Preparing for Your VBAC: Tips to increase your odds of a vaginal delivery

1. Plan for an unmedicated birth. An unmedicated labor helps with dilation, effacement, descent. An upright labor statistically will progress more quickly. Getting an epidural before 4cm dilation significantly increases the odds of a cesarean delivery.

2. Choose your delivery location carefully. In his research, Dr. Neel Shaw determined that the signal most influential factor in whether or not someone has a cesarean is the hospital in which they choose to deliver. If a place a 60% cesarean rate, you chance of having a vaginal delivery has much less to do with you and much more to do with them. If it has a 15% cesarean rate, your odds are much better.

3. Choose your care provider carefully. Not all providers have the same skill set or the same ideas about physiologic labor. Some prefer inductions and active management of labors, others are more hands off.
    a. In general, midwives are trained to manage low risk, low intervention births and are likely to view birth as a normal physiologic process that requires very little intervention in the population of people whom they treat.
    b. In general, OBs are surgical specialists who are more likely to view birth as a potential medical event and have a higher comfort level with using interventions and augmentations to intercede or assist in the physiological process.
    c. Ask questions: Ask about their success rate with VBACs or even vaginal births in general. Ask how often they induce non-VBACs and if they induce VBACs at all. If your care provider says they only do cesareans when necessary, ask them how often they typically view a cesarean as necessary, and how frequently their inductions end in cesarean.
    d. Some potential policies of care providers that are likely to have lower rates of VBAC outcomes:
        i. You must go into labor on your own before 41 weeks or before you due date or they do a cesarean.
        ii. They will not induce or augment your labor under any circumstances.
        iii. Your baby must be estimated to be under a certain weight.
        iv. You have to have an epidural.
        v. They require an intrauterine pressure catheter to be placed.
        vi. They use a VBAC calculator (which has no evidence-basis).
        vii. They are the only care provider in their group practice who will attend TOLAC
    e. Some potential policies of care providers that are more likely to have higher rates of VBAC outcomes:
        i. They wait for your labor to start on its own up to 42 weeks.
        ii. They only use induction/augmentation if medically necessary.
        iii. They don't use weight guesses to discourage TOLAC.
        iv. They don't place time limits on labor as long as you and baby are doing well.
        v. They encourage upright positions and movement in active labor.
        vi. They have a low cesarean and high VBAC rate.
        vii. They discuss the risks of multiple repeat cesareans as well as the risks of TOLAC in .the informed consent process.
        viii. They work with care providers who share their encouragement of TOLAC.

f. It's ok to change practices if you do not feel that your care provider supports your goals. It's especially important to change care providers if you do not trust your care provider to make decision about your care based on medical necessity. Trust is an essential element in labor. A lack of trust causes an increase in stress hormones that can stall your labor. Don't put yourself in a position where you feel you will have to labor defensively.

4. Take a natural birth childbirth preparation course. Hospital classes often focus on patient preparedness classes rather than strategies and practice for an unmedicated birth.
   a. You need concrete skills to achieve the goal of unmedicated birth. Most people who simply say they will trying, without having a skill set, will get an epidural. Statistically, taking a stand-alone class can increase rates of unmedicated birth substantially.

5. Let your labor start on its own. Inducing doubles the risk of a primary cesarean. It can also lead to low heart rate, infection, umbilical cord problems, uterine rupture, and hemorrhage postpartum.
   a. If your care provider is encouraging induction, ask your Bishop Score. Scores under 5 are not favorable for induction without cervical ripening and very frequently lead to cesarean (70%). Scores over 10 are more likely to result in vaginal delivery.

6. Be active before labor to prepare your body and balance the ligaments in your pelvic floor (seek pelvic floor therapy if basic stretches don't help). People who remain sedentary in pregnancy are 4 times more likely to have a cesarean.

7. Hire a doula. ACOG noted in 2014 that the single most important thing you can do to lower your risk of cesarean is to hire a doula. Studies show a 50% decrease in cesarean, as well as decreases in need for medications, assisted deliveries, and increases in maternal satisfaction with birth experience, maternal/baby bonding, and breastfeeding rates.

8. Shut down negativity. Tell people who want to share their negative stories that your baby is listening. Join your local ICAN chapter to hear positive stories about VBAC.
   a. This includes shutting down your own mental negativity. Track your fears and release them. This is a different baby and a different birth than last time. Don't get tripped up on worrying that it will be the same.

9. Choose a comfortable birth environment.
   a. If you are low risk, stay home (or in a hotel nearly your hospital), until you are in active labor. Take the above mentioned class to feel confident about what that looks and feels like.
   b. Failure to progress (FTP) is the #1 reason that labors end in cesarean. Active labor starts at 6cm. FTP at 4cm is failure of patience, not failure of progress. In 2014, ACOG started telling providers not to consider FTP before 6cm.

10. Get your partner on board with your plan, so they aren't coming at this from a place of fear. If they aren't comfortable, you'll be worried about them, not you, and you'll be less likely to labor well.

11. Be active in active labor. Use movement. Pain in labor is your body telling you that baby isn't lined up right. Move your body to move the baby.
    a. Know your options for movement in labor. If you have to have continual fetal monitoring, ask for a wireless telemetry unit.

12. Keep things out of your vagina to decrease infection risks.
    a. Avoid frequent routine cervical checks if your membranes have ruptured.
    b. Decline sweeping of the membrane or stretching the cervix UNLESS actively trying to induce labor (it rarely works and more frequently causes a rupture of membranes).
    c. Avoid artificial rupture of membranes unless medically necessary.

13. If baby is breech, choose to be active about getting baby to turn beforehand using the techniques on spinningbabies.com, do internal work with a specialize pelvic floor therapist, use acupuncture and moxibustion (which has an excellent evidence-basis for results), and find a Webster-certified chiropractic care. Our clients who do these body balancing things rarely need to follow through with breech vaginal delivery.
    a. If baby remains breech, check your options for breech vaginal delivery (mybreechbaby.org). With a trained care provider, breech vaginal delivery is a safe option for most.

14. Lastly, remember that no one is promised an uncomplicated birth. Prepare for any outcome.
    a. Know that it's ok to mourn the birth you didn't get.
    b. Reach out for support.