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WELCOME TO MIDWIFERY CARE ASSOCIATES

Congratulations, you're pregnant! Whether you have anticipated this moment or it comes as a complete surprise, you are now faced with choices regarding how you want to experience your pregnancy and birth. Thank you for choosing Midwifery Care Associates to assist you on this journey!

Our small practice size enables us to provide a premium service of high-quality, comprehensive, and individualized care with a holistic wellness approach. This approach includes attention to social circumstances, good nutrition, and moderate exercise, as well as guidance toward positive childbirth education and preventive care. We place a strong emphasis on education, encouraging you to make informed decisions that will empower you to participate fully in your prenatal care and birth. Our primary commitment is to the safety of you and your baby.

We look forward to working closely with you over the next few months, and we are honored that you have chosen us to be part of the miracle of your pregnancy and birth.

STAFF

PAMELA ERICKSON ROSSER, CNM
(RETIRED)
TREASURER AND CO-OWNER MCA,

GALE LOUISE AUCOTT, CNM, MS
(RETIRED)
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CAPITAL HEALTH OB/GYN
COLLABORATIVE PHYSICIANS

PHILOSOPHY

MCA believes that every woman has the right to safe, sensitive health care, provided with respect for her individual wishes, cultural background, and her right to self-determination.

In as much as we believe that the healthy family unit is the basis of community and national health, we strive to provide care in a manner that promotes family strength and unity. To this end, the midwives and physicians associated with **MCA** further believe that they share with the client a mutual responsibility to maintain high standards for quality care, provide and practice preventive health habits, and keep lines of communication open and honest.

Our focus on the physical, emotional, educational, social, and spiritual needs of the family is grounded in practice by our certified nurse-midwives. Midwifery as a profession assumes the responsibility for ensuring that CNMs have a solid base in theory and clinical practice, and that they demonstrate professional standards of practice in accordance with the ACNM.

By offering to low-risk women the professional care and support necessary for a safe home birth, this practice affirms pregnancy and birth as a uniquely creative process, centered in home and family life. The choice of low-risk women to give birth at home is seen as recognition of the rights of these individuals and their families to share responsibility for their own birth screening and preventive prenatal care. Supported by individual medical back-up plans for unanticipated birth complications, a safe and healthy outcome may be achieved for the majority of women.

We believe that our mission to promote family health and comprehensive health maintenance is best achieved by an interdisciplinary team approach, involving physicians, other health care professionals, and the preceptorship of student midwives as they complete their studies and become integrated into practice. Student midwives and newly graduated midwives enhance our full range of care and are welcome members of our professional team.

While the primary focus of midwifery is on women of childbearing age, our practice extends to preventive health care for all women.

INQUIRIES

Our office hours are Tuesday 9:30 AM until 3:00 PM, Wednesday 11:00 AM until 6:00 PM and Thursday 11:00 AM until 6:00 PM. Our main office number is (609) 737-7512. Appointments may be scheduled or changed during these times. You may also call with general or insurance questions during these hours. At other times you may leave a message on our voice mail, at our main office number, and your call will be returned within 24 hours. You may also use our email, themidwives@midwiferycare.org, for non-urgent matters, and expect a response within a few days to a week.

IMMEDIATE CONTACT

A midwife is available 24 hours a day, 7 days a week. You can reach the midwife by calling the main office number, which will connect you to our voice mail. If you have a medical problem, emergency, or are in labor, you will be directed to call our **Answering Service at 1-800-553-3824**, and a midwife will return your call as soon as possible. If you have not heard back from the midwife within ten to fifteen minutes, please call the answering service again.

EMERGENCY PHONE CONTACT

In the unlikely event of a power failure affecting our phone service, you may reach a midwife through our back-up hospital. If you are in labor or have an emergency and cannot get through to our main office number, (609) 737-7512, or the answering service number, 1-800-553-3824, please call Capital Health at Hopewell, (609) 303-4000, and ask to speak to a Labor and Delivery Nurse. The Nurse will be able to reach one of us, who will call you as soon as possible.

DANGER SIGNALS

Please call us if you experience any of the following:

- ***Vaginal bleeding or spotting***
- ***Persistent or severe abdominal pain***
- ***Persistent or severe headache***
- ***Sudden swelling of fingers, feet, or face***
- ***Blurring of vision***
- ***Gush or trickle of fluid from vagina***
- ***Persistent vomiting***
- ***Difficulty urinating or pain upon urinating***
- ***Temperature above 101 F***
- ***Reduced fetal movement***
- ***If you are not experiencing any definite symptoms but are not feeling well, please call and talk to us.***

PRENATAL CARE

At your first visit to MCA, we discuss your medical, social, obstetrical, and gynecological history. We also provide a physical and perform lab work. You will be oriented to the self-care concept of our practice and shown how to check your urine and weigh yourself. An important purpose of this initial visit is to help you to identify any risk factors that may enter into your decision about where your baby should be born. This visit lasts about one hour. Subsequent visits last about a half hour, and consist of an interval history, focused examination, and time for your questions. The prenatal care schedule consists of monthly visits until 26–28 weeks, then every two weeks until 36 weeks, then weekly until delivery. A home visit will be scheduled at about 35–36 weeks for those planning a home birth. We encourage the involvement of your family and welcome them at your visits.

PLANNED HOME BIRTH

The choice to give birth at home can be the best and safest option for some women and their families. To help you make an informed decision, we will discuss the pros and cons of home birth with respect to your individual situation. The advantages of birthing at home, for low-risk mothers, include privacy, intimacy, and autonomy. Birth can take place as you wish, within the bounds of medical safety, and you will get highly personalized constant care. Breastfeeding is initiated early, fostering strong family bonds. Your level of comfort with your own familiar surroundings can have a very positive impact on your pattern of labor, and on your later memories of the birth of your baby. Even so, some women may not want to be at home because they are concerned that only non-pharmacological methods of pain relief are employed in a home setting. Another fact of home birth is that there are fewer personnel and fewer diagnostic and therapeutic means available if a problem unfolds rapidly. Acceptance for midwifery care and approval for home birth is contingent upon your low-risk status, as continuously assessed by the midwives, and by our associated perinatology group as needed. If some aspect of your medical condition or history necessitates a hospital birth, we can continue to provide your care at our hospital. Risk factors can also arise at the time of your birth that preclude staying at home, and at those times you must accommodate to being moved, whether by private car or by emergency medical services. Certain medical complications are beyond the scope of our practice. Should any of these arise, we will discuss options for the transfer of your care to a physician. We are happy to continue to provide you with information, and may even offer to attend your birth as a support person.

PLANNED HOSPITAL BIRTH

You may choose our care for a planned hospital birth that embraces a natural birth experience with minimal intervention. Whether you are choosing to birth in the hospital due to risk factors, or whether by your own preference, you will find our style of care unique. Giving birth in the hospital may alter your level of privacy and intimacy, but you will find there a cooperative and very skilled team of care providers. We are committed to continuous attendance at your hospital birth, and work to make it the very best experience it can be. The policies on laboring at our hospital are midwife-friendly, including freedom to eat and drink, bathe or shower, and even soak in a deep whirlpool tub. Wireless, waterproof monitors are available when your circumstances require continuous electronic fetal monitoring. Board-certified obstetricians, neonatologists, and nurses are all standing by to help you and your baby as needed. Capital Health has implemented the UNICEF/WHO “Baby-Friendly” hospital initiative. Lactation consultants are available during your stay, and for follow-up. For those who desire it, we can help arrange for early discharge from the hospital if both baby and mother are well.

OTHER TEAM MEMBERS

Most women can rely solely on us, with our associated perinatology group and collaborative physicians, for the majority of their care in pregnancy. Even so, you may have a medical condition that pre-dates the pregnancy, or a condition that develops during pregnancy requiring medical management outside the pregnancy care we give. We strongly encourage you to designate a primary physician who can participate in the management of any such medical conditions and coordinate your care with us. Additionally, we will refer you to outside specialists for specific issues as needed. Examples of outside referrals include general surgeons, psychological counselors, dietitians, chiropractors, osteopaths, cardiologists, hematologists, infectious disease specialists, neurologists, pediatricians, breastfeeding specialists, and vascular surgeons. Though we look to you to choose your own physician in these cases, we are prepared to work together with any and all specialists to ensure that the highest contemporary standard of care is met.

TESTS IN PREGNANCY

Many sources of information are taken into account when we help you assess your state of health and evaluate any risk factors that influence your choice of place of birth. This guide is to help you navigate the course of testing according to what is routine, what is optional, and what is sometimes needed depending on individual circumstances.

You should receive a full explanation of any proposed tests in pregnancy, regardless of your individual needs or risk factors. Understanding the test itself, its limitations, and the implications associated with any out-of-range results will help you to make better decisions about which tests would benefit you and your baby. Think carefully about your value system when considering tests that may help you and your midwife prepare for the birth of a baby with problems requiring treatment, and ask your midwife how the information gained from testing will be used to manage your care.

ROUTINE TESTING

Some tests are routinely performed, such as blood type and Rh factor, antibody screening, complete blood count, rubella titer, hepatitis B surface antigen, syphilis test, and urinalysis/urine culture. New Jersey now mandates HIV screening for all mothers in the first and third trimesters of pregnancy. You may opt out of the testing, but if third trimester results are not obtained, your baby may need to be tested.

At the start of the third trimester, approximately 26–28 completed weeks, a glucose challenge test is performed to screen for glucose intolerance of pregnancy, and the complete blood count is repeated to check for anemia. HIV testing at this time meets the NJ requirement and can be done in the same draw.

At 36 weeks a vaginal culture is offered for detection of Group B Strep. A complete blood count may be repeated if anemia was present at 28 weeks.

All routine tests may be sent directly from our office to a laboratory approved by your insurance plan, if any. If insurance does not cover your lab work, you may be eligible for a program through one of our two associated labs to accommodate this situation. For either program, certain labs must be drawn at official patient care centers, not in our office. Our office manager will supply you with specific lab information at your request.

OPTIONAL TESTING

Additional optional laboratory testing may be in order, depending on risk factors that have been identified, or by request. These include tests for gonorrhea, chlamydia, and/or herpes; tests for exposure to cytomegalovirus (CMV), varicella (chickenpox), and toxoplasmosis; and screens for Tay Sachs, cystic fibrosis, and sickle cell trait. If you have a history of thyroid issues or you currently take thyroid medication, tests are done each trimester for thyroxine and thyroid-stimulating hormone and the results relayed to the physician managing your medication. If you are Rh negative, a second antibody screening will be done at 26–28 weeks with your glucose and iron tests, and RhoGam administered.

Ultrasound

An anomaly screening ultrasound examination is offered to all clients. This scan, performed at 18–20 weeks, examines the fetus for any structural abnormalities or markers for genetic abnormalities. Ultrasound is also sometimes indicated for gathering specific information, such as dating of pregnancy to determine estimated date of delivery, as well as size or position of the baby. It may help research the cause of abnormal bleeding, or even check for fetal viability in early pregnancy. It may also be performed as part of a biophysical profile to evaluate fetal well-being.

Our clinical guidelines dictate that women at or beyond age 40 at term and desiring home birth must have an anomaly screening ultrasound to rule out any significant defects.

CHOOSING OTHER TESTS IN SPECIFIC CIRCUMSTANCES

There are many screening and diagnostic tests available to obtain information about particular conditions affecting the health of the mother or baby. Screening tests determine whether your individual results rest outside established parameters and may point to the need for further diagnostic testing. Screening tests may give results that guide clinical decisions about preventive treatment in pregnancy, labor, and birth. Diagnostic tests point the way toward obtaining a final diagnosis, essentially a "yes" or "no" answer, for a particular condition or characteristic. Screening tests tend to be sensitive but not specific: diagnostic tests are specific and highly accurate. Navigating the array of tests available is not always easy, but it is worth your time to gain an understanding of what tests are commonly requested and how they may impact the care you receive.

Genetic Counseling

Genetic counseling is offered to all clients over the age of 35 and those with special risk factors. Genetic counselors at Capital Health System will meet with you to evaluate the risk of genetic complications based on age and personal history. At an in-depth counseling session you will learn which tests fit your individual risk profile, and how to schedule tests at the appropriate time of pregnancy. A meeting with a counselor may be arranged by calling Capital Health Maternal Fetal Medicine and Genetics: (609) 537-7252

Cell free dna

Often referred to as NIPT is a blood test that isolates and analyzes fetal DNA circulation in the mothers blood. It is a test that is offered to women age 35 and over or those with special risk factors for Trisomy 21 (Down syndrome). This test has a sensitivity of 99.1% and a specificity of 99.9

First Trimester Screening/Ultra Screen

First trimester screening for Trisomy 21 (Down syndrome) and Trisomy 18 (a rare but severe chromosomal abnormality) assesses a mother's risk of carrying a pregnancy with either of these abnormalities. It does not detect other birth defects. About 80 percent of pregnancies affected with Trisomy 21 or 18 will result in a high-risk result. This test is a screening test only, and a high-risk result does not mean that a baby actually has Trisomy 21 or 18. It means that the result falls outside established screening parameters, and further diagnostic is then offered. This limited screening test does not evaluate risk of neural tube defects, so the Maternal Serum Alpha-Fetoprotein blood test should be offered at the appropriate time.

First Trimester screening is a combination of a specialized ultrasound to measure nuchal fold thickness and a blood sample taken between 11 weeks, 1 day, and 13 weeks, 6 days. The results take about 10 days to be reported if the blood test is done at the time of the ultrasound. A mother can choose to do the blood testing prior to the ultrasound (kits are available) and results will be immediately available at the time of the ultrasound. This test can be scheduled at Capital Health Maternal Fetal Medicine and Genetics: (609) 537-7253

Maternal Serum Alpha-Fetoprotein Screening

MSAFP, or maternal serum AFP, is a blood test drawn from the mother to check the levels of a unique protein secreted by the fetal liver, then found in the mother's blood. It is used for determining the risk of open neural tube defects, but positive screening results may point to other physical anomalies or placental complications. Reduced levels of MSAFP could also signify increased risk of Down syndrome. An elevated AFP calls for testing to rule out a neural tube or spinal defect, such as a Level II ultrasound. This screening test is most sensitive between 15 and 17 weeks of gestation.

Triple , Quad or Tetra Screening

Researchers have added new components to MSAFP screening to improve test accuracy and usefulness. The MSAFP Triple Screen, Quad Screen, and Penta Screen include additional biochemical markers. The Triple Screen measures AFP, beta-hCG and unconjugated estriol (uE3). This test screens for additional genetic problems and is beginning to replace the standard AFP. Any combination of the testing will identify 60 percent of babies with Down syndrome and 80–90 percent of babies with neural tube defects. In addition to the substances screened in the Triple Screen, the Quad Screen also checks the level of the hormone inhibin A. The Penta Screen looks for those four substances as well as Invasive Trophoblast Antigen (ITA). Any result showing a genetic risk greater than that of a woman aged 35 is considered a positive screen, but it does not mean that a baby has Down syndrome. A detailed ultrasound (Level II) or even amniocentesis can then be performed to determine the baby's exact chromosomal make-up and to rule out Down syndrome.

Amniocentesis

Amniocentesis is a specialized genetic diagnostic test offered to women over the age of 35, women who have had a baby with a chromosomal abnormality, those who are carriers of sex-linked diseases, or who have a strong family history of neural tube defects. It is also recommended when results of any screening test show increased risk of genetic abnormality. Amniocentesis involves withdrawing a small amount of amniotic fluid with a needle under ultrasound guidance between the 16th and 17th week of pregnancy. The fluid is sent to the lab for analysis and can take up to 1–3 weeks for results. Amniocentesis, like all medical procedures, carries certain risks. Mild complications like cramping, bleeding, or leaking fluid occur rarely and are usually not serious. However, there is a small chance of miscarriage or infection or injury to the baby from the procedure. The risks of complication are about 1 in 200. Perinatologists perform this procedure at Capital Health Maternal Fetal Medicine and Genetics: (609) 537-7252

Chorionic Villus Sampling

A chorionic villus sample (CVS) is a diagnostic test that can be done around 11 weeks. CVS is offered to women who will be 35 or older at the time of the birth, or with a family history of a chromosomal abnormality. The cells collected in the CVS procedure are from the baby's placenta. A needle is passed through the mother's abdomen under ultrasound guidance and a few cells are withdrawn. Results are generally ready in 3–4 days. CVS does not assess the risk of having a baby with a neural tube defect. The risk of ruptured membranes, bleeding, or infection is about 1 in 150. This test can also be scheduled at Capital Health Maternal Fetal Medicine and Genetics: (609) 537-7252

TESTS OF FETAL WELL-BEING

Fetal Movement Counts

A mother's perception of how well her baby is moving is one of the most important indicators that the baby is doing well in the uterus. In pregnancies at increased risk, or those that extend beyond the due date, fetal movement counts, or "kick" counts, confirm that the baby is still receiving nutrients and oxygen from the placenta in abundant supply. To count fetal movements, we suggest choosing a time of day when your baby tends to be active, roughly the same time each day. Sit quietly or lie on your side, then time how long it takes for you to feel ten distinct movements—kicks, twitches, thumps, hiccups, and whole body movements all count. If you don't feel ten movements in two hours, stop counting and call your midwife. Fetal movement counting is not considered necessary in most pregnancies. However, any time you are not sure that your baby is moving as you would expect, speak with the midwife right away.

Non-Stress Test (NST)

The Non-Stress test is a simple, non-invasive test performed in pregnancies over 28 weeks gestation. The test is named "non-stress" because no stress is placed on the baby during the test. It may be done if you sense that your baby is not moving as frequently as usual, if you are overdue, or if any risk factors arise that cause concern about placental function. This test consists of recording your baby's heart rate on a Fetal Monitor and correlating it with his or her movements. The test may be done in our office or at the hospital and takes about 20–30 minutes. A non-reactive NST indicates a need for further testing.

Amniotic Fluid Index (AFI)

An amniotic fluid index measures the volume of amniotic fluid present using a focused ultrasound examination. This testing is done when it is suspected that the fluid level is too high or too low, based on the clinical judgment of the midwife. An AFI is also ordered when pregnancy has progressed over a week beyond your due date.

Biophysical Profile (BPP)

A biophysical profile may be done if you pass your due date or if you are experiencing problems with your pregnancy that are affecting the growth of your baby. This test includes an NST and an ultrasound to evaluate your baby's respiratory motions, gross motor movements, and muscle tone, as well as the amount of amniotic fluid. We typically use a modified biophysical profile for postdate pregnancies, consisting of an NST and an AFI.

TESTING NOTES:

Group B Streptococcus Informed Choice

What is GBS?

Group B streptococcus (GBS) is a type of bacteria that is often present in the rectum, vagina, or urinary tract of adults. It usually causes no symptoms in young, healthy adults. It is of concern when a pregnant woman has it in her vagina because it can infect her baby, both during labor and during birth. Once GBS has infected the baby, serious complications can arise within hours. GBS infection can cause sepsis (blood infection) and meningitis (infection of the fluid and lining around the brain) and pneumonia. These infections in the newborn may cause long term disability and even death. It may also cause infection in a baby several weeks after birth, called late onset infection. Treatment requires NICU admission, antibiotics, repeated blood draws, lumbar punctures, and separation from the mother.

Women are usually tested for colonization with GBS at 35-37 weeks of gestation. There is much ongoing research on preventing transmission of GBS to infants. The current recommendation by the Centers for Disease Control and Prevention is to administer IV antibiotics to GBS-positive women during labor. Although IV antibiotics do not prevent all cases of GBS infection, the likelihood of neonatal infection is as follows:

- If a GBS-positive mother receives antibiotics: 1 in 4000
- If a GBS-positive mother does not receive antibiotics: 1 in 200

In all, in the U.S., about 1,700 out of 2.1 million babies per year get GBS disease at birth, and another 1,500 get GBS disease in the weeks after birth.

Risk factors associated with GBS and its treatment

Some women are at higher risk of having a baby that becomes infected with GBS. They have the following conditions:

- Urinary tract infection from GBS during pregnancy
- Previous baby with GBS disease
- Fever during labor
- Rupture of membranes 18 hours or more before birth
- Labor or rupture of membranes before 37 weeks gestation

The risk of GBS transmission to the baby is increased when routine obstetrical interventions, including frequent vaginal exams, stripping and/or artificial rupture of membranes, are used during labor and birth. In our style of midwifery practice obstetrical interventions are kept to a minimum, and may limit the probability of

GBS infection. It is important to note that although stillbirth can be caused by a prenatal infection, the likelihood of GBS being the cause of infection and stillbirth is unknown. All pregnant women are encouraged to be aware of their baby's movement each day and should immediately contact their care provider if a decrease in fetal movement is noticed.

There are some adverse or unintended effects of GBS prevention efforts that have raised concern these include allergic or anaphylactic reactions to the antibiotics used and the development of antibiotic resistance in GBS and other bacteria, such as E. coli and MRSA. Antibiotics given to newborns may also disrupt the colonization of their GI tract with beneficial bacteria.

GBS research

Currently, estimates of the incidence of GBS in newborns are based solely upon research done in hospitals, most of them large, tertiary care centers.

Personalized care and avoidance of interventions are not the norm in this setting. As of yet, there are no GBS statistics derived from out-of-hospital births attended by midwives. This is significant, since studies have shown that midwife attended births are associated with fewer interventions during labor, fewer maternal fevers, and shorter times between rupture of membranes and birth.

The standard of care emphasizing antibiotics for all GBS-positive women does not address other issues pertinent to understanding why GBS infects certain babies and not others, nor how therapies can be more effectively targeted. For example, it is not known whether antibodies to GBS are excreted in breast milk. It is not known whether mothers produce antibodies to GBS that pass through the placenta. It is not known whether certain strains of GBS are more pathogenic than others. Significantly, it is not known whether maternal colonization by GBS occurring for the first time during pregnancy increases the rate of newborn infection, as happens with certain other infections during pregnancy. New research will likely address these topics.

Our GBS recommendations and protocols

Evidence supports a non-invasive style of practice as a way to reduce the incidence of GBS disease. This is our first-line of defense against neonatal infections. GBS colonization in the vagina comes and goes throughout pregnancy as the GI flora fluctuates. For this reason, we recommend probiotics and a healthy diet to our clients throughout pregnancy so that the beneficial bacteria naturally out-compete the GBS.

We recommend that our clients all be tested for GBS at 35-37 weeks of pregnancy. If the test is positive for GBS, we recommend following the current CDC guidelines for antibiotic prophylaxis to reduce the risk of neonatal GBS infection.

Clients have the right to refuse antibiotic treatment; even so, GBS status is important to know. In the event of a hospital birth or transfer to the hospital from a home birth, women whose GBS status is either positive or unknown can anticipate that the baby will be treated aggressively, including observation in the NICU or a full sepsis work-up unless they have had adequate antibiotic prophylaxis.

Information and references

The CDC discusses GBS clearly and succinctly. Please look at the information on early-onset, late-onset and adult-onset GBS infection.

http://www.cdc.gov/GroupBStrep/general/gen_public_faq.htm

Some prenatal GBS recommendations.

http://www.obgyn.net/pregnancybirth/pregnancybirth.asp?page=/pregnancybirth/articles/prenatal_onset_group_B_strep

Group B Strep International is devoted to researching and educating about GBS infections.

<http://www.groupbstrepinternational.org/>

DIET AND NUTRITION

The importance of good nutrition during pregnancy cannot be overstated. The choices you make during these months will benefit your child, not just in infancy but for the rest of his or her life. At your prenatal visits, we will help you review your diet to ensure that it is well-balanced and that you are eating a variety of nutritious foods. Adequate iron, nutrient, and vitamin intake can be achieved by following an excellent diet, but most women will want the added insurance afforded by taking a daily supplement. The health benefits to you and your growing baby are important to remember. Iron deficiency can increase the fatigue that goes along with pregnancy, make labor more tiring and painful, make even a moderate loss of blood with the birth more significant, and delay your healing and recovery following the birth. Babies who are well-nourished as they develop seem to cope better even with a difficult passage into this world, and have better birth weights and greater reserves in their early days. We are committed to helping you and your baby achieve the best outcome possible. You can make a big difference in how you feel, and this can carry over into your experience as a new mother. Through the years, we have seen many women succeed in growing healthy, “blue ribbon” babies using the Brewer No-Risk Diet plan for pregnancy and lactation. This diet was created by Dr. Tom Brewer in the 1960s and focuses mainly on adequate protein intake during pregnancy. What follows is a list of all the food categories and the importance of each for the pregnant mother. We have devised a weekly checklist, enclosed in your folder, for you to copy and post on your refrigerator, for keeping handy until it becomes “second nature”!

Protein

Proteins are broken down into amino acids by your body and used to repair body tissues and organs. Your baby will be built from these amino acids. It is also required for the placenta, amniotic tissues, and maternal tissues. Further, as a woman's blood volume increases by 50 percent during pregnancy, protein is needed to produce new blood cells and circulating proteins. Inadequate protein intake can lead to fatigue, swelling, and even lack of appetite. The average non-pregnant person needs approximately 56 grams of protein per day. The Brewer Diet recommends that pregnant women aim for 80–100 grams of protein per day. This may seem like a lot of protein in one day, but if you consider that a 3-ounce piece of chicken (which is about the size of a credit card) has 20 grams of protein, 80 grams doesn't seem like quite so much. Eight ounces of plain Greek-style yogurt contains 25 grams of protein.

Milk and Calcium Foods

Milk and milk products provide calcium and other essential vitamins and minerals. They are important for bones, muscle growth, muscle contraction, and nerve transmission. Calcium is essential for healthy blood, can ease insomnia, and helps regulate your heartbeat. Four servings per day are recommended.

Eggs

Two eggs per day provide protein, vitamins, and minerals, including vitamin A, the anti-infection vitamin. Together, milk and eggs provide a protein, vitamin, mineral, and calorie foundation for the rest of the pregnancy diet.

Greens

Fresh, dark green vegetables are rich in vitamins and minerals, particularly A and B complex, which are necessary to help your body utilize protein in other foods. Greens are also high in folic acid, which is essential for good growth. Greens play a role in the formation of red blood cells and help prevent anemia. The Brewer Diet recommends two servings per day.

Whole Grains

Whole grains are excellent sources of the carbohydrates you need to fuel your body. Too few carbohydrates in your diet will cause your body to burn the protein you eat for energy, thus robbing you and your baby of the building blocks for tissue growth and repair. Carbohydrates from whole grains are a good source of B vitamins, which are necessary for growth and the normal functioning of nerve tissue. The Brewer Diet recommends four or more servings per day.

Citrus and Vitamin C Foods

Citrus and other foods high in vitamin C are important for the body's manufacture of collagen, the substance that holds tissue together. Without adequate vitamin C your uterus may not perform well in labor, and you will not have a strong amniotic sack (bag of waters). Vitamin C is crucial in the body's defense system against infection, and improves iron absorption. The Brewer Diet recommends one to two servings per day.

Fats and Oils

Healthy fats and oils, like real butter and olive oil, are needed to help your body absorb the fat-soluble vitamins A, D, E & K. They also contribute to a fine-textured skin (aka: stretchy pregnancy skin). This food group offers a concentrated source of calories, important during pregnancy when calorie need is increased to

2500–3000 calories per day. The Brewer Diet recommends three servings per day.

Yellow- and Orange-Colored Fruits and Vegetables: Vitamin A Foods

These specific foods are high in vitamin A, which is known to fight infection. During pregnancy, when pressure of the growing uterus on the bladder is constant, extra vitamin A helps protect you against bladder and kidney infections. The Brewer Diet recommends five servings per week.

Salt

Salt is an essential nutrient in pregnancy. Cutting back can cause a decrease in the amount of blood circulating through your body and placenta (hypovolemia), thus reducing the supply of nutrients passing to your baby. Too little salt in the diet can also lead to leg cramps, fatigue, and even swelling. The Brewer Diet recommends salting your food to taste.

Water

Water accounts for 75 percent of your baby's total body weight at birth and acts as a solvent and a catalyst for biological reactions. Dehydration can lead to headaches during pregnancy. The Brewer Diet recommends drinking to thirst or approximately eight, 8-ounce glasses per day.

Other Important Nutrients for Pregnant Women include:

Omega-3s: These fatty acids are vital for fetal brain and central nervous system development, and may even lower a mother's risk of postpartum depression. Best sources: salmon, anchovies, walnuts, flax seeds, pumpkin seeds, canola oil, flaxseed oil, soy, and some brands of eggs.

Choline: This vitamin B–like compound plays a critical role in fetal brain development and may help prevent spinal cord defects. Best sources: beef (with the exception of beef liver, which pregnant women should avoid), chicken liver, eggs, soybeans, and wheat germ.

Fiber: A high-fiber diet helps avert common pregnancy complaints, such as constipation and hemorrhoids, and provides an even release of glucose in the bloodstream, helping prevent surges and dips in energy. Best sources: whole-grain foods, oatmeal, fruits, and vegetables.

Iron: All pregnant women need to have adequate levels and intake of iron and folic acid during pregnancy. Iron in red blood cells carries oxygen everywhere in your body, and to your baby via the placenta. A mother also supplies her baby with all of the iron needed to develop his or her own red blood cells. Some women, especially if they follow a vegetarian diet, may need to supplement their iron intake. Floradix is a natural supplement we commonly recommend for this.

Folic Acid: This B vitamin is very important in cell division and growth, and for the prevention of anemia during pregnancy. It is needed by both children and adults.

FOODS TO AVOID DURING PREGNANCY

Caffeine

The consumption of high doses of caffeine daily during pregnancy—whether from coffee, tea, cola, cocoa, or energy drinks—has long been associated with an increased risk of miscarriage, and a 2008 study from the Kaiser Permanente Division of Research seems to confirm that link. This study found that women who consumed 200 milligrams or more of caffeine per day (that's two or more cups of regular coffee or five 12-ounce cans of soda containing caffeine) had twice the miscarriage risk as women who consumed no caffeine.

Alcohol

Recent research has shown that fetal alcohol syndrome is a disease of malnutrition that occurs in severe alcoholism. An occasional small glass of wine is probably fine, though we don't know scientifically how much is too much. It is safest to avoid alcohol altogether.

Raw Fish or Eggs and Deli Meats or Hotdogs

Any raw food should be avoided because of the risk of contamination with coliform bacteria, toxoplasmosis, and salmonella. Any unpasteurized milk product may contain listeria, a bacterium that can trigger food poisoning and cause serious pregnancy complications. Some deli meats may be contaminated with listeria, thus it is best to heat all meats to 165 F to kill any bacteria they may contain.

Soft Cheeses

It's recommended that pregnant women avoid any imported soft cheeses, such as Brie, goat, Camembert, feta, queso blanco, and blue or other veined varieties, because they may be unpasteurized and contaminated with listeria. All domestic soft cheeses made from pasteurized milk are considered safe to eat in pregnancy. Aging of cheeses, like cheddar or Parmesan, kills bacteria naturally.

Large, Fatty Fish

Mercury, which is present in many fish, is a neurotoxin that impairs fetal brain development. When mercury from pollution gets into the water, it works its way up the food chain, leaving the big swimmers the most contaminated. Fish with high levels of mercury include shark, tilefish, king mackerel, swordfish, and albacore tuna. Some pregnant women make the mistake of swearing off all fish,

but salmon, for example, doesn't contain mercury, and is a great source of the omega-3 fatty acids needed in abundance during pregnancy.

PEDIATRIC CARE FOR YOUR BABY

We ask you to name a pediatric care provider for your new baby at about the 30th week of pregnancy. If you do not have older children, or experience with a particular pediatric care provider, now is the time to find care you feel will meet your needs.

- A logical first step is to decide whether you want a practitioner who specializes only in children, or a practitioner who will care for the whole family. Pediatricians, Pediatric Nurse Practitioners, and Family Practice doctors, for example, all receive education in pediatrics. Family Practice doctors may take care of the whole family as well. A health care provider need not specialize in pediatrics to be an excellent choice for your baby's care.
- The next step is to decide what qualities are most important to you in the care provider that you choose. Many of our clients are focused on finding someone who is very supportive of breastfeeding and knowledgeable about resolving breastfeeding issues. Others look to their care provider as a guide in general child-rearing issues. Some prefer a holistic approach to pediatric care, while others are more comfortable with a mainstream approach.
- Third, get referrals to providers in your area. You can start by gathering a few names word-of-mouth, asking friends with small children, or fellow participants in mothering support groups. Searching the web may yield some leads, or you may want to stick with the providers listed by your insurance company as being "in-network."
- Once you have a list of potential care providers, make contact. You might initially call when the offices are closed to test how promptly phone calls are returned, and to assess the administrative staff's responsiveness and attitude. Friendly, helpful nurses also often end up being as important to you as the care provider. Nurses are the ones who screen phone calls, give shots, and, when the doctor isn't available, counsel and advise.
- Finally, conduct interviews before making a final decision. A face to face meeting, even if only 15 minutes long, is a chance to assess your fit with the practice you are considering. Ask questions about the practice philosophy on breastfeeding and supplementation, treatment of jaundice, circumcision, immunizations, and prescribing antibiotics. Ask also about the use of alternative and complementary therapies and about continuity of care if your child must for some reason be hospitalized.
- Once you settle on a care provider, have the Pediatric Care Agreement signed and returned to our office to be placed in your chart.

LABOR AND BIRTH

THE ONSET OF LABOR

Labor is very individual and may begin in a variety of ways. The following information is provided to help you evaluate the onset of labor and when to call the midwife.

Rupture of Membranes

Your water can break before the onset of labor or at any time during labor and birth. It can be a gush of fluid or a trickle. If you think you are leaking fluid, note the time it began, stay on a clean pad, and call the midwife.

Contractions

Labor contractions are stronger than the Braxton Hicks contractions you may have been having and are consistent. They may start out every 15–20 minutes and gradually get closer, or they may begin at every 5 minutes and get stronger. The key is the combination of increasing frequency and strength of contractions, combined with other symptoms, such as bloody show or loss of mucous plug, increased pelvic pressure, or rupture of membranes. Call the midwife if you are having strong, regular contractions.

Prodromal or Latent Phase of Labor

This phase may last several hours or days. Contractions will be consistent but not increasing in intensity, and often your cervix will not make much change. During this phase of labor it is important to get as much rest as possible, so you are not exhausted when the active phase of labor begins.

Bloody Show

As the cervix thins out (effacement) and opens (dilation), small blood vessels may break, causing a bloody show. The show may be pink or red and combined with mucous. Bloody show may occur before the onset of labor or after an internal exam of your cervix.

Loss of Mucous Plug

A mucous plug fills the opening to the cervix during pregnancy. As the cervix effaces and dilates, the plug comes out. It may come out as one large clump of mucous with or without bloody show, or shred out gradually over several days. It is often a signal that labor is soon to begin, within hours or even a few days.

ACTIVE LABOR

Active labor is when you are having regular contractions about every 5 minutes **and your cervix is changing**. In other words, contractions may be occurring every 5 minutes, but if your cervix remains the same over a period of several hours, you are not in active labor.

Once you are in active labor the midwife on call and an assistant will come to your home or meet you at the hospital. When we arrive we will observe your labor pattern, listen to your baby's heartbeat, and set up our equipment.

If you are having your baby in the hospital, your baby's heartbeat will be monitored for a short period of time on a fetal monitor. The monitor allows you freedom of movement, as it uses telemetry with no wires attached. At home we use a hand-held fetal Doppler to listen to your baby before, during, and after a few contractions. We will continue to evaluate your baby's heart rate during the course of your labor, about every 15–30 minutes. During the second stage, or pushing phase, we listen more frequently.

Usually within the first hour of active labor we do a vaginal exam. This exam is important because it allows us to assess the position of your baby's head and its descent, as well as the dilation of your cervix. Further exams will be done at your request or at the discretion of the midwife.

We will stay with you throughout the active phase of your labor, providing support, encouragement, and information. You may wish to labor with your partner alone, knowing the midwife is nearby, or have the midwife and assistant in constant attendance.

Any family, friends, or support professionals that you want at the birth are welcome. In the hospital, you can designate three people as your support team, who may come and go as you wish them to during your labor. We easily incorporate family members and older children into the process. When appropriate, fathers or partners may choose to "catch" their baby.

We have great respect for your birth wishes, unobtrusively monitoring labor with a minimum of vaginal examinations. You may be completely mobile while in labor and may choose a variety of positions. All women are encouraged to eat lightly and stay well-hydrated during labor. Occasionally, a woman is unable to keep fluids down during her labor and IV hydration may be used.

Mothers, families, and babies are never separated, even during baby exams, which will be explained as we go. An exception to this could arise if your baby is born in the hospital and requires treatment or monitoring in the NICU. In this case, fathers are encouraged to stay with the baby and mothers will be brought to the nursery as soon as possible.

Early breastfeeding is encouraged and supported. Before we leave your home, or before you are discharged from the hospital, we will review what to expect in the days and weeks to come, and how to monitor your and your baby's health. Included in your folder is a printed list of what to watch for in the early days postpartum.

LABOR NOTES:

Count contractions from the start of one to the start of the next, noting the duration.

VAGINAL BIRTH AFTER CESAREAN (VBAC)

We are fortunate to have support at our hospital for the care of VBAC mothers. If you have experienced a prior Cesarean birth, we will help you to weigh the pros and cons of a trial of labor, using contemporary research and standards of care. It is very important for us to have access to your prior records, as we must document the type of surgery you had in the past. Generally, unless we determine together that you are a good candidate for VBAC, we will encourage you to use a physician-based practice. During the pregnancy, you will have a visit scheduled with Capital Health Maternal Fetal Medicine, and the perinatologist will reiterate the benefits and risks associated with your individual history and current status.

A risk factor may arise during the course of your pregnancy or labor that necessitates a repeat Cesarean. Since we do VBACs only in the hospital setting, there is always a physician available to handle any sudden complication. We will be in constant attendance during your labor as we are with all births. We use continuous electronic fetal monitoring during labor, and maintain an intravenous access. If a Cesarean must be done, we will stay with you and your partner through the experience and make sure that your baby is in your arms as soon as both of you are ready.

We ask that you prepare yourself for all possibilities, and we depend upon your fully informed consent in this mutual endeavor. Through the years, encompassing more than 60 attempted births, we have achieved a VBAC success rate of over 90 percent. The credit for this goes to the hard work of the mothers in our care who have placed such a high value on experiencing natural birth with minimal intervention.

COMPLICATIONS AND TRANSFER

The key to safety in birth, whether at home or in a hospital, lies in expert risk-screening; following sound, medically approved practice guidelines; preparing for difficulties; and cooperating with readily available backup physicians. It has often been said that about 90 percent of all serious complications are predictable through good prenatal care. The other group of complications that can arise might happen anywhere, regardless of setting. Thorough prenatal care and an eye for the unpredictable are keys to managing emergencies during a home birth.

Your midwives watch the health of both you and your baby prenatally to ensure that no surprises come about on the day of delivery. To give birth safely at home, there must be just one baby, head down in the pelvis, within 37 to 42 completed weeks of pregnancy, with no underlying medical problems noted.

Risk screening is an on-going, dynamic process. As midwives guide mothers through the stages of birth, they must constantly be on the lookout for unexpected challenges. If risk factors arise once labor has begun, transfer to a hospital might be necessary. For this small number of births, unpredictable events, such as lack of progress, maternal distress, bleeding, non-reassuring fetal signals, and malpresentation can present problems in a home setting. You and your midwives share in the final decision of when to contact the backup physician and whether to go to the hospital. The categories of reasons why a transfer to the hospital might be considered are listed, below.

Lack of Progress

Approximately 80 percent of hospital transfers result from a lack of progress in labor. A mother may feel she has been in labor for a long time, and if progress is not being made she can get tired and frustrated. When labor stalls, sometimes it may take some extra help through medication to get the baby born. Natural methods of stimulating labor may be tried at this point, but there are times when the judicious use of pitocin is necessary. The hospital is the only place this may be safely administered, as the response of both mother and baby must be continuously monitored. In most cases, this sort of transfer is accomplished using a private vehicle, and is not an emergency. First-time mothers have about a one in ten rate of transfer after labor is established. For mothers who have had prior births, the rate is approximately one in fifty.

Maternal Distress

In a very few instances, conditions such as extreme fatigue, fever, bleeding in excess of “bloody show,” or increasing blood pressure may create serious concern once labor is established. To address any of these situations, a transfer to the hospital is in order, as additional help may be needed.

Bleeding

Serious blood loss at any point in the birth process, whether before or after the birth or following the birth of the placenta, must be immediately addressed. Your midwives work to stabilize a mother’s condition with the same therapeutic approach that would be used in any setting: first, determine the cause and source of the bleeding; next, apply techniques to stop it; and finally, replace fluids and administer any appropriate medications. Once the mother is stabilized, it can be determined whether or not transfer to the hospital is necessary.

Non-reassuring Fetal Signals

Midwives monitor the condition of the baby by listening to fetal heart sounds throughout labor. Unless the birth is imminent, a non-reassuring pattern would be a reason for immediate transfer to the hospital. If the birth is about to occur and the baby’s heart rate pattern is suddenly questionable, the midwife will prepare for potential resuscitation in the home once the baby is born. When a newborn is unexpectedly depressed at birth, oxygen is administered as needed to stabilize the baby until a possible transfer to a higher-tech setting. The equipment and supplies at a home birth are comparable to that which would be present in any low-tech setting, such as a free-standing birth center or Level I community hospital, including the means for monitoring the status of baby and mother, and a neonatal resuscitation set-up (e.g., bag and mask, oxygen, intubation equipment, and mechanical suction). Your midwives and all members of the birth team are certified in neonatal resuscitation and are trained to handle a depressed baby just after birth.

Malpresentation

This category includes anything other than the baby’s head coming first—arms, feet, butt, or umbilical cord. Any malpresentation is a contraindication to a home birth. Even if the birth seems imminent, a call to emergency services is usually made to ensure that medical help is on the way.

In summary, while emergency situations are a rare occurrence in the home birth setting, the midwife, the mother, and the family must be prepared for an unexpected transfer to the hospital if needed. This means having a clear idea of the route to the closest hospital, and to the primary backup hospital (if not the same). It also means having a small emergency bag packed, a working car with a full tank of gas, an approved infant car seat in the family car, and a friend or family member designated to stay behind with any other small children in the home. In snowy weather, it also means clearing paths and driveways for good access to the house by either midwives or emergency personnel.

Informed Consent

The management of emergencies dictates thorough, informed consent on everyone's part. Please carefully read our Consent for Home Birth to ensure everyone is clear about the degree of responsibility that the family shares by choosing to birth outside a hospital, where immediate emergency care would be available. Once an emergency situation is identified, the family needs to be completely willing to be responsive to the suggestions of the midwife and her team. A trusting relationship created between all involved may be one of the most important elements needed in a home birth.

Even when the circumstances of a birth change, and non-conforming labors or other reasons for hospital transfer arise, you can count on the continuous support and care of your birth team. On your baby's very first birthday, this support makes the difference in creating an optimal atmosphere surrounding the birth. Together, midwives and families can help prepare for the positive outcomes that all mothers dream of in the weeks and days preceding birth—a healthy baby, healthy mother, and a safe and rewarding birth experience.

DIRECTIONS TO CAPITAL HEALTH HOPEWELL CAMPUS

From Morrisville, PA: W. Trenton Ave. over Calhoun St. Bridge. Stay right and exit onto route 29 north continue on 29 North for about 3 miles and exit onto route 95 North. Take Exit 3B Scotch Rd North: the hospital is on your right after you cross over route 95.

From Levittown, Bristol, PA: Follow Rt. 1 North or Rt. 13 North. Continue on Rt. 1 North and cross Delaware River Toll Bridge. Exit onto Rt. 29 North. Follow directions above

From Yardley, PA - Philadelphia: I-95 North. Cross over Scudder Falls Bridge. Exit 3B at Scotch Rd North the Hospital will be on your right

From Hamilton, NJ - Points East: Take I-195 West to Rt. 29/Capitol Complex/Lambertville. Continue directions above from 29 North

From Princeton, NJ - Points North: Take Rt. 1 South. To exit for I-295N/I-95S to Pennsylvania. Continue on 95 South to exit 3 Scotch Rd north Hospital on your right just off exit.

From Burlington, NJ - Points South: I-295 North to I-95 South to exit 3 Scotch Rd North hospital is on the right just off exit

From Flemington NJ- Points North West: Take Route 31 south to I-95 south to Exit 3 Hospital is on the right.

From Midwifery Care Associates: Exit office parking lot to route 31 South turn right onto Pennington Harbourton Rd. Turn left onto Burd Rd/Scotch Rd. Hospital will be on your left at a traffic light just before intersection with I-95.

HOME BIRTH SUPPLY LIST

Essential:**Birth supply MCA Tote: Purchase from us by 36 weeks \$55**

This is a savings of \$30 compared to the previously ordered box

2–3 vinyl shower curtains liners (aired out if possible)
6–8 old towels, home laundered
2–4 wash cloths
Cookie sheet or tray
Unbreakable bowl for placenta
Quart-size plastic container or zip lock bags for placenta
6–8 cotton flannel receiving blankets
Extra cotton knit caps for baby
Baby gowns and diapers
Package of extra-large absorbent bed under pads
Maternity sanitary supplies
Extra sheets for your bed
Car seat installed in your car
Overnight bag for emergency transport to hospital
Coffee for midwives

Handy:

2–3 instant ice packs or frozen washcloths
Electrolyte replacement drinks, like Recharge, Gatorade, or Pedialyte
Heating pad or hot water bottle
Postpartum discomfort remedies: herbal tonics, Aleve, Motrin, Extra- Strength Tylenol
For water birth/labor: extra towels, medium-size mesh fish tank net
Camera, film, video camera, if desired
Oil for perineum (olive or sweet almond)

HOSPITAL BIRTH SUPPLY LIST

Extra pillows (Hospital pillows are uncomfortable and in short supply)
Personal care items
Comfortable clothing for labor
Nightgown, robe, and slippers
Nourishing snacks for both you and your support people
Camera, film, video camera, if desired
Oil for perineum (olive or sweet almond)
Clothes for the baby to go home in
Infant car seat

WHAT ABOUT WATER BIRTH?

Many women are attracted to warm water for soothing the hard work of labor; it eases our aches, relaxes, refreshes, makes us feel buoyant, and relieves pressure. Scientific evidence has shown that the use of a warm pool makes active labor more progressive for many women. In the tub, a woman's body is less likely to produce stress hormones, which inhibit or slow progress and raise blood pressure. As physical relaxation helps women achieve mental relaxation, fear and pain are reduced and calm and concentration are increased. Women report feeling soothed just hearing the water running into the tub; some give birth before entering the tub, and others stay to give birth in the water.

We often explain to women interested in water birth that they should regard it as water labor, with the possibility of water birth. The focus should be on water as a powerful resource for pain relief in labor, with no restrictions or expectations about where the actual birth will take place. About 20 to 30 percent of women who are given the option to birth in water decide to pursue it, and prepare a special birthing tub, tank, or pool for this purpose. These are rigid or soft-sided pools at least 30 inches deep and usually 4 to 6 feet in diameter. Some are oval, some round. Most are available for rental with a personal disposable liner for easy clean-up, a heater and thermometer, plumbing connectors for filling, and a pump for emptying. The water may be put into the tub any time up to 24 hours prior to expected use; heat-retaining covers are usually included with the tub. Women reserve their tubs according to due date, and request approximately two to three weeks surrounding the expected birth. A few women simply labor in a standard or oversize, Jacuzzi-style bathtub.

The benefits to both mother and baby of allowing free use of warm water are considerable. A woman's perception of her labor as less painful, gentler, and more progressive will be one of the factors that shapes her response to the baby. The infant is aquatic prior to the birth, cushioned and protected in a watery world while supplied with oxygen through the umbilical cord. As the baby emerges into the warm bath, the warmth and familiarity of water are there as a mother's hands reach to lift him or her to the surface. Babies generally take a first breath when stimulated by air on the face. No data shows an increased risk to mother or baby when water birth is conducted by an experienced practitioner. Additional information on water birth is available through our office or by contacting the Global Maternal/Child Health Association: PO Box 366, West Linn, Oregon, 97068; (503) 682-3600.

POSTPARTUM

We understand that the postpartum time can be quite challenging. During your prenatal visits we will discuss your postpartum support plans. We encourage you to enlist the help of your family and friends during the first week for household duties, to allow you and your family to adjust to your new life. We ask all clients to call in daily for the first few days, and a home visit is done usually on the third day. We check in again with you by phone at 1 week. A 4–6-week postpartum visit is scheduled to do family planning and to make sure that all is back to normal. This schedule is flexible and adjusted according to your family's needs.

REST!!! REST!!! REST!!! REST!!! REST!!!

During birth, your body goes through a dramatic change. The combination of lost sleep and what may have been a marathon labor could leave you feeling like you were hit by a truck. It is vital that you now listen to your body. Sleep when your baby sleeps, stay in your pajamas, and limit your visitors to brief visits. Accept help, and meals, from friends and family.

Once your baby is born, the focus you have had on good nutrition is far from over. The nutritional demands of pregnancy now give way to the increased nutrition needed to make milk for your baby. Your postpartum diet should be rich in protein, calcium, and iron, keeping you strong through the challenging early months of reduced sleep and the constant care of your new baby.

You should stay in bed for the first few days, only taking care of your own and your newborn's personal needs. Avoid stairs and stay away from cooking, cleaning, and laundry! After the first week you may gradually increase your activity, but allow for only one activity per day and make time for naps as needed. We expect you to let us know of any issues that arise with you or your baby, even if you are working closely with your pediatric care provider.

Pediatric Visit

Your baby should be seen by your pediatric care provider as soon as possible. Your pediatrician should have signed the pediatric agreement form and be prepared to see you on short notice. Some will make a home visit; others will require you to bring your baby to the office. It is often less stressful for you to accompany your baby to the pediatric care provider than to be separated even briefly. Try to schedule that visit at the end or beginning of the day to avoid exposure to sick children. If you delivered in the hospital your baby will have been checked out there. You will need to arrange a follow up visit at about 1–2 weeks.

Midwife Postpartum Visit

This visit includes completion of the baby's birth certificate, for home born babies, and Inborn Errors of Metabolism (IEM) testing, as well as physical exams of mother and newborn, breastfeeding support, and weight check as needed. Once the birth certificate is completed, you will need to go to your local municipal registrar of vital statistics, bearing proof of residency and proof of identity. A certified copy of the birth certificate will then be issued to you. You may apply for your baby's Social Security number by checking off a box on the birth certificate, but from that point on, inquiries must be made to the Social Security Administration. We speak with you again at about 2 weeks postpartum, to check in and also to schedule your 6 week visit. By the time you come in for your 6 week appointment, you should be feeling strong and healthy and ready to return to all activities and exercise.

Hearing Screening

We expect parents to have the NJ state–required Newborn Hearing Screening performed on their baby within the first thirty days of life. Ask your pediatrician to provide you with a prescription to get this important state-mandated screening, performed at your local hospital or other screening facility.

Breastfeeding

We encourage all our clients to breastfeed in the first hour after their baby is born. Most babies are interested in latching on and nurse well in the period between 20 minutes and 1 hour following birth. This first nursing is important both because it establishes a strong foundation for the breastfeeding experience and because of the valuable colostrum produced before your milk lets down.

Colostrum is nature's miracle food, delivering nutrients ideally suited for the needs of your newborn in a very concentrated, low-volume form. Its mild laxative effect encourages the passing of your baby's first stool, called meconium, which clears excess bilirubin from your infant's body and helps prevent jaundice. Rich in proteins, carbohydrates, fat, vitamins and minerals, and several molecules essential for specific functions, this precious liquid also contains immunological factors, which are passed to your infant through your breast milk to provide the first protection against pathogens.

Newborns need to nurse approximately every 2 hours in the first few weeks. La Leche League groups and The Family Breastfeeding Association, 888-322-1843, a smaller group serving Bucks and Mercer counties, offer excellent information and support for breastfeeding mothers. We encourage you to make these

connections before your due date, to establish a network for the early days and weeks of nursing. We are fortunate to have many support organizations and lactation consultants in our area, and we can help you to find the best resources for you.

Perineum/Stitches

The area of skin between your vaginal opening and your rectum is called the perineum. After giving birth, this area may be bruised and swollen. Ice packs applied in the first 24 hours after birth can reduce swelling and pain. You should apply warm water with your peri bottle every time you use the bathroom, and use the bathroom about every 2 hours to change your pad, even if you don't need to urinate. If you had a tear or episiotomy you may have stitches in your vagina and perineum. The material used for stitches will dissolve in about 10 days to 2 weeks, around which time you may find pieces of the stitches on your pad. You may also use herbs like calendula to make an infusion to use in your peri bottle, or in a sitz bath. You can also soak in a clean bath tub filled with warm water. Tucks or witch-hazel pads can also provide relief to stitches and hemorrhoids. You may use them for cleaning the perineal area, as well as place them on your sanitary pad. Chilled pads can provide extra relief to swollen, painful hemorrhoids. You can use over the counter hemorrhoid creams, or if necessary we will give you a prescription for something stronger.

If your perineum is extremely painful or swollen, call the midwife.

Bleeding

The bleeding following birth is called the lochia. After the placenta separates from the inside of your uterus, a clot will form over the surface where the placenta was attached. The large blood vessels that once fed the placenta are constricted by the contracting uterine muscle, preventing excess bleeding. As the clot breaks down it flows out onto your sanitary pad.

Week one: Your bleeding will be red, gradually changing to pink/brown. You may pass clots up to the size of a small egg. You will need to change your pad frequently, about every 2–3 hours.

If you are fully soaking a large sanitary pad in less than one hour, call the midwife.

Week two: Your bleeding should lessen and be brownish pink. Return of the bright red bleeding indicates you have been too active; slow down!

Week three–six: Your bleeding will gradually decrease in amount and the color will lighten to yellow with occasional streaks of pink/brown. Some women experience some red bleeding in the last few days of the flow; this may be the final healing of the placental site.

Afterpains

Contractions of your uterus will occur in the first weeks after birth. They rapidly return your uterus to its former non-pregnant state. Though rarely painful with your first baby, you will be aware of them and they will be more pronounced during breastfeeding. With subsequent births, these contractions become painful and may require pain relief measures. It is important to keep your bladder empty, which allows the uterus to contract more efficiently and with less pain. Use a heating pad or hot water bottle for additional relief. Aleve, Ibuprofen, and Tylenol are all safe for you and your breastfeeding baby and can be very helpful. Or you may choose to use herbs like Shepherd's purse or homeopathic arnica.

NEWBORN CARE

Snuggle, Feed, Warm, and Dry

This short but accurate description of newborn care is explained in further detail below.

Snuggle: Babies love to be swaddled. They have been snug inside your uterus for months and are used to the feeling. A fussy baby will often settle down once swaddled warmly in blankets. Newborns should be placed on their back or side to sleep, never on their tummies.

Feed: As discussed in the breastfeeding section, newborns need to nurse every 2 hours, even if you have to wake them up. Most babies will have one period of longer sleep, about 4–5 hours, when you cannot wake them and they are like rag dolls. If your baby is gaining weight and having lots of wet and soiled diapers, don't worry. However, if your baby is a slow gainer or having trouble breastfeeding you need to be more aggressive and wake them for feedings.

Warm: Newborns have a hard time regulating their temperature and lose heat rapidly through their skin. If the temperature is cool keep an extra layer of clothing on them as well as a hat. If the temperature is very warm (85–90 F) and humid keep them in a diaper and T-shirt; they can overheat as well.

Dry: Your baby should pass meconium in the first 24 hours. Meconium is the first stool and is black/green in color. As your milk comes in it will gradually change to mustard yellow with occasional milk curds. This is normal breastfeeding stool. Babies can have stools every time they nurse or 1–2 times a week. As long as the stool is soft, not hard, this is normal. Your baby should have a wet diaper in the first 24 hours; if you can't tell, put a tissue in the diaper.

Cord Care: The only thing to remember about the cord is to keep it dry. We will remove the cord clamp when we return for your postpartum visit. In the meantime, keep the baby's diaper rolled down below the cord. If it accumulates a sticky, crusty substance you can clean it off with alcohol pads in your birth kit.

If the skin around the cord is hot and looks red and infected, similar to a bee sting, call your pediatrician.

Bathing: Babies are born with a protective coating on their skin called vernix. This thick, creamy substance has protected their skin for many months in the amniotic fluid. Rather than washing off the vernix, we recommend that you allow it to absorb into the skin. Newborns do not get very dirty, and usually cleaning of the diaper area is the only bathing required in the first week. Some babies have a small crusty discharge from their eyes; this can be wiped away with a damp cloth or cotton ball. If your baby's eyes appear red or swollen, contact your pediatrician as your baby may have a clogged or infected tear duct.

Diaper Basics: Babies should be producing at least one wet diaper in the first day, two on the second day, three on the third day, and so forth until they make about 6 wet diapers per day. You may see some pink crystals in the diaper, looking like brick dust, in the first few days. These are uric acid crystals, and are normal as the baby's kidneys start to function. If you have trouble telling whether the baby has wet the diaper, you can put a bit of tissue paper inside the diaper which will appear wet when you change the baby. Babies should pass their first bowel movement, called meconium, by the second day. As your milk supply becomes established, the color of the bowel movements will change from tarry black to greenish yellow to yellow with whitish curds. The texture of the movements will be quite loose and liquid. This is not diarrhea, but normal in infants. Breast milk is highly digestible, so some babies may absorb almost all of the milk and pass very infrequent bowel movements, while others may grace every diaper with a bit. Unless the texture of the bowel movement is very stiff and hard, infrequent movements are not a sign of constipation. It is also not uncommon for girl babies to have a thick mucous discharge at the vulva, resulting from withdrawal of your pregnancy hormones.

Jaundice: Most babies will show a slight degree of jaundice at about three days of age, with the skin of the upper body and the whites of the eyes somewhat yellow. As the baby breaks down excess red blood cells, the iron from the cells is stored in the baby's liver and the pigment, or bilirubin, must be broken down and excreted. Sunlight helps this process. Place your baby in just a diaper at a sunny window four times a day for about fifteen minutes per session. Even the amount of light that comes through a window on a cloudy day can help reduce jaundice in the baby. Be sure that the room is very warm, so that the baby doesn't get chilled during the sun baths. If you think that your baby looks especially yellow, or if the jaundice begins sooner than the third day, be sure to call the midwife.

Circumcision: As you prepare for parenthood you will begin to make many decisions about your baby's care, including whether or not to circumcise if you have a baby boy. Circumcision is the surgical removal of the foreskin, which covers and protects the end of the penis. It is a significant religious observance for Jewish families, accompanied by prayer and celebration. In this case, the baby is circumcised on the eighth day of life. Special provisions are usually made for a mohel, or ritual circumciser, to conduct a bris at the home of the parents.

If you have a newborn and do not belong to a group for whom circumcision is a religious necessity, you may wish to examine the pros and cons of this procedure. Circumcision was not widely practiced as a routine operation on newborns until the 20th century. It was thought in the Victorian era that circumcision would prevent masturbation, believed to be the cause of insanity. Many doctors thought that circumcision would prevent diseases and make males cleaner. Scientific research has shown that these beliefs are inaccurate.

Circumcision has not been shown to prevent diseases. In most countries, boys grow up intact and do not need to pay any more attention to the cleanliness of the foreskin than any other part of the body. Routine bathing is all that is necessary. There is no data suggesting a medical advantage to this procedure. And, since circumcision is a medical procedure, there can be complications requiring immediate treatment or surgery. We now understand that a baby does feel pain with the procedure, and usually no anesthesia is used.

While you cannot know in advance how your son will feel later about either being circumcised or uncircumcised, he will usually accept your explanation of your choice. Since circumcision is no longer universally practiced, your uncircumcised son will probably have other friends whom he "matches." In many families, there may be one or more circumcised son and intact others. This is rarely problematic for the family.

A generation ago, little information was given to parents about most medical procedures, including circumcision. There was also a lack of general information on the care of uncircumcised boys. This led to complications that were accidentally caused by well-intentioned but over-zealous attempts to retract the baby's foreskin for cleaning. We know now that the baby's foreskin is normally sealed tightly to the glans, and should not be loosened or forced back during infancy or early childhood. As your son grows, the foreskin will loosen itself naturally. To put this decision into perspective, you can take into account studies that show that most men and boys say they are happy with themselves the way they are. Most circumcised males are content with being circumcised, and most

intact males are pleased to be intact. You will need to make this decision, and many other decisions, for your baby based on a constellation of social, religious, and family considerations. Since your baby cannot consent to circumcision for himself, great care should be taken to look at your personal set of pros and cons, and to get as much information as you may feel you need.

BABY NOTES:

POSTPARTUM DEPRESSION

Postpartum depression can and *often does* happen

Many people believe that postpartum depression is fairly rare. Actually, 15–20 percent of new mothers—about 1 million women in the US each year—experience PPD, and some studies report that the number may be even higher.

It is quite common. In fact, it is the number one complication of childbirth.

You Are Not Alone

Perinatal mood and anxiety disorders include antepartum depression, postpartum depression, postpartum anxiety, postpartum OCD, postpartum psychosis, and postpartum post-traumatic stress disorder. One size does not fit all. There are a variety of symptoms you may (or may not) experience in the period during pregnancy and following birth. These include:

- Sadness
- Mood swings
- Difficulty concentrating
- Irritation or anger (with yourself and/or those around you)
- Lack of interest in things you used to enjoy
- Sleep and appetite changes
- Anxiety
- Excessive worry about your baby
- Disturbing thoughts about harming yourself or your baby
- Mania
- Racing thoughts
- Panic attacks
- Headaches and stomach problems
- Guilt
- Feeling like you should never have become a mother or that you won't be able to do it
- Delusions or hallucinations

We will evaluate your risk of PPD by using the Edinburg Postpartum Depression scale at your postpartum visits. The scale may also be used during your pregnancy to evaluate your risk for depression, allowing us to help you come up with a plan for support.

EDINBURG POSTPARTUM DEPRESSION SCALE

The following questionnaire was developed to detect if a woman may have depression following childbirth. Please choose the answer that comes closest to how you have felt in the past 7 days, not just how you feel today.

1) I have been able to laugh and see the funny side of things

- As much as I always could (0)
- not quite so much now (1)
- definitely not so much now (2)
- not at all (3)

2) I have looked forward with enjoyment to things

- As much as I ever did (0)
- Rather less than I used to (1)
- Definitely less than I used to (2)
- Hardly at all (3)

3) I have blamed myself unnecessarily when things went wrong

- Yes, most of the time (3)
- Yes, some of the time (2)
- Not very often (1)
- No, never (0)

4) I have been anxious or worried for no good reason

- No, not at all (0)
- Hardly ever (1)
- Yes, sometimes (2) Yes, very often (3)

5) I have felt scared or panicky for no good reason

- Yes, quite often (3)
- Yes, sometimes (2)
- No, not much (1)
- No, not at all (0)

6) Things have been getting on top of me

- Yes, most of the time I haven't been able to cope at all (3)
- Yes, sometimes I haven't been coping as well as usual (2)
- No, most often I have been coping quite well (1)
- No, I have been coping as well as ever (0)

7) I have been so unhappy that I have had difficulty sleeping

Yes, most of the time (3)

Yes, sometimes (2)

Not very often (1)

No, not at all (0)

8) I have felt sad or miserable

Yes, most of the time (3)

Yes, quite often (2)

Not very often (1)

No, not at all (0)

9) I have been so unhappy that I have been crying

Yes, most of the time (3)

Yes, quite often (2)

Only occasionally (1)

No, never (0)

10) The thought of harming myself has occurred to me

Yes, quite often (3)

Sometimes (2)

Hardly ever (1)

Never (0)

Scoring

Add all your scores together from the questions above. A score higher than 12 indicates that you may be experiencing symptoms of depression. Talk to your midwife right away for further information.

Question Your Score

1

2

3

4

5

6

7

8

9

10

WELL-WOMAN HEALTH CARE
AND CONTRACEPTIVE SERVICES

As Certified Nurse Midwives, we offer a full scope of well-woman services to all ages. This includes complete annual gynecological exams, Pap smears, and STI (sexually transmitted infection) screening.

Annual exams may include other preventive health services, such as tests for cholesterol and triglycerides, thyroid screening, or referrals for mammography or bone density screening.

Our contraceptive counseling includes all modalities currently available, including hormonal contraceptives, diaphragm and cervical cap fitting, IUD insertion, and natural family planning.

PHYSICIAN GYN SERVICES

Clients requiring gynecological care outside of our scope as midwives will be referred to a physician. We have relationships with many local OB/GYN practices and can help you to find excellent care.