heart rate are normal. For mom, this means she is able to eat, has been able to urinate, her vital signs are stable and her bleeding is a normal amount. The family is usually able to go home in about 4 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. 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 and will be given a Postpartum Discharge Instructions Summary handout and the nurse will go over it 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. 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. Women in Western society 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. Women 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 women prepare the placenta fresh (we have recipes) 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. We have instructions on how to do this yourself and can rent the equipment to you for \$100. 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.

Infant Car Seat Information: 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.



Place children under one year old and weighing under twenty pounds in the back seat of the car in a rear-facing seat

CAR SEATS

Protecting your child from the #1 cause of unintentional injury!

THE LAW

- **Under 1 year** must ride rear-facing in the back seat
- **Between 1 and 5 years, and any child under 40 pounds**, must ride in a child safety seat
- Booster seats required up to **7 years old and 60 pounds**.
- Kids 7 through 12 must also use a booster seat until the adult seat belt fits correctly.

Infant



Convertible



Never place a rear-facing car seat in front of an airbag!
The center back seat is the safest place for a child!



KEEP YOUR BABY REAR-FACING AS LONG AS POSSIBLE, up to 2, 3, or 4 years old!
Rear-facing is 5 times safer!

Fewer head and neck injuries!



Sarah 2 years old!

TYPES OF SEATS

- Infant seats or "carriers"
- Convertible seats (can be used rear-facing and then forward-facing)
- Forward-Facing Only (some convert to boosters)
- Booster seats (High-back or Backless)

SEATS ACCEPTABLE FOR INFANTS

Infant seats

- Usually start at 4 or 5 pounds, some start at "birth"
- Variable upper weight limits—look for 30 pounds or more
- Usually have a detachable base—some can be used without the base
- Can only be used rear-facing

Convertible seats

- Usually start at 5 pounds and can be used up to 35 or 40 pounds rear-facing
- Can be turned around for forward-facing use later
- Usually do not have a detachable base and are not used as "carriers"

HOW DO CAR SEATS WORK?

- Keep children in the car.
- Contact the strongest parts of a child's body.
- Spread crash forces over a wider area of the body.
- Protect the brain and spinal cord (especially for rear-facing children).

INSTALLING YOUR SEAT

Car seats should not move more than 1 inch in any direction at the belt path.

1. Thread vehicle seat belt or LATCH straps through the proper belt path.
2. Buckle the seat belt or attach the LATCH hooks to approved anchor points.
3. Push down on seat while pulling slack out of seat belt or LATCH straps.
4. Lock the seat belt or engage lock-offs on your car seat.
5. Test for tightness at the belt path.
6. Double-check for proper recline angle! (Look for indicators on seat.)

LATCH or SEAT BELT?

- Both are equally safe.
- LATCH is often easier—try it!
- Make sure your vehicle is equipped with LATCH in center rear seat. Many are not.
- Whichever one you use, make sure you have the seat belt or LATCH straps through the proper **belt path**.

USING YOUR REAR-FACING SEAT

- Seat must be installed at the proper recline angle
- Shoulder straps at or below the shoulders (move as child grows)
- Harness straps must be snug
- Harness retainer clip at armpit level



THINGS TO AVOID

- Used or pre-owned seats with unknown history
- Expired seats (most seats last 6-8 years)
- "Tray-shield" or "T-shield" seats
- Seats that are too large for your vehicle
- Bulky clothing or blankets under the harness



Need more help?
Have questions?
Nancy Anthony
Certified Child Passenger Safety Instructor
980-0940

DISCHARGE INSTRUCTIONS FOR MOM 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.

What to expect over the next few days:

You will 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 as much as you can (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- you should not be up for more than 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. Moms 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 women 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.
 - **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 moms 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 women find their first bowel movement was nothing more than normal and soft.
- Perineum / Sutures (stitches): Your 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 repair of your vagina or perineum after your birth, the sutures that were used are a synthetic material that usually dissolves in 2-3 weeks. The suture may be purple or white and dissolve faster and with less discomfort if you take a warm bath at least once a day every day. Use this recipe to make your own frozen postpartum pads (lovingly called padsicles or peri-pops) that will be very comforting:
 - Witch hazel (preferably alcohol-free)
 - Aloe vera gel
 - Lavendar 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 wash cloths. These pads are for pain relief and may not hold all of your bleeding discharge. Place them inside your postpartum pad.
 - 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.

Feeding

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 mothers 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 trying to nurse. 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.

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 s/he is 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.

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: Tylenol Extra Strength 1000 mg every 4-6 hours with a maximum of 4 grams in 24 hours
- You may take: Ibuprofen 800 mg every 8 hours
- You may take: Colace 100 mg twice a day (stool softener)

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 mother's are eating but it is just trial and error.

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 100.4° F and/or chills and body aches**
- **Foul smelling vaginal discharge**
- **Pus or throbbing pain from stitches**
- **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 > 100.4, 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**

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, put 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 maybe we can help.

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 need to stimulate and wake your baby up to feed. Babies are just as tired as their mother is- they worked hard to be born too. The best way to wake your baby and stimulate him/her 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. 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 moms 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 his/her 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 it 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.

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 amount 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 (G Diapers, Nature BabyCare) 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 (505-877-6311) is a local diaper cleaning service. Moms 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 after your milk comes in.

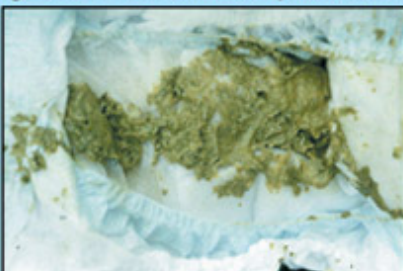
Diapers of the Breastfed Baby

Looking at a baby's poop and pee can help you tell if your baby is getting enough to eat.

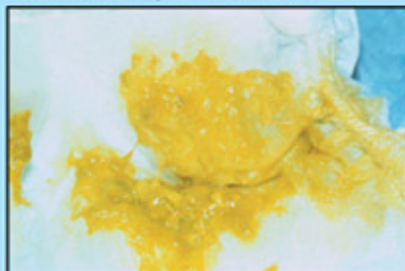
The baby's poop should change color from black to yellow during the first 5 days after birth.



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.



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 30 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 by 36 weeks of pregnancy and let us know who that person is by the 4-week visit after the baby is born. There is a list of providers on **page 185**.

Home Visit: Home visits between 24-36 hours after birth are available to clients who live or can stay **within 30 minutes of the birth center (see map on page 12)**. We no longer do visits on Kirtland Air Force Base. 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 midwives will come see you at the hospital during this time. This visit will last 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. This visit is a time to ask any questions you may have about infant feeding, your recovery, care for the baby and parenting.

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, notarized and then sent to the state within 10 days of birth. The birth center has these forms and staff will help you with this and can notarize the form at your 3-day visit. 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 at a later date 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 4-8 weeks so that you can get a copy of the birth certificate which costs \$10 per copy.

Newborn Metabolic Screen: New Mexico requires that all babies born in the state receive screening for 29 disorders included in these categories: amino acid, endocrine, fatty acid oxygenation, hemoglobin, organic acid and other disorders.

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 is done at the home visit. The second part must be done within 10-14 days of age and can either be done at the birth center or by your pediatric provider. We strongly recommend doing this testing but if anyone chooses to decline the testing, we have a consent form that must be signed and sent to the state.

The most common disorders include:

1. **Biotinidase Deficiency (BIO)**: Is an enzyme deficiency that occurs in about 1 in 60,000 newborns and can result in seizures, hearing loss and death in severe cases.
2. **Congenital Adrenal Hyperplasia (CAH)**: Is caused by decreased or absent production of certain adrenal hormones. The most prevalent type is detected in about 1 in 15,000 newborns. Early detection can prevent death in boys and girls and sex misassignment in girls.
3. **Congenital Hypothyroidism (CH)**: Inadequate or absent production of thyroid hormone results in CH and is present in about 1 in 3,500 newborns. Thyroid hormone replacement therapy begun by 1 months of age can prevent mental and growth retardation.
4. **Cystic Fibrosis (CF)**: Occurs in about 1 in 4,000 newborns and is characterized by progressive lung disease, pancreatic dysfunction and other organ failures. Caucasians are at an increased risk.
5. **Galactosemia (GAL)**: Failure to metabolize the milk sugar galactose results in GAL and occurs in about 1 in 50,000 newborns. This can lead to cataracts, liver cirrhosis, mental retardation and/or death. Usually need soy instead of milk.
6. **Homocystinuria (HCY)**: Is caused by an enzyme deficiency that blocks the metabolism of an amino acid that can lead to mental retardation, osteoporosis and other problems if left undetected and untreated. Found in about 1 in 350,000 newborns. May need dietary restrictions and supplemental medications.
7. **Maple Syrup Urine Disease (MSUD)**: Is a defect in the way that the body metabolizes certain amino acids and is present in about 1 in 200,000 newborns. Early detection and treatment with dietary restrictions can prevent death and severe mental retardation.
8. **Medium Chain Acyl-CoA Dehydrogenase (MCAD) Deficiency**: The most common disorder in the way the body metabolizes fatty acids is MCAD and is found in about 1 in 15,000 newborns. Undetected, it can cause sudden death.
9. **Organic Acid (OA) Disorders**: Organic acidemias are a group of metabolic disorders that lead to accumulation of organic acids in the blood and urine. Screening for these disorders is new and the incidence of them is not yet known.
10. **Other Fatty Acid Oxidation (FAO)**: Undetected and untreated they can cause seizures, coma, and even death. Screening for these disorders is new and the incidence of them is not yet known.
11. **Phenylketonuria (PKU)**: An enzyme defect that prevents metabolism of phenylalanine, an amino acid essential to brain development is found in about 1 in 19,000 newborns. Undetected and untreated with a special diet, PKU leads to irreversible mental retardation. Persons of European descent are at higher risk.
12. **Severe combined immunodeficiency (SCID)**: Is an inherited condition in which the body is unable to fight off serious and life-threatening infections. In babies, certain parts of their immune system do not work properly putting them at risk of getting many infections. Untreated children rarely live past age 2.
13. **Sickle Cell Disease (SCD) / Hemoglobinopathies**: Sickle cell anemia is the most prevalent SCD and causes clogged blood vessels resulting in severe pain and other severe health problems. It is detected in about 1 in 2,500 newborns and persons of African or Mediterranean descent are at higher risk.
14. **Tyrosinemia**: Is an amino acid disorder which occurs in 1 in 100,000 newborns. Causes severe liver and renal disease and peripheral nerve damage. Treatment involves a special diet.
15. **Urea Cycle Disorders (UCD)**: Is a genetic disorder caused by a deficiency of one of the enzymes responsible for removing ammonia from the blood stream. They are characterized by seizures, poor muscle tone, respiratory distress, and coma and result in death if left undetected and untreated. Screening for these disorders is new and the incidence of them is not yet known.

Babies with these conditions appear normal at birth and may have no family history of the disorder. These conditions might not be noticeable by you or your baby's healthcare provider. 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 before the infant becomes sick prevents serious health problems or even death and most babies develop normally and lead healthy lives.

Tongue Tie (Ankyloglossia) / Frenotomy:

What is Ankyloglossia (Tongue-Tied)?

The tongue is the only muscle in our body that has one end that moves freely, unattached to any other body structures and at its other end 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, causing 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 more than one family member has the condition). Ankyloglossia 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.

Why should there be treatment of Ankyloglossia (Tongue-Tied)?

Until recently there were few studies, recommendations or consensus on what constitutes an abnormal lingual attachment, which can lead to the diagnosis and treatment of ankyloglossia. Today that is changing, although traditional medical teaching in the past has been that a tongue-tie is of little relevance, will have no adverse sequelae, and can be ignored; the facts now do not support that belief. A common myth that is often repeated is that the lingual frenum will stretch and that we do not 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 ankyloglossia or a tongue-tie may include difficulties from birth to problems that may exist a lifetime. A tongue remaining abnormally attached may be responsible for allowing many of the following concerns to develop.

Problems resulting from tongue-tie for infant

- Colic and excessive gassiness
- Reflux (spitting up)
- Difficulty with adequate milk intake. Poor weight gain
- Falling asleep on the breast. Extended nursing episodes
- Unable to sustain a latch. Unable to develop a deep enough latch
- Unable to hold a pacifier
- Early weaning from the breast

Problems resulting from tongue-tie for mother

- Difficulty or unable to breastfeed
- Painful compression of nipples
- Mastitis, engorgement, thrush
- Vasospasm of the nipple
- Anxiety, stress & fatigue
- Postpartum depression
- Slow weight loss from pregnancy
- Early cessation of lactation
- Bleeding, cracked and flattened nipples
- Low milk supply
- Feelings of guilt

Treatment of Tongue-tie

Treatment of the tongue-tie in newborns has a low risk for infection or bleeding and does not require sedation, numbing agents or stitches. The newborn is wrapped in a blanket or held by the parents for a few seconds while the frenulum is clipped. He/she cries more from being restrained than from the pain. It takes a few seconds to clip the frenulum (about 2-8 mm) with a small scissors to release the tongue enough to allow for improved movement. The frenulum contains almost no blood, so there is usually only a drop or two of blood. After the treatment is completed, newborns can immediately begin nursing and the mothers have reported immediate relief of pain, extended nursing and improved infant sleeping. If the tongue-tie isn't identified and the frenulum isn't clipped until the baby is several weeks or months old, then it may take longer for him to learn to suck normally. Sometimes suck training is necessary in order for him to adapt to the new range of motion of his tongue.

Even though the anterior tongue-tie has been released, there may still be some posterior tongue-tie remaining or a lip tie. It is recommended to have further evaluation by a pediatric dentist if breastfeeding problems continue. 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.



Simple thin tongue-ties can be clipped with scissors which usually helps. Then the baby can be further evaluated by a pediatric dentist to evaluate for posterior tongue and lip ties if problems persist.



Classic diamond shape wound after laser revision of tongue-tie. Done by a pediatric dentist.

Three-Day Visit: This is a follow-up visit at the center to see how mom and baby are doing. Mom's 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.

Screening for Critical Congenital Heart Disease (CCHD): 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.

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 2 and 4, 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 breastfeeding jaundice.



Sometimes, infants with significant jaundice have extreme tiredness and poor feeding. If your baby does not feed every 3-4 hours or you can not 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 bili lights". 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 at approximately 14 days of age to check your baby's growth and do the second part of the newborn metabolic screen and the hearing 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 mom and support given as needed.

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: The auditory brainstem response (ABR) and otoacoustic emissions (OAE). An ABR test monitors brain wave activity in response to sound using electrodes that are placed on the baby's head and ears. An 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 clicks. ABR and OAE testing are painless and can be used for newborn babies and infants as well as older children and adults.



All infants born at the birth center will be screened for hearing loss using the OAE test at the 2-week appointment. If your baby does not pass this hearing screening by the 4 week visit, you will be referred for ABR testing at UNM Audiology. All babies born in the hospital will be tested with the ABR test prior to discharge. Even if your baby has passed his/her 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 later in life, bring this to the attention of your pediatric provider immediately.

Four Week Visit: This is baby's last visit at the birth center to check growth and breastfeeding. You will need to make an appointment at 2 months with your pediatric provider. You may sign a release of records at the pediatric office and we will send the baby's records to the provider or you can pick up the baby's records at your 6-week visit.

Six Week Visit: This is mom's last postpartum visit. Breastfeeding, emotional adjustment, physical recovery are assessed. 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 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 well woman 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, mammograms, bone scans and assist with hormone therapy.

Postpartum Changes – Weeks 2 to 6

Please refer to the Discharge Instructions for Mom and 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 6 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 about 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.

Nutrition

- Most women 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 moms may burn up to 500 calories per day so it is important to continue good nutrition.
- Use the food group chart on **page 85** to eat a healthy diet. This will help your body recover from pregnancy.

Exercise/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 In Relation To Others

- Be sure to ask your family and friends for help with the care of your baby when you are 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 women's 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.

Emotions



Many women 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 During and After Pregnancy

Depression is more than just feeling “blue” or “down in the dumps” for a few days. It’s a serious illness that involves changes in the brain chemistry and structure. The sad, anxious feelings don’t go away and can mild to severe and will interfere with day-to-day life and routines. About 13% of pregnant women and new mothers have depression. Depression is usually the result of a combination of factors. Stressful life events can trigger depression and hormonal factors unique to women may also contribute to depression. Women 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 mother 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.

Some women are more at risk for depression during and after pregnancy. These risk factors include:

- A personal or family history of depression 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 people with depression get better with counseling and some need counseling and medications. 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 mothers 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 women may eat poorly and not gain enough weight during pregnancy. Women often 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 women with depression. Untreated postpartum depression can affect your ability to parent. You may lack energy, have trouble focusing and not be able 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.

Depression Warning Signs



You or a family member needs to ***call the birth center (924-2229) or the midwife on call (944-5488)*** if you have the following symptoms that last more than 2 weeks:

- Feeling restless or moody
- Feeling sad, hopeless, and overwhelmed
- 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 100°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 100°F, chills or body aches

Support Groups for Mothers, Partners and Families

At Dar a Luz, we care about every family and constantly strive to find ways to support you!. **All groups are FREE and open to the community. No registration is required. For full group descriptions and current schedules, please visit our website at www.daraluzbirthcenter.org**

Here's a quick overview of our groups.

- ❖ **Breastfeeding and New Mom Support Group** every Wednesday 10:00 a.m. to noon.
- ❖ **Evening Latch and Toddler Group**, 1st & 3rd Wednesdays each month from 6:30 to 8:30 p.m.
- ❖ **Mindful Partnering, Mindful Parenting (adults only)**, the second Thursday of each month from 6-8 p.m.
- ❖ **Birth Trauma Circle (adults only)**, the fourth Thursday of every even-numbered month (February, April, etc.) from 6:00 to 8:00 p.m., unless otherwise noted*
- ❖ **Pappy Hour (dads only)** - scheduled monthly.
- ❖ **Piñon Pappies (for dads and partners, children welcome but not required)** - scheduled monthly.
- ❖ **Reunion groups** - scheduled with birth class teachers. Reunite with your five-week class group (either Dar a Luz birth class or Blissborn)



POSTPARTUM EXERCISES

Pregnancy puts a huge strain, not just physically but emotionally on a new mother. During this early recovery period, a woman 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 every day activities, to protect the joints and ligaments until the muscles regain their former strength. Many new moms find that walking is a great way to start exercising and helps them get outdoors with their baby.

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.

Post Pregnancy Abdominal Routine - The Sahrman Technique

Abdominal exercises designed by the physical therapist Shirley Sahrman 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 muscles group 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 your 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.

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

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 women 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.



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 of women out of 100 women that 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 some women may not have a period as long as they 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
Diaphragm, cap, sponge	32% to 16%	Inserted into vagina prior to sexual contact	Vaginal and urinary tract infections, less effective in women 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
Female condom	21%	Covers labia area and fits inside vagina	None known	May be noisy, less sensation	Protects against sexually transmitted infections
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

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 Skyla 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
Essure (tubal inserts for female sterilization)	0.17%	Office Procedure. Requires confirmation test. Effective in 3-6 months.	Damage to fallopian tubes. More risk for ectopic pregnancy. Allergy to nickel.	Pain, cramping, bleeding. Regret of doing procedure.	No surgery or hormones. Less concern about unwanted pregnancy
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

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. <http://www.chop.edu/service/vaccine-education-center/home.html>

Below is the New Mexico Department of Health recommended immunization schedule and you can access more information at <http://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 the need arises?
- 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 moms?
- 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 was not 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?



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.....298-2505

Paseo Del Norte

5904 Holly Ave298-2505

Rio Rancho

1534 Unser Blvd SE.....298-2505

West Side

9210 Golf Course Rd NW.....298-2505

Bebe Care, Dr Beggs 4333 Pan American Fwy NE266-3835

Davita Medical Group Pediatrics (ABQHP)

Coors

2929 Coors Blvd NW, Suite 200.....839-2300

Journal Center

5150 Journal Center Blvd NE (3rd Floor)262-3219

Rio Rancho

1721 Rio Rancho Blvd SE.....896-8600

Sunport

2901 Transport ST SE (2nd Floor)262-7594

Family Practice Doctors in the area giving high quality low volume care

Mark Unverzagt, MD

925 Coal Ave SW www.medicinedowntown.com.....246-1670

Jeff Miller, MD

3900 Eubank Blvd NE, suite 18 www.jeffreymillermd.com.....292-1818

Melissa Garcia, MD

711 Encino Place NE Ste D224-7400

Scott Brown, MD

1817 Central Ave NW265-2244

Carmen Rodriguez, MD

500 San Mateo Blvd NE Ste B.....262-6500

First Choice Community Healthcare

Alameda

7704 – A 2nd ST NW890-1458

Alamosa

6900 Gonzales Rd. SW..... 831-2534

Belen

120 S. 9th St., Belen 861-1013

Edgewood

8 Medical Ctr Rd, Edgewood.....281-3406

Los Lunas

145 Don Pasqual NW.....865-4618

North Valley	
1231 Candelaria Rd NW.....	345-3244
Rio Grande High School	
2300 Arenal Rd SW.....	873-0220 ext. 50086
South Broadway	
1401 William St SE.	768-5450
South Valley	
2001 N. Centro Familiar SW.....	873-7400
First Nations Community Healthsource	
5608 Zuni Rd SE.....	262-2481
High Desert Pediatrics	
8650 Alameda Blvd NE, Suite 101E.....	255-1866
Indian Health Service	
801 Vassar Dr. NE	248-7810
Presbyterian Pediatrics	
Belen	
609 S. Christopher Rd.....	864-5454
Isleta	
3436 Isleta Blvd SW.....	462-7777
Northside	
5901 Harper NE.....	823-8282
Rio Rancho – High Resort	
4005 High Resort Blvd SE.....	462-6000
Rio Rancho	
3777 NM Highway 528 NE.....	404-2590
San Mateo	
401 San Mateo Blvd SE.....	462-7333

Public Health Clinics – Immunizations only. No Cost. Only available to non-Medicaid eligible patients and patients without private insurance. WIC services.

Belen	
617 Becker	864-7743
Bernalillo	
1500 Idalia Bldg B.....	867-2291
Estancia	
300 S 8 th Street.....	384-2351
Los Lunas	
445 Camino del Rey.....	222-0940
Midtown	
2400 Wellesley Dr NE.....	841-4100
Moriarty	
1110 Rt 66.....	832-6782
North Valley	
7704 2 nd Street NW.....	897-5700

Northeast Heights	
8120 La Mirada NE.....	332-4850
Santa Fe	
605 Letrado St.....	476-2607
Southeast Heights	
7525 Zuni SE.....	841-8928
Southwest Valley	
2001 Centro Familiar SW.....	873-7477
Westside	
6911 Taylor Ranch Rd NW Suite C-12.....	899-8574

UNM Hospital Ambulatory Care Center, Pediatrics Clinic, 3 rd Floor	
2211 Lomas Blvd NE	272-2345

UNM Family Practice and Community Medicine

Atrisco Heritage Center for Family and Community Health	
10800 Dennis Chavez SW	272-6009
Eubank Clinic	
2130 Eubank Blvd NE	925-2273
Family Health – 1209 Clinic	
1209 University NE.....	272-4400
Family Medicine Clinic	
2400 Tucker NE	272-1734
Northeast Heights Family Health	
7801 Academy Blvd NE	272-2700
North Valley Clinic	
3401 4th ST NW.....	994-5300
Southeast Heights on Central	
8200 Central SE.	272-5885
Southwest Mesa Center for Family and Community Health	
301 Unser Blvd NW.....	925-4126
UNM Family Health – Westside Clinic	
4808 McMahon Blvd NW.....	272-2900
Young Children’s Health Center	
306-A San Pablo SE	272-9242

Los Alamos Pediatricians

Children’s Clinic	
3917 W Rd # 128	505-662-4234

Resources

Adoption Assistance Agency	821-7779
Agora (Suicide Support Helpline)	277-3013
AIDS Hotline (CDC Information line)	1-800-232-4636
Amistad Crisis Shelter (teen temporary crisis center)	877-0371
Baby Net (referrals for medical and support services)	1-800-552-8195
Barrett House	243-4887
(meals, clothing for homeless women and children)	
Birth Certificates (Vital Records)	1-866-534-0051
Head Start	1-866-763-6481
(education and family support services)	
Center for Reproductive Health	925-4455
(family planning, pregnancy options)	
Child Support Enforcement Division.....	1-800-288-7207
Trumbull Family Resource Center (Car Seat Assistance).....	256-2005
Domestic Violence Hotline/Shelter (S.A.F.E. House).....	1-800-773-3645
ENLACE Comunitario (Domestic Violence and Sexual Assault survivor support)	246-8972
Joy Junction (family shelter)	877-6967
La Leche League (breast feeding support)	821-2511
Low-income Home Energy Assistance Program (LIHEAP).....	1-800-283-4465
Milagro Program	463-8293
(substance abuse program for pregnant women)	
New Day Youth & Family Shelter (teen shelter).....	938-1060
New Futures High School, 5400 Cutler Ave NE	883-5680
(for pregnant and teen moms)	
New Mexico Solutions Center	505-268-0701
(Medicaid inquiries/verification)	
New Mexico Poison Control Center.....	1-800-222-1222

Nurse Advice Lines	
PresRN	1-866-221-9679
Molina Health Care 24 hr Nurse Advice Line	1-888-275-8750
Blue Cross Blue Shield Nurseline	1-877-213-2567
NM Health Connections CareConnect 24x7 Nurse Advice	1-844-308-2552
Tricare Nurse Hotline	1-800-874-2273
Paternity Testing by Mobile Medical Associates (costs \$300-375)	323-7999
Planned Parenthood (family planning, pregnancy options)	
Central	265-3722
Candelaria	294-1577
San Mateo (surgical center)	265-9511
Rio Rancho	899-7900
Santa Fe	505-982-3684
Rape Crisis Center	266-7711
Roadrunner Food Bank	247-2052
Safer New Mexico Now (Car Seat Assistance)	332-7707
Saint Joseph Community Health	924-8000
(Home visiting program for first time parents)	
Salvation Army (Family Assistance Program)	881-4292
STD Clinic at Department of Health (DOH)	841-4100
Storehouse (Children's clothing & food)	842-6491
Storehouse West (Children's clothing & food)	892-2077
WIC Offices at First Choice	
Alamosa Center	831-4245
North Valley	345-8181
South Broadway	764-0271
South Valley	873-7416
WIC Office at First Nations	262-2481
WIC Offices at Public Health	
Belen	864-7743
Los Lunas	222-0940
Moriarty	832-6782
Northeast Heights	332-4850
North Valley	897-5700
Rio Rancho, Bernalillo	867-2291
SE Heights (ABQ)	841-8928

Santa Fe 505-476-2607
Taylor Ranch, Westside 899-8574

Women's Housing Coalition (housing for single mothers)..... 884-8856

Youth Crisis Shelter (New Day)..... 938-1060

*** For more resources log on to www.mycommunitynm.org ***



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 woman's 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, Down's 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 woman'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.

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 a pregnant woman's cervix begins to dilate (widen) and efface (thin) before her 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 10 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 stitches. **Third and fourth degree** lacerations involve the rectal capsule and/or the rectal muscle and may require a doctor to repair them.

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.

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.



Visit Diary

Appt. Date	Appt. Time	Weeks Preg	Weight	Baby Heart Rate	Comments