What to include in a birth plan

What a birth plan is, and what it is not

A birth plan is a structured summary of your preferences for labor, delivery, and the first hours after birth. It can include clinical preferences, comfort measures, cultural or religious needs, communication style, support people, and newborn care choices. Its purpose is to help your team provide care that is both safe and respectful.

It is equally important to understand what a birth plan cannot do. It cannot guarantee a vaginal birth, a particular timing of labor, avoidance of all interventions, or a specific newborn course. Birth is dynamic, and decisions may change quickly in response to maternal vital signs, fetal heart rate patterns, labor progress, bleeding, infection risk, hypertensive disease, or other clinical factors.

The strongest plans use flexible language such as "I prefer," "if medically appropriate," and "please discuss options with me before proceeding when time allows." This supports informed consent during labor while acknowledging that emergencies may require rapid action. Many people also include a short "top priorities" section, such as wanting a support person present, wanting pain relief options explained early, or wanting immediate skin-to-skin contact if

the baby is stable.

How to format the plan so it is clinically useful

A birth plan should be easy to read in a few minutes. One to two pages is usually sufficient. Use headings, short phrases, and clear spacing. If a preference is especially important, place it near the top rather than burying it in a long paragraph. Some people use bold text for non-negotiable cultural, communication, or trauma-informed care needs, but the overall tone should remain collaborative.

Start with identifying information: your name, estimated due date, planned birth location, clinician or practice, relevant medical conditions, allergies, medications, prior uterine surgery, blood product preferences if relevant, and key contacts. Avoid including unnecessary personal history unless it affects care. If you have a high-risk pregnancy, a planned induction, a trial of labor after cesarean, placenta-related concerns, diabetes, hypertensive disease, or a known fetal condition, discuss how those factors may shape available options.

Bring copies for your hospital bag, birth partner, and clinician. Review the plan during prenatal visits, ideally before the final weeks of pregnancy. Ask which items depend on hospital policy, staffing, fetal monitoring requirements, anesthesia availability, neonatal protocols, or infection-control rules. A plan that has already been discussed is much more helpful than one first presented in active labor.

People, environment, communication, and emotional support

Include who you want present during labor and birth: partner, doula, family member, friend, interpreter, spiritual support person, or photographer if permitted. List who may receive medical updates and who should not be present. If you want the room kept quiet, dim, or low-traffic when safe, say so. If you prefer explanations before each vaginal examination, procedure, medication, or change in monitoring, include that clearly.

Communication preferences can be particularly important for people with prior birth trauma, pregnancy loss, sexual trauma, anxiety, sensory sensitivity, disability, or language needs. You might request that staff knock before

entering when possible, introduce themselves, ask permission before touch except in emergencies, and explain findings in plain language. You can also state whether you want detailed medical information or a brief summary with recommendations.

Consider listing comfort measures: music, aromatherapy if allowed, warm packs, massage, hydrotherapy, breathing techniques, focal points, prayer, affirmations, or nonpharmacologic coping strategies. If you are planning a low-intervention birth plan, specify the support you hope for without framing medications or procedures as failures. Compassionate flexibility protects your emotional wellbeing if labor unfolds differently than expected.

Labor preferences: movement, monitoring, hydration, and examinations

Labor preferences often include mobility, positions, fetal monitoring, oral intake, intravenous access, and cervical examinations. If medically appropriate, you may prefer to walk, use a birth ball, shower, kneel, squat, side-lie, or change positions frequently. If continuous electronic fetal monitoring is recommended, ask whether wireless or mobility-compatible monitoring is available.

Monitoring preferences should be discussed ahead of time because they depend on clinical risk. Intermittent auscultation may be an option for some low-risk labors, while continuous monitoring is often recommended with oxytocin, epidural analgesia, meconium concerns, fetal heart rate abnormalities, certain high-risk conditions, or after some interventions. The plan can say that you prefer the least restrictive safe monitoring method, while recognizing that fetal heart rate concerns may change this.

You can also document preferences about vaginal examinations, membrane rupture, IV placement, oral fluids, and nausea treatment. Some hospitals recommend or require IV access in labor even if fluids are not running continuously. If you prefer fewer cervical checks, ask how labor progress will be assessed and when examinations become clinically useful. For induction or augmentation, include that you want risks, benefits, and alternatives reviewed when time allows, including options such as cervical ripening, amniotomy, or oxytocin if relevant to your care.

Pain relief and coping options to include

Pain management is one of the most practical sections of a birth plan. You can state whether you hope to avoid pharmacologic pain relief, want to decide in the moment, or would like early anesthesia consultation. Common options vary by facility and may include breathing techniques, movement, water immersion, sterile water injections, nitrous oxide, systemic opioids, pudendal block, and neuraxial analgesia such as an epidural or combined spinal-epidural.

If you strongly prefer an unmedicated vaginal birth, describe the support that would help: continuous encouragement, position changes, counterpressure, hydrotherapy, privacy, and coaching from a chosen support person. You may also ask staff not to offer an epidural repeatedly unless you request it. Conversely, if you know you want an epidural, include that you would like it discussed before pain becomes overwhelming, recognizing that timing may depend on platelet count, anticoagulant use, labor progress, anesthesia availability, and clinical status.

It is reasonable to include concerns about side effects such as nausea, sedation, pruritus, hypotension, limited mobility, or urinary catheterization. Ask your clinician or anesthesiology team to explain benefits and risks in your specific context. Pain relief is not a measure of strength or success; it is a medical and personal decision that can change during labor.

Birth preferences: pushing, positions, perineal care, and interventions

For the second stage of labor, include preferred pushing guidance and birth positions. Some people prefer spontaneous pushing with the urge to bear down; others appreciate directed pushing. You may want to try side-lying, hands-and-knees, kneeling, squatting with support, semi-recumbent, or a birth stool if available. If you have an epidural, ask which positions are feasible and safe.

Perineal preferences may include warm compresses, perineal support, slower crowning when possible, and avoiding routine episiotomy. Modern obstetric practice generally reserves episiotomy for specific indications rather than routine use, but your clinician can explain when it may be recommended, such as urgent delivery for fetal compromise or facilitation of certain operative

vaginal births. You may also document preferences about mirror use, touching the baby’s head as it crowns, who announces the baby’s sex if unknown, and who cuts the cord.

Include how you want decisions handled if operative vaginal delivery with vacuum or forceps is considered. A concise statement such as "Please explain the indication, alternatives, and expected risks when time allows" supports consent-centered care. In urgent situations, the team may need to act quickly, but your stated preference for explanation remains valuable whenever feasible.

Planning for cesarean birth and unexpected changes

Even if you are planning a vaginal birth, including cesarean birth preferences can reduce distress if surgery becomes necessary. This section is not pessimistic; it is practical. Preferences may include having your partner or support person present if allowed, receiving clear explanations, using regional anesthesia when appropriate, lowering the drape or using a clear drape if offered, immediate or early skin-to-skin contact if parent and baby are stable, and breastfeeding or chestfeeding support in recovery.

If you have a scheduled cesarean, include anesthesia questions, nausea prevention preferences, postoperative pain-control goals, newborn contact, feeding plans, and whether you want photos if permitted. If an emergency cesarean is needed, some preferences may not be possible, especially if general anesthesia, neonatal resuscitation, hemorrhage management, or rapid delivery is required. Still, the plan can help staff preserve what is possible, such as keeping your support person informed and reuniting you with the baby as soon as safe.

It can also be helpful to name your decision-making preference if the plan must change: Do you want the clinician to give a direct recommendation? Do you want a moment alone with your partner if safe? Do you want risks quantified when possible? These communication details often matter as much as the clinical preference itself.

Newborn care, feeding, and postpartum preferences

The immediate postpartum section should address your preferences for the third

stage of labor, cord clamping, skin-to-skin contact, newborn assessment, feeding, and routine medications. Many families request delayed cord clamping if mother and baby are stable, immediate skin-to-skin contact, and postponing nonurgent newborn procedures until after the first feeding or bonding period. Facility policies and clinical circumstances will influence timing.

State your feeding plan: breastfeeding, chestfeeding, expressed milk, donor milk if available, formula feeding, or combination feeding. If you want lactation support, include it. If you do not want supplementation unless medically indicated, say so; if you plan formula feeding, you can request respectful, practical support without pressure. You may also include preferences about pacifiers, glucose monitoring if indicated, newborn bath timing, vitamin K, eye prophylaxis, hepatitis B vaccination, circumcision if relevant, and who accompanies the baby if transfer to a nursery or neonatal unit is needed.

Postpartum preferences can include rooming-in, quiet hours, visitor limits, pain control, mobility after birth, pelvic floor concerns, mental health screening, and discharge teaching. Ask your team what warning signs require urgent evaluation after discharge, including heavy bleeding, severe headache, chest pain, shortness of breath, fever, calf pain, wound concerns, or thoughts of self-harm.