

(introductory music)

**DISCLAIMER:** *Taking Back Birth* is a production of the Indie Birth Association and indiebirth.com. No material on this podcast should be considered medical advice. Birth is not a medical event.

**MARYN:** Welcome to Indie Birth's series of podcasts here on iTunes, *Taking Back Birth*. Hi. Maryn here with an episode today about Group B Strep, or GBS. This podcast has been on my mind for awhile mostly because this is such a popular topic for whatever reason whether it's amongst midwives or students or pregnant women. It seems like GBS is always being talked about. So this past year, 2016, I have taught my own hour plus long class or presentation on Group B Strep, and the focus of that class was basically what kind of risk are we incurring on future generations with routine care. Now that's a little bit dry for a podcast, I thought. So simplifying it today. Lots of the same information but wanting to just make it more fun and a little less boring especially since this is just audio. And my other presentations have been visual as well.

But today we're going to talk about ten myths about GBS. So in case you're wondering why I care, I do have some personal interest in Group B Strep. And it dates almost ten years now to my third pregnancy when I tested for GBS and was positive surprisingly after two pregnancies where I was not. I also was in the midst of an apprenticeship with a third pregnancy. And so I won't bore you with the whole long story. But it was basically a learning experience just like many of us know. Those of us who serve women in any variety sometimes you're challenged with situations because you have to walk through them, I think, so that you can adequately support other people. So funny enough, GBS was one for me. I was fine. I never had a sick baby or anything like that. But just purely going through the motions of testing positive and dealing with the fear surrounding that.

At the time, I worked with a couple of midwives, who were pretty fearful about Group B Strep. And I learned firsthand how even women planning home births can become fearful about these routine procedures and routine testing. And so that was also something that was fascinating to me. And of course, something that has continued to be fascinating to me over the last ten years. How can we eliminate fear and routine from yet another fearful routine in mainstream pregnancy and birth? So ten myths about Group B Strep. How fun.

First of all, what is Group B Strep? Most of you listening probably know especially if you've been pregnant. Pretty standard test here in the U.S., which I'll talk more about. But Group B Strep is a bacteria and group beta streptococcus is the formal and very long name of the bacteria. The bacteria is a gram positive bacteria, which is only relevant, I think, for most people in the sense of it not usually showing up on a urine

strip. So that's a tidbit I've learned along the way that I feel like is pretty helpful as we talk about testing and that sort of thing. That you really can only see or identify the Group B Strep bacteria in a culture. Excuse me. A urine culture because of the type of bacteria it is.

Okay. So very basic. But let's start with the first myth about Group B Strep. The first myth is that Group B Strep is an infection. And I can guarantee you that that's a common definition whether or not that's what you were taught or what you believe. If you just Google it, which is always a habit of mine as many of you know with researching some of the things for these podcasts, you'll find that there are several sources—mainstream sources—that cite Group B Strep in pregnancy as an infection. I'm pretty sure it's American Pregnancy. It's a very mainstream pregnancy site. A very highly visited. And pregnant women that read their definition are immediately, I'm sure, scared because Group B Strep, according to them, is an infection.

Now next you could look up what's an infection. In my own words, an infection is a disease process. And as we talk more about Group B Strep, you'll see that most of the time Group B Strep present in a pregnant woman's body is not an infection. It can become an infection for a sick baby. But that is very rare, and that's not what we're actually talking about when we're testing women. We're not, most of the time, testing them for infection. So what we are testing them for with the Group B Strep swabs, for example, is colonization. Now colonization is a completely different word, obviously, a completely different meaning, and, I think, completely different feeling. Infection, like I said, I think sounds intimidating or scary. And if not given any other information, most pregnant women would probably proceed with whatever was told to them. So that's why it's so relevant.

Colonization, on the other hand, just simply indicates something that's growing. And in some cases, we can see how much or how little is growing or is just there. So to go off on a tiny tangent, our bodies and our guts, in particular, are colonized by all kinds of things. So bacterias and fungi, for example. And that's just how our bodies operate. That kind of brings us to the next myth. And these two do go hand in hand, which is GBS is a bad bacteria. Now I think that's really one that's hard to shatter because, again, we're testing every pregnant woman for this bacteria. We're trying our hardest to get rid of it with antibiotics. We're over treating babies that have moms that may have been positive for this bacteria. So how on earth could your average pregnant woman not think that GBS is bad? Now, of course, I know what they mean just like you do. Any bacteria that is in excess or that attaches itself to a compromised person can become bad, obviously. Can make someone sick. Can cause infection. So that's how this kind of works with the first myth.

But I'm just trying to be clear that infection is not colonization as we talk about these things for pregnant women. And GBS, on its own, isn't bad. And that might sound silly, but, again, I think, it's rephrasing and rewording so that we're not adding fear. The Group Beta Strep bacteria is no more bad than anything else. Other bacteria have the same reputation, right? Staph, strep. This is obviously part of the strep. But staph, E. coli. We think they're all bad. They're really not. They're part of most people's normal gut flora, but it's only when they get out of hand and it's not in balance with what else is going on in our bodies that they can cause trouble. So, again, I feel like this is a refreshing way to reframe what we're even talking about because I think we do need to talk about this mainstream routine issue because most pregnant women will be faced with the choice of testing and treating even with a home birth midwife. And instead of getting off on the wrong foot that this is all kind of evil and gross bacterium, we want to wipe it out. We really want to reframe the whole process as restoring balance.

So even if a pregnant woman does test positive for this bacteria in her vaginal tract, and we're going to talk more about testing, that we reframe it as a need for balance. It's not bad. She's not dirty. This isn't an STI. This isn't an STD at all. It's simply an imbalance. So that is myth number two. Oh, it looks like I got off on my numbers here. So I'll have to keep myself on track.

Okay. Number three, we are making progress with Group B Strep protocol and treatment in the U.S. And if you're not aware, maybe it's because you haven't been in the line of fire of testing and treatment in the U.S. Maybe you live somewhere else or maybe you haven't been pregnant here. But the protocol in the mainstream medical world is to test everyone. Every woman. Every pregnant woman. That is not the way it is elsewhere in the world such as in the UK where they only test women that have risk factors. So that was my myth that we are making progress with this kind of protocol. And, of course, the reality to the myth is that we're not. That despite the across the board testing and very heavy treatment of GBS positive women in the U.S., GBS is still the number one cause of infant morbidity and mortality in the U.S. So over the last four decades, we haven't found a way to change that. So my point—and this is the point of my larger lecture—is that we're not making a difference with routine testing and treatment. We need to start thinking outside of that box if we really care and if we really care about not exposing future generations to things like antibiotics all the time.

So myth number four, GBS is a vaginal infection, and the way to treat it is vaginally. So I've already covered the first half of that myth. It's not a vaginal infection. It's a colonization. If we're going to talk about—a little bit more about infection just for a moment, I did mention there are a couple ways to actually have a GBS infection. One I mentioned I think is pretty obvious is a baby that has contracted the GBS bacteria during birth or before birth and is ill and has a sickness. And then the other way that we might consider it to be an infectious process is if it shows up in the mom's urine as a

UTI. But vaginally when we're just doing a vaginal swab, that's not what we're testing. We're not testing for a UTI. We cannot really predict that that will produce a sick baby. And so when we're just swabbing the vagina and we're getting the presence of Group B Strep, it's not an infection. It's a colonization.

Now the tricky part is—and a lot of these myths will kind of overlap—it is not a vaginal issue. So it's typical Western medicine, if you ask me. It's looking at sort of the wrong part of the equation. Making some kind of assumption or diagnosis and then simply trying to either cut that out of the equation or clean it up without paying attention to the rest of the equation. And that's exactly what's happening with GBS with vaginal treatment. And, again, I don't think midwives are any more off the hook than your average doctor. Midwives probably talk more about how to treat vaginally. In fact, isn't that always part of the conversation, right? Garlic and all of these things that midwives suggest vaginally. What I'm suggesting is that for real balance—and that's what we want when we're dealing with a colonization—we need to look at gut health. And yeah. It's a lot more work for you, the midwife, or for you, the woman. But it's a lot better because it makes a lot more long term and whole person sense than just looking at one of the parts. So treating vaginally might change a colonization perhaps of what's in the vagina. But because Group B Strep originates in the gut, if you don't change the gut flora, you're just going to have to keep dealing with it vaginally.

So the reservoir or where GBS originates is in the gut. That is a fact. So if you have a high colonization in the vagina then your gut is out of whack. And what has happened is it's gotten so out of whack that it's kind of—for lack of better description—kind of trickled down into the vaginal tract. And, again, treating that isn't really going to solve the problem. So we need to treat gut health. If we are going to treat vaginal health—and I definitely am advocating for that. I'm just saying we need to look at gut health first and not act like vaginal treatments are really going to do anything more than put a band aid on the problem. But we can work on our vaginal flora just like we can work on our gut flora. And, again, I think this is one of those areas that most people aren't really spending time on. In busy midwifery practices, for example, there's just a lot of people and not a lot of time. And so to help a woman clean up her diet and work on her vaginal flora, as funny as that sounds, does take time. It takes effort. It takes attention. It takes months. It takes weeks. So I don't know. That's my guess as to why this isn't something that it's just part of normal midwifery care. But vaginal health is more than inserting garlic. That is not vaginal health. That is putting a band aid on the problem.

So vaginal flora balance is all about pH balance. The vagina is supposed to be acidic. And what we're really looking for is the presence of lactobacilli to keep things in check. So if your vaginal pH is not acidic enough—in other words it's more alkaline—then it will favor the growth of GBS and actually BV or bacterial vaginosis as well. So that's been proven in studies. And I'll kind of read a little quote here. "The risk of colonization was

greater when there was concurrent colonization with Candida, but Group B Strep was not associated with cure of Chlamydia and some other stuff. pH greater than 5 was associated with increased colonization.”

So I'll back up a little. But it basically said that the risk of colonization was greater when the woman also had the presence of yeast in excess. And also a pH greater than 5. So if normal vaginal pH is 4.5, then 5 is high. And in that alkaline environment, BV can proliferate as well as GBS. So they found that to be true. So if you're wanting to know more about vaginal pH, it's a fascinating topic, I think. Maybe it deserves it's on podcast. But there's a lot one can do to help balance the vaginal pH. Again, let's start with the gut. But after that and not to go into gut health, but I'm sure most people are aware of probiotics and fermented foods and having a whole foods diet and all that kind of stuff amongst perhaps some digestive assistance for some pregnant people. Digestive enzymes, for example, can really do a lot for gut health. But anyway after all that, vaginal pH is its own separate issue. And the way we do that, again, lactobacilli is really important, so we can get that even from plain yogurt. And so that can be inserted vaginally to help repopulate the good bacteria. We can do things like hydrogen peroxide rinses for BV or bacterial vaginosis. We can use probiotics vaginally. And, again to me, this isn't putting a band aid on the issue. This is trying to help the—for lack of a better word—I think it's Gail Hart that says the—she says something like the vaginal permaculture. Think of it like a garden. Think of it like your reseeded a garden and how you would do that to make the most healthy soil that you could.

So that's really important. And if you are somebody that has dealt extensively with yeast or bacterial vaginosis or GBS, for that matter, then all of these things are relevant. And, again, I think for midwives too it's really important to remember that, unfortunately, there's not really a magic pill to rebalance the body. We usually have to work a little bit and, of course, individualize our care. So let's see. What number was I even up to?

I think this is number 5. And all in all, I might actually have 11, which will be a funny name for this podcast. But anyway, number 5, mandatory testing of all women is improving outcomes. Well, I kind of talked about this one already. But, again, we're only testing all women in the U.S. They're not doing that in the UK. So yeah. Totally reiterating here, but that's not helping. It's probably just spending more money, and it's not really reducing the number of sick babies. So what on earth are we doing? In the UK, just so you know, they do test. But the testing is only offered to women that have risk factors. And I think that's reasonable. So if she's had a previous Group B Strep positive baby that would be a risk factor. And so she would automatically be tested. But everybody else is not automatically tested. It doesn't seem to change anything except spend more money.

So maybe we'll kind of group that in with one of the other myths that way I can get back on number track. I'm going to screw myself up. So we're going to say this is number 5 myth that the gold standard of testing is a vaginal rectal swab. So brief review, if you haven't been this way before. The way that they test for Group B Strep bacteria in the U.S. is to insert a swab in the vagina at around 37 weeks. Kind of wipe it around. And then after that they usually take the same swab and swab the rectum with it. Now in a lot of places, you can even do that swab yourself. In many places, it's not offered that way. It's not a hard test or terribly expensive test to do. But that's the way, at least to my knowledge, that it's currently done in most places. I remember, again, way back when I was dealing with this 10 years ago and I was a student and just as curious about things as I am now. And I remember wanting to do a different swab for each. This is a vaginal swab. This is a rectal swab because even back then it didn't make any sense to me why we would use the same swab when GBS lives in the colon.

So because GBS originates in the gut, the rectal testing may increase positive results by 40%. So I guess it just depends what side of the fence you're on when you hear me say that. There are some very conservative people, and they're all about this testing. And they want to catch—catch in quotes—everybody in their practice that has GBS. Then they want this rectal swab. They have a really high positive rate. But they're okay with that. They think that maybe that's more protective somehow. To me, it doesn't really make any more sense than a lot of other things that are done routinely. If we know that GBS is probably going to be in the rectum of most people, why would we bother? Then we have no idea what she's dealing with or not vaginally. So hopefully, that makes sense.

So along those lines, GBS can be found in the rectum of people aged 1 day to 80 years. So I guess I'm just saying tell me how that's helpful. If most people are going to come out with a positive, what does that really tell us? Not much. Anecdotally, this was from a quote from a bacteriologist. Someone in the UK. Said, "The fact that a high vaginal swab sample may test positive for Strep B does not necessarily reflect vaginal infection, but is more likely to be relatively benign colonization." So that's exactly what I've been saying. Truthfully, we don't really know much. That's usually what it comes back to. So I know here in Arizona years ago the lab here, if a woman decided to do the Group B Strep vaginal swab, they would tell her what the colonization was on her swab. So they would say high, medium, or low. And I haven't seen that in years. I think the testing, at least in these parts now, is more just positive or negative. So we don't really have any sense of what type of colonization a person is dealing with.

But now that I think about it years later, we don't have any evidence to suggest that a high colonization really means anything over what we call a low colonization. We have no idea how that translates into anything specifically sick babies which is, in the end, all anybody probably cares about. So just a curious bunch of things to think about, I think,

if you're going to test. How are you going to test? Is the rectal swab really what you want to do now that you know more? And is the vaginal swab even something you want to do when it doesn't necessarily mean anything? What could mean something—and this is my own opinion partly is a urine culture, as I said earlier. So according to me, I'm not saying testing is completely ridiculous especially if a woman has risk factors. But why don't we just go for the information that's actually helpful? So if a woman does have risk factors and/or maybe she's had signs of a UTI or maybe she just wants to test for GBS, my recommendation would be that she does a urine culture because if GBS is in the urine we are told that that is more serious. That that would be considered infection, not colonization. And that that might be worth her considering treatment on.

So that's my thoughts. I also think that a woman that is at risk or, again, just is wanting to test should probably do so earlier in her pregnancy. I don't understand the let's wait until 37 weeks. Well, I do understand because really that world doesn't care about prevention. It's all about damage control. So if they find someone is positive at 38 weeks, it's—what's the answer? The band aid of antibiotics. In my mind, we have time and months and weeks if possible to help somebody work on this balance. A GBS urine infection, again, would be considered serious. So if that were me, I would personally want to know way earlier in pregnancy than 37 weeks. And truly, if a woman has an infection with GBS in her urine and it's something that she has a whole pregnancy and no one knows, who knows what that means? It might mean that her baby gets sick more than any other scenario. We don't really know. But, again, it seems like the gold standard of testing at 37 weeks with a vaginal rectal swab is a myth and should be questioned by everybody.

So number six, most babies get Group B Strep when the waters open, and there is no labor or labor is slow. And that is a very prevalent myth, I feel like, out in the world. If it wasn't, then the policy around waters being open before labor even amongst home birth midwives would not be so conservative. The worry, as we all know, is that the woman will get an infection. The baby will get an infection. And, of course, the bacteria could be of any variety. But because GBS is such a popular bacteria at the moment, that's what's on everybody's mind. That if her waters are open for three days and there's no labor, what if? What if the baby gets GBS? Well, that's a myth really because most babies—and, again, this is a very rare thing. But the babies that do, unfortunately, wind up sick with the Group B Strep bacteria are usually sick before birth. And that's been studied. that's not opinion.

So let me back up a little. When a woman—when her uterus gets infected with GBS, it's obviously a serious thing. That's not a vaginal colonization. It's something that has ascended into her uterus and created, again, a true pathology and can make her baby very sick. So we don't entirely understand how this happens. We think it happens through the cervix. And that makes total sense, right? The cervix has a mucous plug.

And that's protective. That's why we don't disrupt that mucous plug. We don't let people stick their hands up there. We may not even stick our own hands up there. But nevertheless, that happens anyway for many women. Some women in mainstream care get vaginal exams in pregnancy for no good reason. So that mucous plug is being dislodged. Bacteria may get in there and ascend into the uterus. And we know that this can happen because many women who have babies that have GBS infection had intact membranes meaning the waters never opened during labor. Perhaps the baby was born in the caul or in the amniotic sac. And when a baby like that gets GBS infection, then our whole theory about waters being open, obviously, goes out the window.

So let's see. A quote or two here. "In utero infection probably accounts for 40 to 60% of newborns with early onset GBS who have poor APGARs and in whom pulmonary signs develop within several hours after birth." So there's early onset and late onset GBS. And this quote is talking about early onset. So they're just saying that babies who develop signs of sickness within several hours after birth were probably sick before. In another study—and this is from 2012 (inaudible)—"In a study of 148,000 infants born between 2000 and 2008, almost all of the 94 infants who developed early GBS infection were diagnosed within an hour after birth suggesting that early GBS infection probably begins before birth." So just something to think about. Not that focusing on that rare sick baby is all that pleasant. But when you're trying to understand how this happens, sometimes you have to go there. So, again, it doesn't seem that just having your waters open is a risk. That the risk was already there and present and was missed for whatever reason which does happen. But, again, when we're going into more detail about the way these things are handled, we wonder what information we could have gotten about somebody.

Okay. The seventh myth about GBS is that fooling the test is a worthy goal and side conversation hibi-clens as treatment. Now this is really for midwives. I hate to say. Or women that are working with midwives especially those that might be of the more medical mind although I don't even know what I mean by that necessarily because this isn't practicing good medicine, in my opinion, to treat something that doesn't need to be treated. And I'm no less medical really than anyone else when it comes to trying to figure out how to handle certain situations. I think there definitely are treatments that I would consider effective. I've already talked about some of the more whole body treatments, in my opinion. But I don't think this is good practice at all to use hibi-clens as treatment or anything or to try and fool the test.

So part of it is just politics. A lot of midwives advocate for women that they're working for to fool the Group B Strep test. And what do I mean by that? Well, let's have women that—everybody or women that maybe we think are more at risk or maybe women that have been positive in the past or something like that, let's have them do a hibi-clens rinse before they take the test. Let's wipe out all the bacteria in their vagina, so GBS



doesn't show up. Now that's just lame. And, again, I think part of the reason is definitely politics. Many would admit to that. And I can understand, as a woman, thinking that maybe this is all ridiculous and not wanting to test and ignoring all of it. I think that's a valid option for women. But I think as midwives our job is to provide as much information as we can about all of these things. So acting like that's legitimate as a treatment or a testing option, I think, is pretty lame. Obviously, it masks any kind of problems she does have. And really why? Is it just to have in your statistics that you don't have a very high GBS read? I don't know. It bothers me though because really it's ignoring this issue. And, again, it's an issue that takes time and patience. And I guess I don't like the band aid treatment of anything.

So yeah. Partly politics. I think that's lame. Maybe it's women. Maybe it's women not wanting to deal with having a positive test because then maybe they'll have to transfer care or maybe they'll have to figure out a way to get antibiotics at their home birth. I don't know. But, again, that's not really helping anything, is it? A baby could still get sick. Or really it's just masking another problem of the medical midwifery profession instead of having full disclosure about these things. So that really bothers me. But if you didn't know, it's happening all over the place and is often recommended. And, again, I don't like it. The brand name is hibiclens. At least here in the U.S. I don't remember what it's called elsewhere. But you can buy it in Walgreens. It's not—it is a pharmaceutical. But it's not a prescription drug.

So the name for it—the trade name for it is hibiclens. But it's—the drug name is chlorhexidine. Chlorhexidine. Sorry. And it's a chemical. So it's not holistic. It's a chemical that's going to wipe out all of the bacteria and everything else in the vagina. So it will sacrifice other systems to achieve a result. It has been shown to be absorbed by the mucous membranes, which is no surprise. The vagina is a very mucous membrane rich area of our bodies, and so it does get into the blood stream. The package directions do say that it's an antiseptic for topical use. They say not to use it in the genital area. And it is proven to be absorbed by the baby's skin. So flush out the vagina in labor with hibiclens, who knows? Maybe that baby is coming two minutes later. It is proven to be absorbed.

So site specific absorption rate has not been done. And, of course, no one is going to study probably how much the baby absorbs. But we would speculate that it could be quite a bit. Hibiclens or chlorhexidine is in the toxicology database. It does cause damage to the skin and eyes. So the argument as far as does this improve outcomes is that it's cheaper and easier than antibiotics. And I need to go back to my first question, which was does it improve outcomes. No. It doesn't. The Cochrane Database in 2014 said that hibiclens is not effective in reducing GBS infection in the baby when used in labor. It's not. So what it can do is reduce colonization in the vagina. But as I said earlier, nobody knows anything. Nobody knows that a high colonization more often

produces a sick baby. Blah, blah, blah. So reducing colonization with hibiclens hasn't changed the number of sick babies. So there you have it. So don't put that in your body. I speak from personal use there. That was something I tried ten years ago. Didn't know anything. I don't know that this research was even available. And I can just personally attest to the fact that it's not ultimately a pleasant thing to put in that part of your body.

So yeah. People that want to argue that can go ahead and argue that with themselves. But, again, it hasn't improved outcomes. And if you're talking about using it in countries where there isn't lots of care or mainstream medicine, perhaps that's a decent argument although, again, it still doesn't improve outcomes. So yes. It may be cheap and easier than antibiotics. But to what cost? And we're messing with the vaginal flora as I said. We're messing with potentially baby's flora. And it's a toxin. So not my favorite idea. Something that comes up a lot.

Okay. Moving on, just a couple more here, the eighth myth about Group B Strep. So the eighth myth is that antibiotics are still the safest treatment for GBS positive moms in labor. And I hear that a lot. Now I'm not expert at this for sure. There's always new information. But I know intuitively what I believe, and I just can't ever believe that a toxic treatment would benefit more people than it would hurt over the long term. But my biases aside, it's, again, not improving outcomes. So even midwives that say but, but, but—well, she's Group B Strep positive. Well, she should have antibiotics. Let's get somebody to do it at home. No. The studies have not said that it's the best thing. And the best thing for the outcome which is is the baby sick or not.

Obviously, there's lots of risks to antibiotics too. And people that are in the mainstream group often just don't want to talk about that other set of risks. So they did a study—I'm not sure when this tower study was. But 43 newborns with blood infections caused by GBS. And when the mothers of the ill newborns had been given antibiotics during labor, 88 to 91% of the infants infection were resistant to antibiotics. And it says it is unlikely to be a coincidence that the drugs to which the bacteria showed resistance were the same antibiotics that has been administered during labor. So hopefully, that makes sense. Give a mom a certain antibiotic during labor and afterwards the babies are resistant. So antibiotic resistance is a real thing. And a new baby can experience that just like anybody else. So my question, again, is why is that being touted as a safe choice.

Antibiotics for the baby after birth, let's read a quote from that kind of study. I don't know how to pronounce this dude's name. (inaudible). He says, "It is thus apparent that the combined use of ampicillin and gentamicin in early life can have significant effects on the evolution of the infant gut microbiota. The long term health implications of which remain unknown." So fancy way of saying that we are destroying baby's guts.

And what comes out of that is huge, right? Babies or people—really anybody—that has been exposed to antibiotics in excess is perhaps different for each person. So we can't even say excess antibiotics. Antibiotics of any variety can cause sickness and illness later in life. We know with the babies that often later in life they'll have asthma or obesity or diabetes. So it's a very serious thing. It doesn't mean that somebody couldn't still choose that. But, again, it's the other side of the story. It's the side that no one is talking about.

Final study, mostly it's not about improving outcomes, Cats study says, "In fact, one study found no decrease in GBS infections or deaths among newborn whose mothers were given IV antibiotics during labor." And that's one that people do argue about. There's all kinds of studies out there for sure. I'm not the most faithful believe in studies to be honest. I do like to use them here and there to just illustrate a point. But in the end, I think we all have to decide for ourselves and our babies what point do we decide what risk is. And that was like a podcast on risk I did last week, so it was called *High Risk for Home Birth*. Nobody can really tell us much of anything. So if we're choosing these interventions, the best we can do is understand what the potential risks on the other side may be. And nobody can say for sure. This would have saved your baby. This would have not saved your baby. It's just not something anybody can tell us. But, again, in general my feeling and with the research that I've come across and it's not surprising is that antibiotics are really destroying human health. And so at the very least, let's use them sparingly and not for every single mom that simply has the colonization of GBS in her vagina. It's ridiculous.

All right. Number nine, hospital birth is no more of a risk. And I know—well, I know that there's lots of people out there that are having hospital births. We all do. You may be one of them. You may have had one yourself. I certainly had one myself. And despite the fact that there's lots of access to information nowadays and education, still more than 90% of people at least here in the U.S. are having their babies in hospitals. And honestly, I think issues like GBS really do come into play. I think there's lots of women that don't know much of these things and just assume that it's a safer place to be. Again, with antibiotics or IVs or whatever they think they need. But really it always comes back to one of the same themes, I guess, for me is that that's false. That there's always a risk to birth in general. And that the risk to hospital birth and the interventions there I know, for me, is not one I would willingly take or recommend to anyone.

I want us to think about the fact that birth as it was meant to happen by our bodies, by our babies—physiological birth is protective of germs and diseases. Now I don't have studies on that. And I never will. And we may not in our lifetimes or even the generation after us. Nobody is going to study how healthy babies from physiological home births are especially as far as this kind of thing goes. It just doesn't make any monetary or political sense in the current climate. But when you learn about birth and

the way it works and you know about not introducing unnecessary bacteria through vaginal exams, through touching the mom too much, through being the first to touch a baby that isn't yours, to hating a baby, to putting blankets on a baby, to wiping that baby off, there's all kinds of tiny little things that are done in an interventive birth scenario. And even some at home, for sure, that reduce a baby's ability to probably fight off illness. And, again, that's something that nobody is going to study or act like is relevant. But just think about it. I guess it's more of a belief system, right?

So if you're staying within the confines of the hormonal system, the baby has appropriate levels of cortisol, for example. And keeping that fear down in the room after birth is really important. So a baby that's feeling warm and snuggly, never gets the vernix wiped off, gets to just be on his mom's skin absorbing the bacteria, colonizing his own gut with her healthy bacteria from birth and from her skin, that baby, to me, is obviously going to be more healthy especially in the immediate postpartum. So that baby often can be born to a Group B Strep positive mom. It doesn't mean that baby is going to get sick. Her having that bacteria present is not indicative of sickness especially when we have a physiological birth situation.

So when we're talking about these things, we always need to consider the risk we're incurring in a hospital or even a home birth setting where birth is interfered with. Again, and you can make your own list of things that might interfere with the microbiome, which is essentially what we're talking about. What things are interfering with the baby's gut being seeded appropriately and, like I gave a few examples, everything from hating a baby to wiping off vernix to bathing the baby to having visitors. There's all kinds of things that we could afford to pay more attention to if we really wanted a baby to thrive. Now, of course, there will always be that exception. But there's no reason, in my opinion, to not try this. It's not a risk to do those things. I don't think it would be considered a risk by most people not to even bathe a baby. So just tiny little changes, I think, can always make a difference with overall health.

And then kind of piggybacking on that, my last and final myth about Group B Strep is that there is nothing we can do to protect ourselves and our babies. It's just a crap shoot. And yeah. Piggybacking for sure. I don't agree at all. I think there's a lot of risk in normal, mainstream prenatal care even with exams—vaginal exams being done the first visit. I know as a midwifery apprentice with a home birth practice that we would do vaginal exams and testing and pap smears and STDs and all that on women their first visit to our home birth practice. So that kind of stuff, I think—not that it necessarily can't be offered to everybody. But women need to understand that it's always a risk to have anything internal happening in your vagina in pregnancy. Like I said, perhaps even your own hand inserting suppositories. I think that's even something that we just have to feel is right for you. We just don't know how germs can get where they get. So being cautious, I think, makes a lot of sense.

And just reviewing some of the other things that we do have control over in pregnancy, our nutrition for sure. So being in the best physical health and also mental, emotional, spiritual health, all of these things we always talk about here on these podcasts. Being a complete, whole person in the best health that we can is always protective for ourselves and our babies. And then just more review, managing our own labors and births to be as natural and physiological as possible, to avoid as much outside interference as we can, to understand the risks of things like vaginal exams, and even touching the baby after birth, having any kind of anything. Maybe it's the midwife taking the baby for a newborn exam. Every little thing, I think, we have to question to make sure that the mama baby bond stays intact and that physically that baby is as well prepared immune wise for the outside world as possible.

And then the last little piece to that is a physiological postpartum. There are cases, of course, of late onset GBS, which means those babies aren't getting sick before birth. They really are getting sick after birth. What they found with that is—it sounds gross. But usually, it's people just coming into the household. Maybe they haven't washed their hands. Again, this isn't a bad bacteria. It can be found in the bodies of many people pregnant or not. And so get people that don't wash their hands or come in and touch the baby, late GBS is something that can happen. All of the things I've talked about I still believe are protective down to keeping the baby close to the mom. Skin to skin. If the mom is naked, the baby is naked. You're probably not going to get a whole lot of people other than really, really close family that want to come in and touch things. It's just too intimate. So that's a way to keep the microbiome intact.

And then last, but not least, I think knowing the signs of infection or distress in a baby is really important. And I know as a midwife that's not something I've ever felt like was privileged information much like most of this. That it's not just my job to recognize a sick baby. That it's really the parent's job. I'm there for just a couple hours after birth. So what happens in all the hours and days later? These parents, you, me, all of us together have to be responsible for our own babies. And, again, know what a sick baby looks like. Know what a baby that's having respiratory problems looks like. And to not mess around if the baby really is displaying signs of illness or just won't nurse or seems lethargic, that those are legitimate reasons to probably get some kind of consultation or help.

So I hope you enjoyed this. If you're a GBS nerd like me, you probably did. Thanks so much for listening. As always, check the Indie Birth site. We've got all of the podcasts on [indiebirth.com/podcastarchives](http://indiebirth.com/podcastarchives). Leaving reviews on iTunes is always appreciated since there's so many of these now and so many faithful listeners. And other than that, I will talk to you next time. Have a great day.

(closing music)