AWHONN

PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

Association of Women's Health, Obstetrics and Neonatal Nurses

2026

Practice Briefs

Concise, evidence-based clinical guidance for bedside practice

Resources & Information

Essential tools and knowledge with Nurse Resources, Research & Evidence-based Practice, Practice Alerts, JOGNN and Nursing for Women's Health, and the AWHONN Insights podcast. Find practical and clinical resources, the AWHONN Standards, and more.

Resources & Information

- Alcohol and FASD Awareness Resources
- AWHONN Back to Basics: Foundations for Mindful Care
- AWHONN Insights Podcast
- Consumer Resources ›
- Cytomegalovirus (CMV)
- Flu Vaccine Resources
- Hepatitis C
- HIV
- Maternal Morbidity & Mortality
- Nurse Resources ›
- Nursing Infection Control Education (NICE) Network
- Perinatal Staffing Initiative
- Practice Alerts
- Published Resources ›
  - AWHONN Position Statements
  - Clinical & Practical Resources
  - Practice Briefs
  - Staffing Standards
  - Staffing Standards Executive Summary
- Research and Evidence-Based Practice ›
- RSV
- Tdap Vaccine Resources
- World Breastfeeding Week
- Journal of Obstetric, Gynecologic, & Neonatal Nursing (JOGNN)

Practice Briefs

AWHONN practice briefs can be used as a quick-reference guide that can and should be incorporated into your clinical practice. Each brief provides a summary of the pertinent details of each technique and rationale for why it should be used in practice.

- Lower Extremity Nerve Injury During Labor and Birth: AWHONN Practice Brief Number 11
- The Emergency and All-Hazards Preparedness
- Optimizing Maternal and Neonatal Outcomes in Perinatal Patients With Diabetes
- Decreased Fetal Movement
- Perinatal Care for People With a History of Metabolic and Bariatric Surgery
- Clinical Guidance for the Use of Progesterone Supplementation
- Management of Newborns with Inutero Substance Exposure
- Intrapartum Pain Management for People on Medication-Assisted Therapy
- Breastfeeding Recommendations for People who use Substances
- Provision of Human Milk in the Context of Gender Diversity
- Sustained Skin-to-Skin Contact for Healthy Late Preterm and Term Newborns After Birth

NEW 2026

View all practice briefs at awhonn.org/practice-briefs

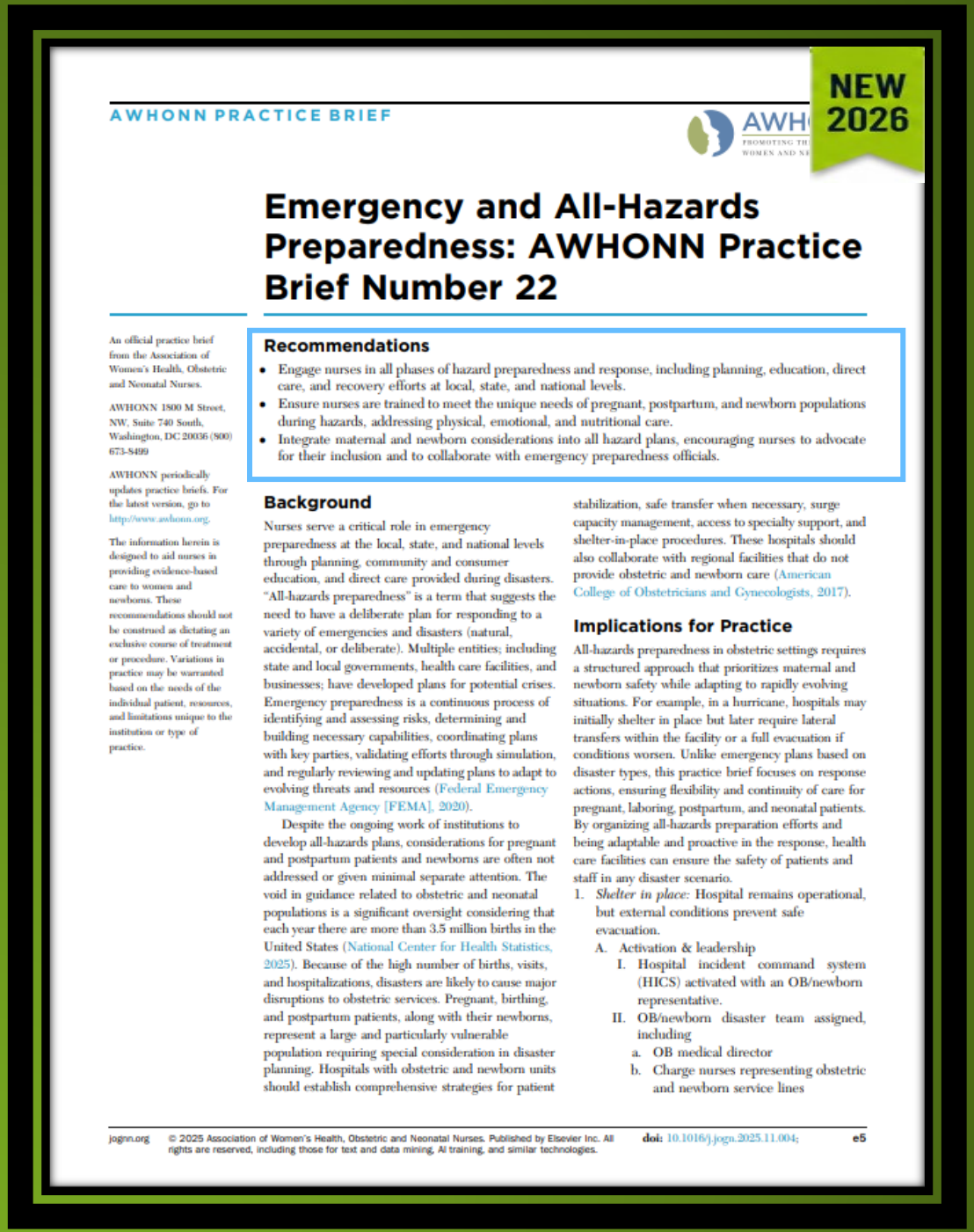
AWHONN

Practice Brief #22

Evidence-based guidance for clinical practice

KEY COACHING POINTS

- **Include nurses in preparedness planning, response, and recovery.**
- **Ensure disaster plans address the unique needs of pregnant, postpartum, and newborn patients.**
- **Integrate maternal-newborn considerations into all-hazards emergency planning.**
- **Promote ongoing education, training, and interprofessional collaboration to improve readiness.**



NEW 2026

AWHONN PRACTICE BRIEF

Emergency and All-Hazards Preparedness: AWHONN Practice Brief Number 22

An official practice brief from the Association of Women's Health, Obstetric and Neonatal Nurses.

AWHONN 1800 M Street, NW, Suite 740 South, Washington, DC 20036 (800) 673-8499

AWHONN periodically updates practice briefs. For the latest version, go to http://www.awhonn.org.

The information herein is designed to aid nurses in providing evidence-based care to women and newborns. These recommendations should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

Recommendations

- Engage nurses in all phases of hazard preparedness and response, including planning, education, direct care, and recovery efforts at local, state, and national levels.
- Ensure nurses are trained to meet the unique needs of pregnant, postpartum, and newborn populations during hazards, addressing physical, emotional, and nutritional care.
- Integrate maternal and newborn considerations into all hazard plans, encouraging nurses to advocate for their inclusion and to collaborate with emergency preparedness officials.

Background

Nurses serve a critical role in emergency preparedness at the local, state, and national levels through planning, community and consumer education, and direct care provided during disasters. "All-hazards preparedness" is a term that suggests the need to have a deliberate plan for responding to a variety of emergencies and disasters (natural, accidental, or deliberate). Multiple entities; including state and local governments, health care facilities, and businesses; have developed plans for potential crises. Emergency preparedness is a continuous process of identifying and assessing risks, determining and building necessary capabilities, coordinating plans with key parties, validating efforts through simulation, and regularly reviewing and updating plans to adapt to evolving threats and resources (Federal Emergency Management Agency [FEMA], 2020).

Despite the ongoing work of institutions to develop all-hazards plans, considerations for pregnant and postpartum patients and newborns are often not addressed or given minimal separate attention. The void in guidance related to obstetric and neonatal populations is a significant oversight considering that each year there are more than 3.5 million births in the United States (National Center for Health Statistics, 2025). Because of the high number of births, visits, and hospitalizations, disasters are likely to cause major disruptions to obstetric services. Pregnant, birthing, and postpartum patients, along with their newborns, represent a large and particularly vulnerable population requiring special consideration in disaster planning. Hospitals with obstetric and newborn units should establish comprehensive strategies for patient stabilization, safe transfer when necessary, surge capacity management, access to specialty support, and shelter-in-place procedures. These hospitals should also collaborate with regional facilities that do not provide obstetric and newborn care (American College of Obstetricians and Gynecologists, 2017).

Implications for Practice

All-hazards preparedness in obstetric settings requires a structured approach that prioritizes maternal and newborn safety while adapting to rapidly evolving situations. For example, in a hurricane, hospitals may initially shelter in place but later require lateral transfers within the facility or a full evacuation if conditions worsen. Unlike emergency plans based on disaster types, this practice brief focuses on response actions, ensuring flexibility and continuity of care for pregnant, laboring, postpartum, and neonatal patients. By organizing all-hazards preparation efforts and being adaptable and proactive in the response, health care facilities can ensure the safety of patients and staff in any disaster scenario.

1. *Shelter in place:* Hospital remains operational, but external conditions prevent safe evacuation.
   - A. Activation & leadership
     - I. Hospital incident command system (HICS) activated with an OB/newborn representative.
     - II. OB/newborn disaster team assigned, including
       - a. OB medical director
       - b. Charge nurses representing obstetric and newborn service lines

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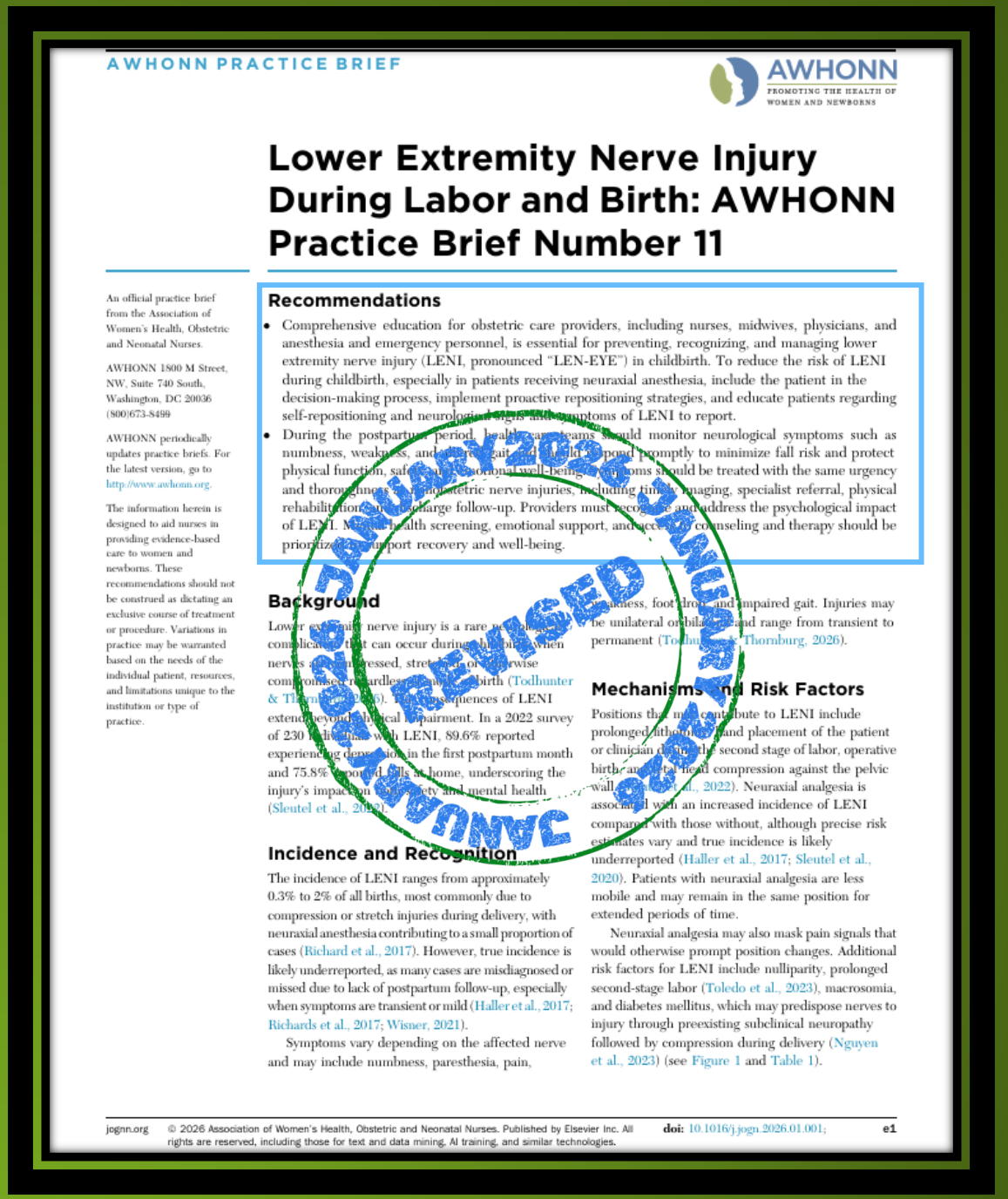
AWHONN

Practice Brief #11

Evidence-based guidance for clinical practice

KEY COACHING POINTS

- **Educate patients receiving neuraxial anesthesia about LENI symptoms**
- **Implement proactive repositioning strategies during labor**
- **Monitor postpartum patients for numbness, weakness, and gait changes**
- **Prompt referral and imaging when neurological symptoms occur**
- **Address emotional and psychological needs.**



AWHONN PRACTICE BRIEF

AWHONN PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

Lower Extremity Nerve Injury During Labor and Birth: AWHONN Practice Brief Number 11

An official practice brief from the Association of Women's Health, Obstetric and Neonatal Nurses.

AWHONN 1800 M Street, NW, Suite 740 South, Washington, DC 20036 (800)673-8499

AWHONN periodically updates practice briefs. For the latest version, go to http://www.awhonn.org.

The information herein is designed to aid nurses in providing evidence-based care to women and newborns. These recommendations should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

Recommendations

- Comprehensive education for obstetric care providers, including nurses, midwives, physicians, and anesthesia and emergency personnel, is essential for preventing, recognizing, and managing lower extremity nerve injury (LENI, pronounced "LEN-EYE") in childbirth. To reduce the risk of LENI during childbirth, especially in patients receiving neuraxial anesthesia, include the patient in the decision-making process, implement proactive repositioning strategies, and educate patients regarding self-repositioning and neurological signs and symptoms of LENI to report.
- During the postpartum period, health care teams should monitor neurological symptoms such as numbness, weakness, and changes in gait and should respond promptly to minimize fall risk and protect physical function, safety, and emotional well-being. Symptoms should be treated with the same urgency and thoroughness as iatrogenic nerve injuries, including timely imaging, specialist referral, physical rehabilitation, and discharge follow-up. Providers must recognize and address the psychological impact of LENI. Mental health screening, emotional support, and access to counseling and therapy should be prioritized to support recovery and well-being.

Background

Lower extremity nerve injury is a rare but [illegible] complication that can occur during labor and birth when nerves are compressed, stretched, or otherwise compromised regardless of mode of birth (Todhunter & Thornburg, 2026). The consequences of LENI extend beyond physical impairment. In a 2022 survey of 230 individuals with LENI, 89.6% reported experiencing depression in the first postpartum month and 75.8% reported falls at home, underscoring the injury's impact on safety and mental health (Sleutel et al., 2022).

numbness, foot drop, and impaired gait. Injuries may be unilateral or bilateral and range from transient to permanent (Todhunter & Thornburg, 2026).

Mechanisms and Risk Factors

Positions that may contribute to LENI include prolonged lithotomy and placement of the patient or clinician during the second stage of labor, operative birth, and fetal head compression against the pelvic wall (Toledo et al., 2022). Neuraxial analgesia is associated with an increased incidence of LENI compared with those without, although precise risk estimates vary and true incidence is likely underreported (Haller et al., 2017; Sleutel et al., 2020). Patients with neuraxial analgesia are less mobile and may remain in the same position for extended periods of time.

Neuraxial analgesia may also mask pain signals that would otherwise prompt position changes. Additional risk factors for LENI include nulliparity, prolonged second-stage labor (Toledo et al., 2023), macrosomia, and diabetes mellitus, which may predispose nerves to injury through preexisting subclinical neuropathy followed by compression during delivery (Nguyen et al., 2023) (see Figure 1 and Table 1).

Incidence and Recognition

The incidence of LENI ranges from approximately 0.3% to 2% of all births, most commonly due to compression or stretch injuries during delivery, with neuraxial anesthesia contributing to a small proportion of cases (Richard et al., 2017). However, true incidence is likely underreported, as many cases are misdiagnosed or missed due to lack of postpartum follow-up, especially when symptoms are transient or mild (Haller et al., 2017; Richards et al., 2017; Wisner, 2021).

Symptoms vary depending on the affected nerve and may include numbness, paresthesia, pain,

  doi: 10.1016/j.jogn.2026.01.001;

AWHONN

Position Statements

Evidence-based guidance to support women's health, obstetric, and neonatal nursing practice.

1. Academic Preparation of Registered Nurses
2. Access to Health Care Revised 10/2025
3. Adoption (New)
4. Advanced Cardiac Life Support in Obstetric Settings
5. Advanced Practice Registered Nurse Position (New)
6. Breast Cancer Screening
7. Breastfeeding and the Use of Human Milk
8. Confidentiality in Adolescent Health Care
9. Continuous Labor Support for Every Woman REVISED 1/2026
10. Contraception and Abortion NEW
11. Elective Induction of Labor
12. Expert Witnesses in Women's Health, Obstetric, and Neonatal Nursing NEW
13. Fetal Heart Monitoring Revised April 2024
14. Health Information Technology for the Perinatal Setting
15. Human Trafficking
16. Infertility Treatment and Fertility Preservation
17. Intimate Partner Violence
18. Marijuana Use During Pregnancy
19. Newborn Screening
20. Nursing Care of Incarcerated Women During Pregnancy and the Postpartum Period (Reaffirmed, June 2024)
21. Nursing Safety on the Job: Workplace Violence and Personal Protection (NEW)
22. Nursing Workforce Diversity Position Statement (NEW)
23. Optimizing Outcomes for Women with Substance Use Disorders in Pregnancy and the Postpartum Period
24. Orientation of the Registered Nurse to the Perinatal Setting
25. Perinatal Mood and Anxiety Disorders
26. Perinatal Palliative Care (NEW)
27. Prevention of Fetal Alcohol Spectrum Disorders (NEW)
28. Racism and Bias in Maternity Care Settings
29. Resuscitative Care for the Obstetric and Neonatal Patient Position Statement (NEW, 2026)
30. Role of the Registered Nurse in the Care of the Pregnant Woman Receiving Analgesia/Anesthesia by Catheter Techniques
31. Tobacco Use and Women's Health
32. The Role of Assistive Personnel
33. The Use of Chaperones during Sensitive Examinations and Treatment
34. The Use of Licensed Practical/Vocational Nurses in Clinical Settings (NEW)

NEW 2026

View all position statements at **awhonn.org/position-statements**

★ OFFICIAL PLAYBOOK ★

POSITION STATEMENT

KEY PLAY

Evidenced-based simulation training improves readiness for obstetric and neonatal resuscitation.

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) emphasizes the critical importance of preparation tailored to the specific, **clearly defined roles of team members involved in out-of-hospital and in-hospital obstetric and neonatal resuscitation**. AWHONN endorses the need for all settings, especially rural and low-resource settings, to develop a plan to ensure that health care team members are equipped with education and frequent**, evidence-based simulation training** to validate specific competencies that support patients during obstetric and neonatal resuscitation. Multidisciplinary teams can collaborate to identify which obstetric and neonatal specific programs best support optimal patient outcomes, including training and coordination with out-of-hospital and in-hospital health care team members who respond to resuscitation efforts. Resuscitation education should align with internationally recognized, science-based standards, such as the International Liaison Committee on Resuscitation (ILCOR) consensus recommendations and professional organization guidelines, while incorporating evidence-based simulation practices to **ensure competency and team readiness** (Greif et al., 2024; Lee et al., 2025).

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NEW 2026

AWHONN POSITION STATEMENT

Resuscitative Care for the Obstetric and Neonatal Patient

Approved by the AWHONN Board of Directors June 2010. Revised and reapproved November 2016. Revised, reapproved, and renamed "Resuscitative Care for the Obstetric & Neonatal Patient" January 2026. The previous version was published in the *Journal of Obstetric, Gynecologic, & Neonatal Nursing* [AWHONN, 2024].

Position

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) emphasizes the critical importance of preparation tailored to the specific, clearly defined roles of team members involved in out-of-hospital and in-hospital obstetric and neonatal resuscitation. AWHONN endorses the need for all settings, especially rural and low-resource settings, to develop a plan to ensure that health care team members are equipped with education and frequent, evidence-based simulation training to validate specific competencies that support patients during obstetric and neonatal resuscitation.

Multidisciplinary teams can collaborate to identify which obstetric and neonatal specific programs best support optimal patient outcomes, including training and coordination with out-of-hospital and in-hospital health care team members who respond to resuscitation efforts. Resuscitation education should align with internationally recognized, science-based standards, such as the International Liaison Committee on Resuscitation (ILCOR) consensus recommendations and professional organization guidelines, while incorporating evidence-based simulation practices to ensure competency and team readiness (Greif et al., 2024; Lee et al., 2025).

Background

Many pregnancy-related deaths remain preventable through timely recognition and intervention (Centers for Disease Control and Prevention, 2024). While maternal mortality in the United States has declined since peaking at more than 33 deaths per 100,000 live births in 2022, significant discrepancies remain among age (e.g., over 40 years of age), race and ethnicity (e.g., non-Hispanic Black women are at increased risk), and geography (e.g., counties lacking birthing facilities or obstetric providers) (Ahmad et al., 2025). Despite advances in neonatal medicine, the U.S. neonatal mortality rate remains among the highest of high-income countries at approximately 3.65 per 1,000 live births (Valenzuela et al., 2025). Approximately 5% to 10% of newborn infants need assistance to initiate breathing at birth, and 1% require advanced resuscitative measures to restore cardiorespiratory function (Lee et al., 2025). In neonatal patients, failure to establish and sustain adequate respiration contributes significantly to early deaths and the burden of adverse neurodevelopmental outcomes (Lee et al., 2025).

In addition to disparities in outcomes, limited access to maternity care contributed to more out-of-hospital births (March of Dimes, 2024). Longer travel times to a medical facility are associated with an increased risk of perinatal and neonatal morbidity and mortality, particularly when adequate emergency care is delayed (Madar et al., 2021; Watterberg et al., 2020). As obstetric units close, especially in rural regions, emergency departments increasingly manage unplanned deliveries and newborns requiring resuscitation (March of Dimes, 2024). These shifts underscore the urgent need for system-wide preparedness to reduce preventable infant morbidity and mortality.

Role of the Nurse

Maternal Resuscitation

Nurses have a critical role in caring for obstetric patients during a cardiopulmonary arrest, including recognizing changes in the patient's condition and initiation of rapid response. All levels of care, across institutions and units that may potentially care for obstetric patients, need to be prepared to respond to an obstetric cardiac arrest (American Academy of Pediatrics & American Heart Association, 2025; Shields et al., 2024). During cardiopulmonary resuscitation, nursing roles should be intentionally assigned. A designated nurse, often the nurse most familiar with the patient, should provide critical patient history, ensure closed-loop communication, and carry out specific roles and tasks to ensure a coordinated and effective response (American Academy of Pediatrics & American Heart Association, 2025; Shields et al., 2024).

Because cardiac arrest during the obstetric period is both rare and complex, nurses need ongoing training and hands-on practice in obstetric-specific resuscitation techniques, including maternal modifications and perinatal interventions (Berteloot & Sabbe, 2025; Shields et al., 2024). Regular

doi: 10.1016/j.jogn.2026.02.006;

★ OFFICIAL PLAYBOOK ★

POSITION STATEMENT

KEY PLAY

No one wins alone.

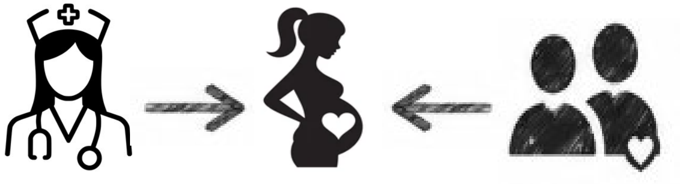
Continuous labor support improves outcomes for mothers and newborns and enhances the childbirth experience.

BENEFITS

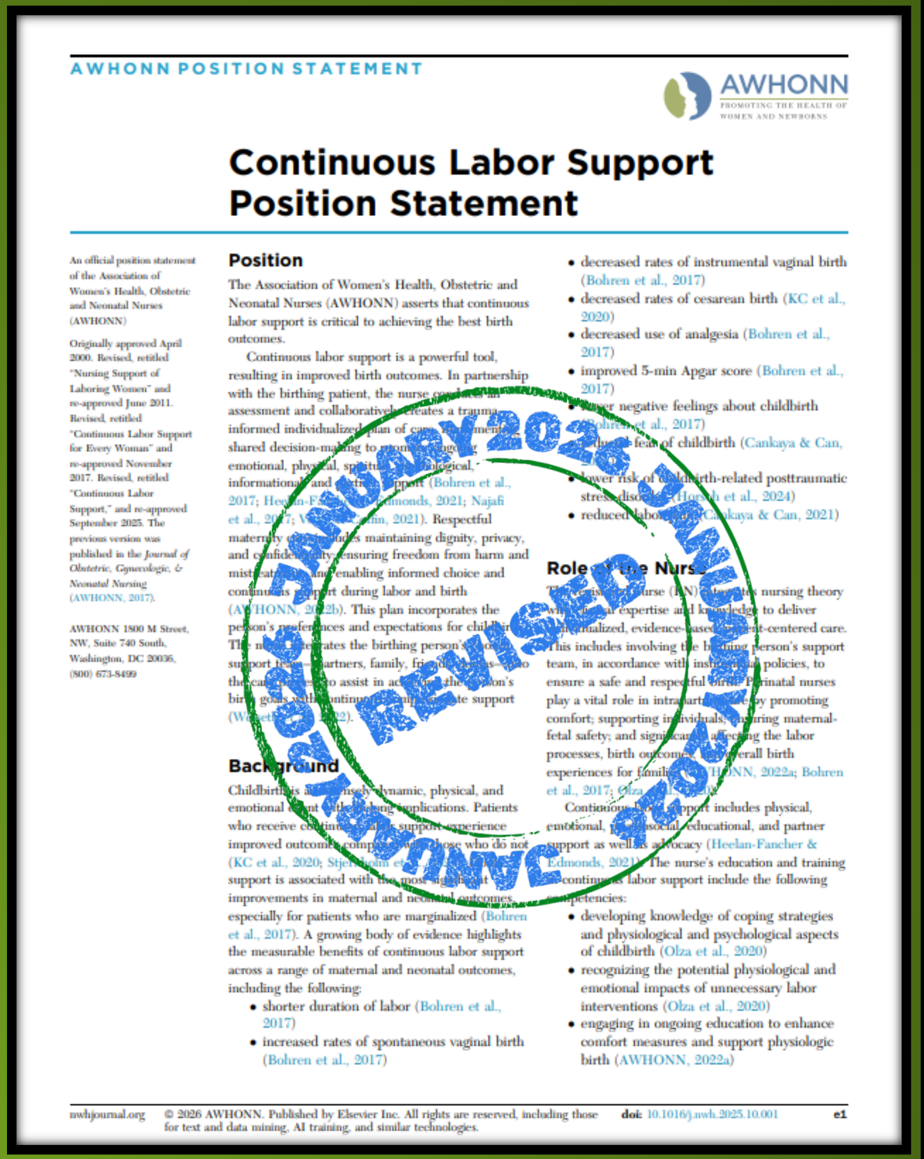
- ★ Lower cesarean rates
- ★ Shorter labor
- ★ Higher satisfaction
- ★ Better newborn outcomes

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) asserts **that continuous labor support is critical to achieving the best birth outcomes.**

TEAMWORK MAKES THE DIFFERENCE



EVERY PATIENT DESERVES A STRONG SUPPORT SYSTEM



AWHONN POSITION STATEMENT

AWHONN
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

Access to Health Care

An official position statement of the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)

AWHONN, 1800 M Street NW, Suite 740 South, Washington, DC 20036; (800) 673-8499

Approved by the AWHONN Executive Board August 1990. Reaffirmed April 1993, 1994, 1996, 2000, and 2005. Revised and reaffirmed November 2008. Revised and reaffirmed September 2016. Revised and reaffirmed June 19, 2025.

Position

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) considers access to comprehensive quality health care services a basic human right. Therefore, AWHONN strongly supports policy initiatives that guarantee access to such health care services for all people.

Background

Access to health care is a critical factor in care throughout the patient life span. Lack of access to health care is associated with poor outcomes given that it stymies timely preventive care, early diagnosis, and effective management of acute and chronic conditions. According to the Office of Disease Prevention and Health Promotion's (n.d.) Healthy People 2030 initiative, health care access and quality is one of the five domains of social determinants of health alongside economic stability, education access and quality, neighborhood and built environment, and social and community context (Office of Disease Prevention and Health Promotion, n.d.). Social determinants of health can directly affect whether people can afford health insurance, travel to appointments, and navigate the health care system effectively, ultimately determining their ability to access necessary care. Below are a number of factors and summaries of the way in which those factors affect individuals' ability to access quality affordable care. For readability, the factors are divided into Structural Barriers and Populations Affected by Systemic Inequities. However, these factors do not exist in a vacuum and often overlap, compounding access challenges.

Structural Barriers

Insurance Eligibility and Coverage

In the United States, a lack of health insurance is a significant barrier to accessing timely, quality health care services and is a key contributor to maternal mortality (Daw et al., 2020). Uninsured individuals are less likely than those with insurance to receive preventive care, recommended screenings, and follow-up care. They are also more likely to delay, or even forgo entirely, necessary medical treatments and prescriptions (Allen et al., n.d.). As a result, uninsured people often experience poorer health outcomes than insured people and face a higher risk of hospitalization for preventable conditions.

Affordable insurance is still limited for many low-income individuals. The Patient Protection and Affordable Care Act (2010) provided the states with the option to expand Medicaid eligibility to many low-income individuals. The primary goal of the Affordable Care Act was to remove insurance-related barriers to health care access and expand Medicaid coverage (Assistant Secretary for Public Affairs, 2022). Since the Affordable Care Act's passage and implementation, the number of uninsured individuals has significantly decreased (Assistant Secretary for Public Affairs, 2022). In the American South, where health outcomes are the worst in the nation, many states have not adopted the Medicaid expansion (Center on Budget and Policy Priorities, 2023, Miller & Vasan, 2021).

In addition, racial and ethnic disparities continue to persist in perinatal insurance. The gap in affordable insurance may be exacerbated by the existing health care inequities in maternal and neonatal health (Daw et al., 2020). One study, Daw et al. (2020) found that racial disparities existed in both preconception and postpartum insurance, which are key elements in providing quality care. Furthermore, racial and ethnic minorities have a higher risk of being uninsured than non-Hispanic Whites. Even for those who can afford insurance, high deductibles and out-of-pocket costs may prevent individuals from seeking the care they need (Office of Disease Prevention and Health Promotion, n.d.).

Reproductive Health Deserts and Underserved Areas

One third of counties in the United States are considered reproductive health care deserts, defined as areas without access to services, obstetric care facilities, or providers (March of Dimes, 2024). Continued closure of rural hospitals and labor and delivery units adversely affects access to care (Taporco et al., 2021). Reproductive care deserts exacerbate existing inequities and further contribute to barriers to accessing care, especially in communities of color, low-income rural areas, and areas with low investment in community-focused care (March of Dimes, 2024). The

  doi: 10.1016/j.jogn.2025.07.001

★ OFFICIAL PLAYBOOK ★

POSITION STATEMENT

KEY PLAY

Health equity begins with access.

Why it matters:

- Improves maternal outcomes
- Reduces disparities
- Supports healthier families
- Advances patient safety

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AWHONN
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RETIRED
FROM THE PLAYBOOK

THESE AWHONN POSITION STATEMENTS ARE NO LONGER IN ACTIVE ROTATION.

- AWHONN, NANN, NPA: Essential Care in the NICU during the COVID-19 Pandemic
- Emergency Contraception
- Health Care Decision Making for Reproductive Care
- Insurance Coverage for Contraceptives
- Midwifery
- Rights and Responsibilities of Nurses Related to Reproductive Health Care
- Women's Cardiovascular Health