**Full birth preparation plan**


**1. Begin with individualized clinical planning**

Start by reviewing your pregnancy and anticipated needs with the clinician responsible for your maternity care. The discussion should consider gestational age, fetal presentation, placental location, previous births or cesarean procedures, uterine surgery, multiple gestation, hypertensive disease, diabetes, bleeding, allergies, medications, and any condition that could affect the recommended setting or timing of birth. A plan for an uncomplicated pregnancy may differ substantially from one requiring obstetric, anesthetic, neonatal, or maternal-fetal medicine input.

Ask which symptoms or events should prompt an urgent call, an assessment, or direct travel to the maternity unit. Clarify how to reach the service outside office hours and whether you should call before leaving home. Your team can also explain local policies for triage, admission, fetal assessment, intravenous access, laboratory testing, and consultation with anesthesia or neonatology.

Consider attending an antenatal education class or tour when available. These sessions may explain the labor rooms, operating theatre pathway, monitoring equipment, visiting rules, infant feeding support, and discharge procedures.

Understanding the environment can make it easier to focus on clinical decisions when labor begins.

**2. Choose the birth setting, attendants, and support network**

Discuss whether a hospital, alongside midwifery unit, birth center, or planned home birth is clinically suitable for you. The decision should account for the level of emergency care available, distance and travel conditions, staffing, access to anesthesia and surgery, neonatal services, and the transfer pathway if complications arise. For a planned home birth, ask the responsible licensed professionals to explain eligibility criteria, equipment, emergency procedures, and the home birth transfer plan in detail.

Identify the health workers who will attend or coordinate your care, including the midwife, obstetric clinician, family physician, doula where applicable, and pediatric or neonatal team. The World Health Organization recommends documenting the facility, health workers, support people, transport arrangements, and expected expenses as part of birth preparedness.

Choose support people based on reliability, emotional steadiness, respect for consent, and practical usefulness. Confirm who may be present under facility policy and who can step in if the primary support person is unavailable. Discuss how you want them to help: offering hydration, communicating preferences, supporting position changes, protecting rest, or contacting the clinical team. A support person should never be expected to interpret medical information or make decisions in place of you unless you have explicitly arranged this.

**3. Create a flexible birth preferences document**

Keep the written plan brief enough for a busy team to review quickly, ideally one page plus a concise medical summary. Include your name, estimated due date, relevant diagnoses, allergies, medications, prior procedures, preferred language, communication needs, and the contact details of your chosen support people. Give a copy to your maternity provider in advance and bring another copy with your records.

Organize preferences by topic rather than presenting them as fixed demands. You

might address mobility and position changes, intermittent or continuous fetal monitoring when clinically appropriate, intravenous access, hydration and food policies, vaginal examinations, rupture of membranes, augmentation, induction, episiotomy, assisted vaginal birth, and delayed cord clamping. Ask what alternatives exist, which interventions are routine locally, and what findings would make a recommendation urgent.

Use specific language such as "Please explain the indication, benefits, risks, and alternatives before non-emergency procedures" rather than assuming that a preferred intervention will always be safe. In an emergency, the team may need to act rapidly, but clinicians should still communicate as clearly as circumstances permit. Include a statement that you understand the plan may change for maternal or fetal safety.

Pain management deserves an open, nonjudgmental discussion. Review nonpharmacologic coping strategies, nitrous oxide where available, systemic analgesia, neuraxial analgesia such as an epidural, and anesthesia considerations if operative birth becomes necessary. Ask about timing, contraindications, monitoring, mobility, side effects, and how quickly each option can be provided. Requesting analgesia is not a failure, and choosing minimal medication is not a requirement.

**4. Prepare logistics, supplies, and communication**

Make a written transport plan with a primary driver, backup driver, and alternatives if travel occurs at night, during severe weather, or when the primary person is working. Record the maternity unit address, preferred entrance, parking or drop-off instructions, and emergency telephone numbers. If public transport is your only option, ask your clinical service or local maternity program about safer alternatives. Do not drive yourself if you are in active labor, feel faint, have heavy bleeding, or have another urgent concern.

Review expected expenses, insurance authorization, payment arrangements, and the cost of transport, prescriptions, parking, childcare, or overnight accommodation. The WHO also emphasizes identifying resources in advance. Arrange care for other children, pets, and essential household responsibilities, and prepare an out-of-office message or workplace plan if useful.

Pack according to the policies of your facility. Typical items may include identification and medical documentation, medication and allergy information, phone and charger, comfortable clothing, hygiene supplies, glasses, infant clothing, and an approved infant car seat for the journey home. Ask whether the unit supplies gowns, diapers, feeding equipment, breast pumps, or postpartum medicines. Avoid bringing valuables or unapproved electrical equipment.

Set up a communication tree. Decide who receives updates, who can make practical calls, and how much information you want shared. Protect privacy by telling support people whether photographs, video, or social media posts are permitted. Include a plan for language interpretation rather than relying on a child or family member to translate clinical information.

**5. Plan for changes and urgent scenarios**

A strong plan includes several pathways: spontaneous labor, induction, prolonged labor, unexpected pain-management needs, assisted vaginal birth, and cesarean birth. Discuss what might lead to each pathway and which decisions could be made in advance. For example, ask how an induction is performed, how cervical ripening and oxytocin are used, what monitoring is required, and how long assessment may take. Your clinician can explain which elements are specific to your circumstances.

If cesarean birth is possible, ask about the usual anesthesia, support-person policy, skin-to-skin contact, newborn assessment, cord management, feeding, and recovery. A cesarean birth contingency planning discussion can reduce uncertainty without implying that surgery is inevitable. If an operative birth becomes necessary, the priority is timely treatment of the clinical indication, while preferences that remain safe can still be respected.

For a planned out-of-hospital birth, understand the reasons for transfer, the transport method, who accompanies you, which records and equipment travel with you, and which hospital will receive you. For any planned setting, clarify how fetal heart-rate abnormalities, maternal fever, hypertension, hemorrhage, meconium-stained fluid, malpresentation, or failure to progress would be assessed and managed. Do not attempt to self-triage a potentially serious problem solely from a written birth plan.

Consent is an ongoing process. You can ask for a pause when time allows, request an explanation in plain language, and tell the team if you do not understand. If you are unable to participate, your designated decision-maker and clinicians will work within applicable law and emergency standards to protect your interests.

**6. Prepare for the first hours and weeks postpartum**

Include immediate newborn preferences in the plan, while recognizing that medical assessment takes priority. Topics may include skin-to-skin contact when parent and infant are stable, delayed cord clamping according to clinical circumstances, routine newborn examination, vitamin K, eye prophylaxis where recommended, immunizations, feeding intentions, and lactation or formula-feeding support. Ask how procedures can be explained and how you will be informed if the baby needs observation or neonatal intensive care.

Prepare for maternal recovery by learning about expected uterine cramping, vaginal bleeding, perineal discomfort, incision care if applicable, bladder and bowel changes, breast or chest changes, sleep disruption, and mobility limitations. Before discharge, confirm medication instructions from your clinician, follow-up appointments, blood-pressure monitoring if relevant, wound or suture review, contraception counseling, and whom to contact with concerns.

Build a postpartum support plan that covers meals, hydration, laundry, infant care, transportation, and protected rest. Identify at least one person who can notice if you are becoming overwhelmed. Emotional changes are common, but persistent sadness, severe anxiety, frightening intrusive thoughts, confusion, or thoughts of self-harm or harm to the baby require prompt professional assessment. Make a list of local mental-health, lactation, community, and emergency services before birth.

Finally, review the plan with your support people and clinician near the end of pregnancy. Keep it accessible electronically and on paper, but treat it as a conversation starter. The goal is not a perfect birth; it is respectful, informed, and responsive care for you and your baby.