

LABOUR AND BIRTH



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Going into labour is exciting, but you may also feel apprehensive, so it helps to be prepared well in advance. Knowing all about the stages of labour and what to expect can help you to feel more in control when the time comes.

GETTING READY

Whether you are having your baby at home, in hospital or at a midwifery unit, you should get a few things ready at least four weeks before your due date.

Packing your bag

Wherever you are having your baby your midwife can help you decide what you will need to pack. You may want to include the following:



- Something old, loose and comfortable to wear during labour eg old shirt. It should not restrict you from moving around or make you too hot. You may need about three changes of clothes.
- Three comfortable and supportive bras, including nursing bras if you are planning to breastfeed. Remember, your breasts will be much larger than usual.
- About 24 super-absorbent sanitary towels.
- Breast pads x 24.
- Your wash bag with toothbrush, hairbrush, flannel, etc.
- Fruit juices and boiled sweets to give you energy in labour.
- Towels, preferably not white.
- Things that can help you pass the time and relax, e.g. books, magazines, MP3 player.
- A sponge or water spray to cool you down.
- Front-opening nightdresses or pyjamas if you are going to breastfeed.
- Light dressing gown and slippers.
- Five or six pairs of pants or disposable pants.
- A loose, comfortable outfit to come home in.
- Clothes (including a hat) and 24 nappies for the baby.
- A shawl or blanket to wrap the baby in.
- Car seat for taking baby home.
- Green MHHR.
- Birth plan.
- Any other letters or test results.



Transport

Work out how you will get to hospital or the midwifery unit, as it could be at any time of the day or night. If you are planning to go by car, make sure that it's running well and that there is always enough petrol in the tank. If a neighbour has said that they will take you, make an alternative arrangement just in case they are not in. If you have not got a car, you could call a taxi. Try to do so in good time. Check which entrance door you should use if you arrive at night.

Home births

If you are planning to give birth at home, discuss your plans and what you need to prepare with your midwife.

Mobile phones

Some hospitals and midwifery units will allow you to use your mobile phone. Check with your midwife. If you cannot use your mobile, make sure that you have a phone card or change for the phone.

If labour starts early

Labour can start as early as 24 weeks. If this happens, call your midwife or hospital immediately.

Stocking up

When you come home you will not want to do much more than rest and care for your baby, so do as much planning as you can in advance:

- Stock up on basics, such as toilet paper, sanitary towels and nappies.
- Buy tinned and dried food like beans, pasta and rice.
- If you have a freezer, cook some meals in advance.



Important numbers

Keep a list of important numbers in your handbag or near your phone. There is space for you to write them down in your notes and at the back of this book.

You need to include the following:

- Your hospital and midwife's phone numbers.
- Your partner and birth partner's phone numbers.
- Your own hospital reference number (it will be on your card or notes). You will be asked for this when you phone in.
- A local taxi number, just in case you need it.

THE SIGNS OF LABOUR

You are unlikely to mistake the signs of labour when the time really comes, but if you are in any doubt, don't hesitate to contact your midwife.

Regular contractions

During a contraction, your uterus gets tight and then relaxes. You may have had these throughout your pregnancy – particularly towards the end. Before labour, these are called Braxton Hicks contractions. When you are having regular contractions that last more than 30 seconds and begin to feel stronger, labour may have started. Your contractions will become longer, stronger and more frequent.

Other signs of labour

- **Backache** or the aching, heavy feeling like that some women get with their monthly period.

- **The 'show'.** The plug of mucus in the cervix, which has helped to seal the uterus during pregnancy, comes away and comes out of the vagina. This small amount of sticky pink mucus is called the 'show'. It usually comes away before or in early labour. There should only be a little blood mixed in with the mucus. If you are losing more blood, it may be a sign that something is wrong, so phone your hospital or midwife straight away.

- **Your waters break.** The bag of water surrounding your baby may break before labour starts. To prepare for this, you could keep a sanitary towel (not a tampon) handy if you are going out, and put a plastic sheet on your bed. If your waters break before labour starts, you will notice either a slow trickle from your vagina or a sudden gush of water that you cannot control. Phone your midwife when this happens.

- **Nausea or vomiting.**

- **Diarrhoea.**



Pain relief in labour

For most women labour is painful, so it is important to learn about all the ways you can relieve pain. Whoever is going to be with you during labour should also know about the different options, as well as how they can support you. Ask your midwife or doctor to explain what is available so that you can decide what is best for you. Write down what you want in your birth plan, but remember that you should keep an open mind. You may find that you want more or less pain relief than you had planned, or your doctor or midwife may suggest more effective pain relief to help the delivery. Use your birth plan to record what you would like to happen in labour.



has
the time
come?

TYPES OF PAIN RELIEF

Self-help

The following techniques can help you to be more relaxed in labour, and this can help you to cope with the pain.

- Learn about labour. This can make you feel more in control and less anxious about what is going to happen. Read books like this one, talk to your midwife or doctor and attend antenatal classes available in your area.
- Learn how to relax and stay calm. Try breathing deeply.
- Keep moving. Your position can make a difference. Try kneeling, walking around or rocking back and forwards.

**staying
calm
will help**



- Have a partner, friend or relative to support you during labour. If you don't have anyone, don't worry – your midwife will give you all the support you need.
- Ask your partner to massage you (although you may find that you don't want to be touched).
- Have a bath.



Hydrotherapy

Water can help you to relax and can make the contractions seem less painful. Ask if you can have a bath, shower or use a birth pool. The water will be kept at a temperature that is comfortable for you but not be above 37°C. Your temperature will be monitored closely.

Water births

Some hospitals have birthing pools (or you can hire one if there is not one available), so that you can be in water during labour. Many women find that this helps them to relax. It is possible to deliver the baby in the pool. Speak to your midwife about the advantages and disadvantages of a water birth. If you want one, you will need to make arrangements in advance.

Bath or shower

Some hospitals may offer you a bath or shower. A warm bath can be soothing in the early stages of labour. Some women like to spend much of their labour in the bath as a way of easing the pain.



'Gas and air' (Entonox)

This is a mixture of oxygen and another gas called nitrous oxide. 'Gas and air' will not remove all the pain, but it can help to reduce it and make it easier to bear. Many women like it because it's easy to use and you control it yourself.

How it works

You breathe it in through a mask or mouthpiece which you hold yourself. You will probably have a chance to practise using the mask or mouthpiece if you attend an antenatal class.

The gas takes 15–20 seconds to work, so you breathe it in just as a contraction begins. It works best if you take slow, deep breaths.

Side effects

There are no harmful side effects for you or the baby, but it can make you feel lightheaded. Some women also find that it makes them feel sick or sleepy or unable to concentrate on what is happening. If this happens, you can simply stop using it. These feelings usually subside when you use it for a little longer.



TENS

TENS stands for transcutaneous electrical nerve stimulation. Some hospitals provide TENS machines. If not, you can hire your own machine.

TENS has not been shown to be very effective during the active phase of labour. It is probably most effective during the early stages, when many women experience lower-back pain.

TENS may be useful if you plan to give birth at home or while you are at home in the early stages of labour. If you are interested in TENS, you should learn how to use it in the later months of your pregnancy. Ask your midwife or physiotherapist.

How it works

Electrodes are taped onto your back and connected by wires to a small, battery-powered stimulator known as an 'obstetric pulsar'. Holding the pulsar, you give yourself small, safe amounts of current. You can move around while using it.



It is believed that TENS works by stimulating your body to produce more endorphins, which are the body's own natural painkillers. It also reduces the number of pain signals that are sent to the brain by the spinal cord.

Side effects

There are no known side effects for either you or the baby.

Intramuscular injections of pain-relieving drugs

Injections of drugs like pethidine or diamorphine can help you to relax, and this can lessen the pain.

How it works

You are given an intramuscular injection. It takes about 20 minutes to work and the effects last between two and four hours.

Side effects

- It can make some women feel very 'woozy', sick and forgetful.
- If it has not worn off towards the end of labour, it can make it difficult to push. You might prefer to ask for half a dose initially, to see how it works for you.
- If pethidine or diamorphine are given too close to the time of delivery, it may affect the baby's breathing. If it does, an antidote may be given.
- The drugs make the baby less alert and can interfere with breastfeeding.

Remifentanil

Remifentanil is a powerful morphine-type drug which can be used for pain relief in labour.

How it works

It is used by inserting a drip into a vein in your arm or hand and attached to a patient-controlled analgesia (PCA) pump. You press the button on the pump and a small dose of remifentanil is given directly into your vein providing pain relief on demand, reducing the severity of labour pain. This starts working within five minutes of the drip being connected. You need to press the button every time you have a contraction because each dose of remifentanil wears off within a few minutes.

To use remifentanil you must be on labour ward (not a midwife led unit) and be in established labour (please discuss this with your midwife). You



cannot start remifentanil if you have had morphine or pethidine in the last four hours.

Epidural analgesia

An epidural is a special type of local anaesthetic. It numbs the nerves which carry pain from the birth canal to the brain. For most women, an epidural gives complete pain relief. It can be very helpful for women who are having a long or particularly painful labour, or who are becoming very distressed.

An anaesthetist is the only person who can give an epidural. If you think you are going to want one, check whether anaesthetists are always available at your hospital.

How it works

- A drip will run fluid into a vein in your arm.
- While you lie on your side or sit up in a curled position, an anaesthetist will clean your back with antiseptic and numb a small area with some local anaesthetic.
- A very small tube will be placed into your back near the nerves that carry pain from the uterus. Drugs (usually a mixture of local anaesthetic and opioid) are then administered through this tube. It takes about 20 minutes to get the epidural set up and then another 10–15 minutes for it to work. Occasionally it doesn't work perfectly at first, and needs to be adjusted.

- After it has been set up, the epidural can be 'topped up' by an anaesthetist or midwife, or you may be given a machine which will let you top up the epidural yourself.
- Your contractions and the baby's heart will need to be continuously monitored by a machine. This means having a belt round your abdomen and possibly a clip attached to your baby's head.

Side effects

- Epidurals may make your legs heavy. It depends on the type of epidural that you have.
- An epidural should not make you feel drowsy or sick.
- Your blood pressure can drop. This is rare, as the drip in your arm will help you to maintain normal blood pressure levels.
- Epidurals can prolong the second stage of labour. If you can no longer feel your contractions, the midwife will have to tell you when to push. This may mean that instruments are used to help you deliver your baby. However, when you have an epidural, your midwife or doctor will wait longer before they use instruments as long as your baby is fine. Sometimes, less anaesthetic is given towards the end so that the effect wears off and you can push the baby out naturally.



- You may find it difficult to pass water, and a small tube called a catheter may be put into your bladder to help you.
- About 1 in 100 women gets a headache after an epidural. If you develop a headache afterwards, it can be treated.
- Your back might be a bit sore for a day or two, but epidurals do not cause long-term backache.
- About 1 in 2,000 mothers gets a feeling of tingling or pins and needles down one leg after having a baby. This is more likely to result from childbirth itself than from an epidural. You will be advised on when you can get out of bed.

Alternative methods of pain relief

Some women want to avoid the above methods of pain relief and choose acupuncture, aromatherapy, homeopathy, hypnosis, massage and reflexology. However, if you would like to use any of these methods it is important to discuss it with your midwife or doctor and to let the hospital know beforehand.

Most hospitals do not offer them for the relief of pain during labour. If you want to try one of these alternative techniques, make sure that the practitioner you use is properly trained and experienced and check with your midwife that this will be available in the maternity unit. For advice, contact the Institute for Complementary and Natural Medicine (see page 183).

WHEN TO GO TO HOSPITAL OR YOUR MIDWIFERY-LED UNIT

If it is your first pregnancy, you may feel unsure about when you should go into hospital. The best thing to do is call your hospital or unit for advice.



- If your waters have broken, you will probably be told to go in to be checked.
- If it is your first baby and you are having contractions but your waters have not broken, you may be told to wait. You will probably be told to come in when your contractions are regular, strong, are about five minutes apart and are lasting about 60 seconds.
- If you don't live near to your hospital, you may need to go in before you get to this stage.
- Second and later babies often arrive more quickly, so you may need to contact the hospital, midwifery-led unit or your midwife sooner.

Don't forget to phone the hospital or unit before leaving home, and remember your notes.

Home birth

You and your midwife should have agreed what you will do when labour starts.

Keep active

Keep active in labour for as long as you feel comfortable. This helps the progress of the birth. Don't do anything strenuous but try and move or walk around normally.



Maternity Assessment (Triage)

ARRIVING AT THE HOSPITAL OR MIDWIFERY-LED UNIT

Hospitals and midwifery-led units vary, so the following is just a guide to what is likely to happen. Your midwife will be able to give you more information about your local hospital or unit.

Take your green MHHR notes to the hospital admissions desk. You will be taken to the labour ward or your room, where you can change into a hospital gown or a nightdress of your own. Choose one that is loose and preferably made of cotton, because you will feel hot during labour and will not want something tight.

Examination by the midwife

The midwife will ask you about what has been happening so far and will examine you. If you are having a home birth, then this examination will take place at home. The midwife will:

- take your pulse, temperature and blood pressure and check your urine
- feel your abdomen to check the baby's position and listen to your baby's heart.
- probably do an internal examination to find out how much your cervix has opened. Tell her if a contraction is coming so that she can wait until it has passed. She will then be able to tell you how far your labour has progressed. If you would prefer not to have an internal examination you don't have to have one. However, if there are any concerns about your own or your baby's condition, vaginal examinations can help the doctor and midwife to make the most appropriate decisions about any risks and plan your care.

These checks will be repeated at intervals throughout your labour.

If you and your partner have made a birth plan, show your midwife so that she knows what kind of labour you want and can help you to achieve it.



Delivery rooms

Delivery rooms have become more homelike in recent years. Most have easy chairs, beanbags and mats so that you can move about in labour and change position. Some have baths, showers or birthing pools.

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ANALISIS



To help yourself get over the urge to push, try blowing out slowly and gently or, if the urge is too strong, in little puffs. Some people find this easier lying on their side, or on their knees and elbows, to reduce the pressure of the baby's head on the cervix.



Fetal heart monitoring

Your baby's heart will be monitored throughout labour. Your midwife will watch for any marked change in your baby's heart rate, which could be a sign that the baby is distressed. There are different ways of monitoring the baby's heartbeat. If you don't feel comfortable with one of these, tell your midwife.

- Your midwife may listen to your baby's heart intermittently, for at least one minute every 15 minutes when you are in established labour, using a hand-held ultrasound monitor (often called a Sonicaid). This method allows you to be free to move around.

WHAT HAPPENS IN LABOUR

There are three stages to labour. In the first stage the cervix gradually opens up (dilates). In the second stage the baby is pushed down the vagina and is born. In the third stage the placenta comes away from the wall of the uterus and is also pushed out of the vagina.

The first stage of labour – dilation

The dilation of the cervix

The cervix needs to open to about 10cm for a baby to pass through. This is called 'fully dilated'. Contractions at the start of labour help to soften the cervix so that it gradually opens. Sometimes the process of softening can take many hours before what midwives refer to as 'established labour'. This is when your cervix has dilated to at least 4cm.

If you go into hospital or your midwifery unit before labour is established, you may be asked if you would prefer to go home again for a while, rather than spending extra hours in hospital.

If you go home, you should make sure that you eat and drink, as you will need energy. At night, try to get comfortable.

Get some sleep if possible. A warm bath or shower may help you to relax. During the day, keep upright and remain active. This helps the baby to move down into the pelvis and helps the cervix to dilate.



Once labour is established, the midwife will check from time to time to see how you are progressing. In a first labour, the time from the start of established labour to full dilation can be between 6 and 12 hours. It is often quicker in subsequent pregnancies.

Your midwife should be with you all the time to support you. She will tell you to try not to push until your cervix is fully open and the baby's head can be seen.



- Your baby's heartbeat and your contractions may also be monitored electronically using a CTG machine. The monitor will be strapped to your abdomen on a belt.

- Alternatively, a clip can be put on your baby's head to monitor the heart rate. The clip is put on during a vaginal examination and your waters will be broken if they have not already done so. Your midwife or doctor should explain why they feel that the clip is necessary for your baby.

Speeding up labour

Your labour may be slower than expected if your contractions are not frequent or strong enough or because your baby is in an awkward position.

If this is the case, your doctor or midwife will explain why they think labour should be sped up and may recommend the following techniques.

- Your waters may be broken during a vaginal examination.
- If this doesn't speed up labour, you may be given a drip containing a hormone, which is fed into a vein into your arm to encourage contractions. You may want some pain relief before the drip is started.
- After the drip is attached, your contractions and your baby's heartbeat will be continuously monitored.

support and encouragement

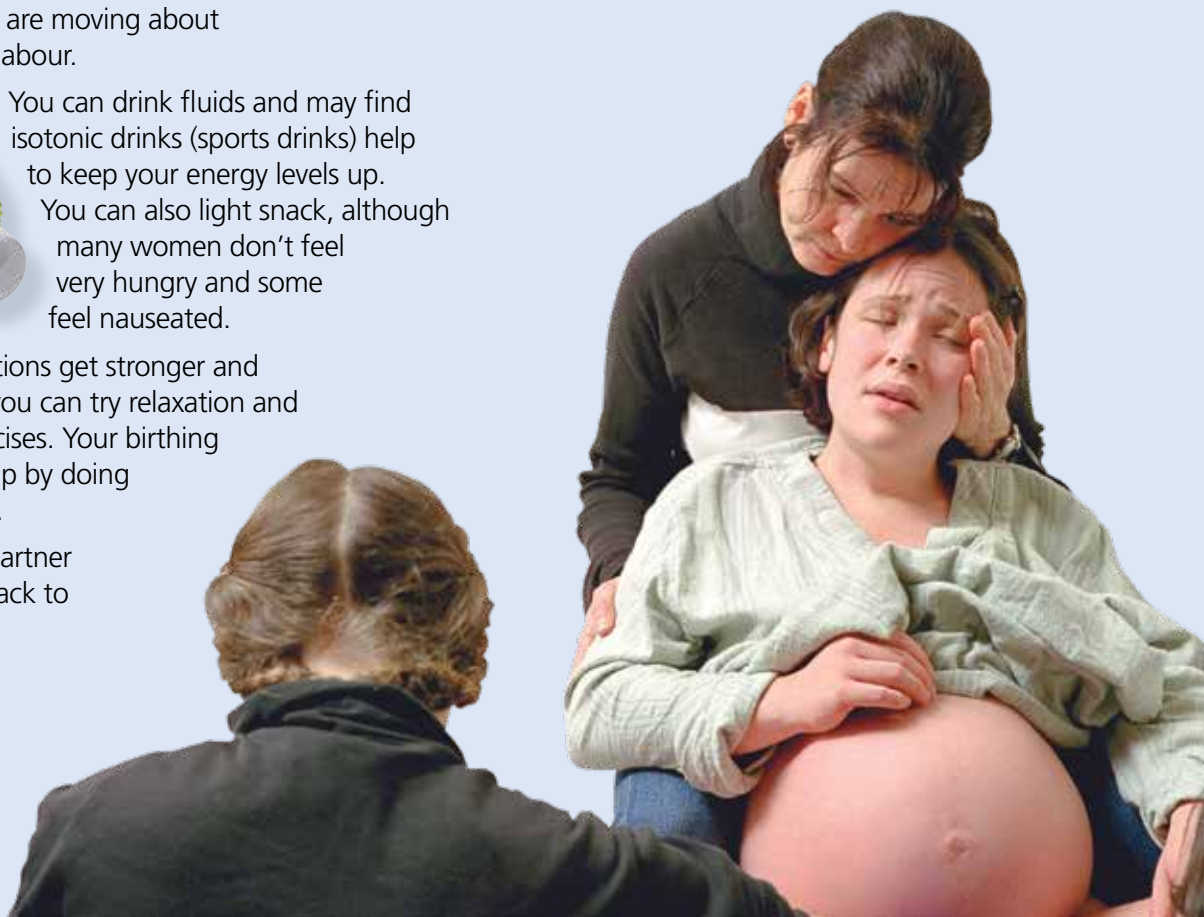
Coping at the beginning

- It is best if you are moving about during labour.



- You can drink fluids and may find isotonic drinks (sports drinks) help to keep your energy levels up. You can also light snack, although many women don't feel very hungry and some feel nauseated.

- As the contractions get stronger and more painful, you can try relaxation and breathing exercises. Your birthing partner can help by doing them with you.
- Your birthing partner can rub your back to relieve the pain if that helps.



The second stage of labour – the baby's birth

This stage begins when the cervix is fully dilated, and lasts until the birth of your baby. Your midwife will help you to find a comfortable position and will guide you when you feel the urge to push.



Find a position

Find a position that you prefer. You can to help the baby's head descend:

- If you stand up, sit forward, kneel or squat (squatting may be difficult if you are not used to it).
- If you are very tired, you might be more comfortable lying on your side. This position is better for your baby than lying on your back.
- You may find kneeling on all fours might be helpful if you suffer from backache in labour.

It can help if you have tried out these positions beforehand and explained to your birth partner how they will help you.

Pushing

When your cervix is fully dilated, you can start to push when you feel



you need to during contractions:

- Take two deep breaths as the contractions start, and push down.
- Take another breath when you need to.
- Give several pushes until the contraction ends.
- After each contraction, rest and get up strength for the next one.

This stage is hard work, but your midwife will help and encourage you all the time. Your birth partner can also give you lots of support. This stage may take two hours or more.

The birth

During the second stage, the baby's head moves down the birth canal.

When the head is visible, the midwife will ask you to stop pushing, and to pant or puff blowing out through your mouth. This is so that your baby's head can be born slowly and gently, giving the skin and muscles of the perineum (the area between your vagina and back passage) time to stretch without tearing is possible.

The skin of the perineum usually stretches well, but it may tear. Sometimes to avoid a tear or to speed up the delivery, the midwife or doctor will inject local anaesthetic and perform an episiotomy if

needed. Once your baby's head is born, most of the hard work is over. With one more gentle push the body is usually born quite quickly and easily.

You can have your baby lifted straight onto your abdomen before the cord will be cut by your midwife or birthing partner if you prefer.

Your baby may be born covered with some of the white, greasy vernix, which acts as a protection while in the uterus.



Skin-to-skin contact

Even if you have a Caesarean section or a difficult delivery, try to have skin-to-skin contact with your baby as soon as possible after the birth. This will:

- keep your baby warm and calm;
- help regulate breathing and heartbeat;
- release mothering hormones to help with bonding.

Try the following:

- place the baby on your tummy with his head near your breast;
- gently stroke and caress your baby;
- allow the baby to focus on your face;
- ask to be left undisturbed to get to know your baby.

Even if you decided before the birth not to breastfeed, this may be a really good time to give it a go and see what you think. You might change your mind!

The first milk you produce in the days after the birth (called colostrum) contains antibodies that will help protect your baby from infection, so even if you decide not to continue breastfeeding, your baby will benefit from those first few feeds.



The third stage of labour – the placenta

After your baby is born, the womb can contract to push out the placenta. Your midwife will offer you an injection in your thigh just as the baby is born, which will speed up the delivery of the placenta.

The injection contains a drug called Syntocinon, which makes the uterus contract and helps to prevent the heavy bleeding which some women experience.

skin
to **skin**





After the birth

Your baby will be examined by a midwife or paediatrician and then weighed (and possibly measured) and given a band with your name on it.

Vitamin K

You will be offered an injection of vitamin K for your baby, which is the most effective way of helping to prevent a rare bleeding disorder (haemorrhagic disease of the newborn). Your midwife should have discussed this with you beforehand. If you prefer that your baby doesn't have an injection, oral doses of vitamin K are available. If given orally further doses will be necessary.

Stitches

Small tears and grazes are often left to heal without stitches because they frequently heal better this way. If you need stitches or other treatments, it should be possible to continue cuddling your baby. Your midwife will help with this as much as they can.

If you have had a large tear or an episiotomy, you will probably need stitches. If you have already had an epidural, it can be topped up. If you have not, you should be offered a local anaesthetic injection.

The midwife or maternity support worker will help you to wash and freshen up, before leaving the labour ward to go home or to the postnatal area.

SPECIAL CASES

Labour that starts too early (premature labour)

About 1 baby in every 13 will be born before the 37th week of pregnancy. In most cases labour starts by itself, either with contractions or with the sudden breaking of the waters or a 'show' (see page 87). About one early baby in six is induced (see next page) and about one early baby in five is delivered by caesarean section (see page 98).

If your baby is likely to be born early, you will be admitted to a hospital with specialist facilities for premature babies. Not all hospitals have these facilities, so it may be necessary to transfer you and your baby to another unit, either before delivery or immediately afterwards.

If contractions start prematurely, the doctors may be able to use drugs to stop your contractions temporarily. You will probably be given injections of steroids that will help to mature your baby's lungs so that they are better able to breathe after the birth. This treatment takes about 24 hours to work.

Many multiple birth babies are born prematurely and twins and triplets may be more likely to need care in a neonatal unit. Your doctor may offer you a planned birth earlier than 38 weeks. The timing of the

planned birth depends on the number of babies and whether or not your babies share a placenta.

If you have any reason to think that your labour may be starting early, get in touch with your hospital or midwife straight away.

Overdue pregnancies

Pregnancy normally lasts about 40 weeks, which is approximately 280 days from the first day of your last period. Most women will go into labour within a week either side of this date.

If your labour does not start by 41 weeks, your midwife will offer you a 'membrane sweep'. This involves having a vaginal examination, which stimulates the neck of your uterus (known as the cervix) to produce hormones which may trigger natural labour.

If your labour still doesn't start, your midwife or doctor will suggest a date to have your labour induced (started off) usually 10-14 days after your due date. If you don't want labour to be induced and your pregnancy continues to 42 weeks or beyond, you and your baby will be monitored. Your midwife or doctor will check that both you and your baby are healthy by giving you ultrasound scans and checking your baby's movement and heartbeat. If your baby is showing signs of distress, your doctor and midwife will again suggest that labour is induced.



Induction

Labour can be induced if your baby is overdue or there is any sort of risk to you or your baby's health – for example, if you have high blood pressure or if your baby is failing to grow and thrive. Induction is always planned in advance, so you will be able to talk over the benefits and disadvantages with your doctor and midwife and find out why they recommend your labour is induced.

Contractions are usually started by inserting a hormone into the vagina, and sometimes both are used. Induction of labour may take a while, particularly if the neck of the uterus (the cervix) needs to be softened with pessaries or gels. Sometimes a hormone drip is needed to speed up the labour. Once labour starts it should proceed normally, but it can sometimes take 24–48 hours to get you into labour. An information leaflet is available.

Assisted birth (forceps or vacuum-assisted delivery)

About one in eight women have an assisted birth, where forceps or a vacuum-extractor are used to help the baby out of the vagina. This can be because:

- your baby is distressed
- your baby is in an awkward position
- you are too exhausted.

Both vacuum extractor and forceps are safe and are used only when necessary for you and your baby. A paediatrician may be present to check your baby's health. A local anaesthetic will usually be given to numb the birth canal if you have not already had an epidural or spinal anaesthetic. If your obstetrician has any concerns, you may be moved to a theatre so that a caesarean section can be carried out if needed.

As the baby is being born, a cut (episiotomy) may be needed to enlarge the vaginal opening. Any tear or cut will be repaired with stitches.

Depending on the circumstances, your baby can be delivered onto your abdomen and your birthing partner may still be able to cut the cord, if they want to.

Vacuum extractor

A vacuum extractor is an instrument that has a soft or hard plastic or metal cup which is attached to your baby's head by a tube that is fitted to a suction device. The cup fits firmly onto your baby's head and, with a contraction and your pushing, the obstetrician or midwife gently pulls to help deliver your baby.

The suction cup can leave a small mark on your baby's head called a chignon and it may also cause a bruise on your baby's head called a cephalhaematoma. A vacuum extractor is not used if your baby is less than 34 weeks old, because the head is too soft.

A vacuum extractor is less likely to cause vaginal tearing than forceps.

Forceps

Forceps are smooth metal instruments that look like large spoons or tongs. They are curved to fit around the baby's head. The forceps are carefully positioned around your baby's head and joined together at the

handles. With a contraction and your pushing, an obstetrician gently pulls to help deliver your baby.

There are many different types of forceps. Some forceps are specifically designed to turn the baby to the right position to be born, for example if your baby is 'back to your back'.

Forceps can leave small marks on your baby's face. These will disappear quite quickly.

Afterwards

You will sometimes have a catheter fitted (a small tube that fits into your bladder) for up to 24 hours. You are more likely to need this if you have had an epidural, as you may not feel when your bladder is full.





Caesarean section

There are situations where the safest option for you or your baby is to have a caesarean section. As a caesarean section involves major surgery, it will only be performed where there is a real clinical need for this type of delivery.

Your baby is delivered by cutting through your abdomen and then into your uterus. The cut is made across your abdomen, just below your bikini line. The scar is usually hidden in your pubic hair.



If you are expecting twins, triplets or more, it is more likely that you will be advised to have a caesarean section. This will depend on how your pregnancy progresses, the position of your babies and whether the babies share a placenta.

Whenever a caesarean is suggested, your doctor will explain why it is advised and any possible side effects. Do not hesitate to ask questions.

Urgent (emergency) caesareans

Urgent (emergency) caesarean sections are necessary when complications develop and delivery needs to be quick. This may be before or during labour. If your midwife and doctor are concerned about your or your baby's safety, they will suggest that you have a caesarean straight away. Sometimes your doctor or midwife may suggest an emergency caesarean if your cervix does not dilate fully during labour.

The operation

In the UK, most caesarean sections are performed under epidural or spinal anaesthesia, which minimises risk and means that you are awake for the delivery of your baby (see page 89). A general anaesthetic is sometimes used – particularly if the baby needs to be delivered very quickly.

If you have an epidural or spinal anaesthesia, you will not feel pain – just some tugging and pulling as your baby is delivered. A screen will be put up so that you cannot see what is being done. The doctors will talk to you and let you know what is happening.



Planned (elective) caesareans

A caesarean is 'elective' if it is planned in advance. This usually happens because your doctor or midwife thinks that labour will be dangerous for you or your baby.



It takes about 5–10 minutes to deliver the baby and the whole operation takes about 40–50 minutes. One advantage of an epidural or spinal anaesthetic is that you are awake at the moment of delivery and can see and hold your baby immediately. Your birth partner can be with you.

After a caesarean section

After a caesarean section, you will be uncomfortable and will be offered painkillers. You will usually be fitted with a catheter (a small tube that fits into your bladder) for up to 24 hours and you may be prescribed daily injections to prevent blood clots (thrombosis).

Depending on the help you have at home, you should be ready to leave hospital within two to four days.

You will be encouraged to become mobile as soon as possible, and your midwife or hospital physiotherapist will give you advice about postnatal exercises that will help you in your recovery. As soon as you can move without pain, you can drive – as long as you are able to make an emergency stop. This may be six weeks or sooner. Always check with your insurance company as they may have specific post operative conditions about how soon you can drive again.

Once a caesarean always a caesarean?

If you have your first baby by caesarean section, this does not necessarily mean that any future baby will have to be delivered in this way. Vaginal birth after a previous caesarean can and does happen. This will depend on your own particular circumstances (see page 155). Discuss your hopes and plans for any other deliveries with your doctor or midwife.

Help and support

Contact the Caesarean Support Network for information and support (see page 180).

first moments together



Breech birth

If your baby is breech, it means that it is positioned with its bottom downwards. This makes delivery more complicated. Your obstetrician and midwife will talk to you about the best and safest way for your breech baby to be born. You will be advised to have your baby in hospital.



External cephalic version

You will usually be offered the option of an external cephalic version (ECV). This is when pressure is put on your abdomen to try to turn the baby to a head down position.

Caesarean section

If an ECV doesn't work, you will probably be offered a caesarean section. This is the safest delivery method for breech babies but there is a slightly higher risk for you. See the section on caesarean sections for more information (see pages 98–99).

If you choose a caesarean delivery and then go into labour before the operation, your obstetrician will assess whether to proceed with an emergency caesarean delivery. If the baby is close to being born, it may be safer for you to have a vaginal breech birth.

TWINS, TRIPLETS OR MORE

If you are expecting twins, labour may start early because of the increased size of the uterus. It is unusual for multiple pregnancies to go beyond 38 weeks. If there are no complications in your pregnancy your doctor may offer you a planned birth earlier than 38 weeks. The timing of the planned birth depends on the number of babies and whether or not your babies share a placenta. Your doctor will discuss this with you during your pregnancy. More health professionals will usually be present at the birth. For example, there may be a midwife, an obstetrician and two paediatricians (one for each baby).

Your doctor will discuss with you what type of delivery may be appropriate. Although you are more likely to have a caesarean section in some cases twins can be delivered vaginally.

The process of labour is the same but the babies will be closely monitored. To do this, an electronic monitor and a scalp clip might be fitted on the first baby once the waters have broken (see page 87). You will be given a drip in case it is needed later, and an epidural is usually

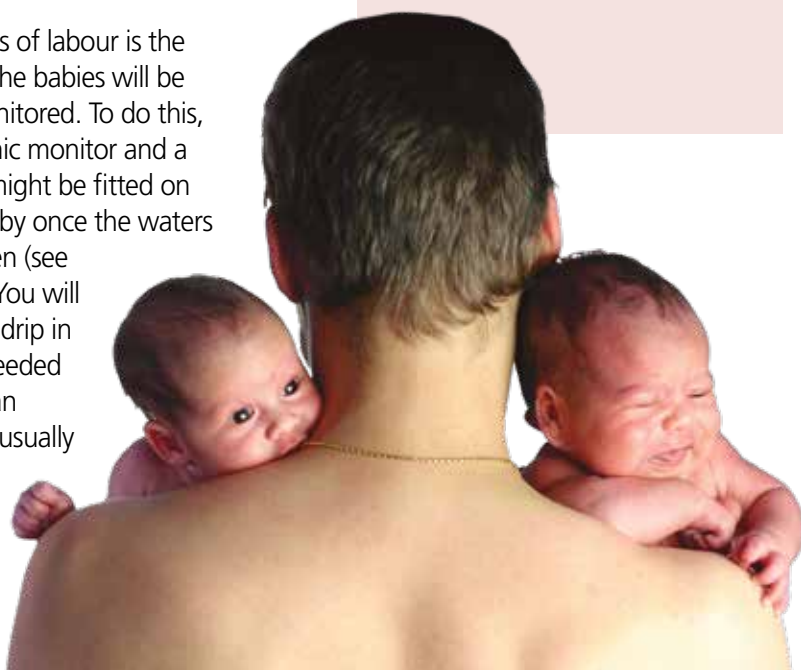
recommended. Once the first baby has been born, the midwife or doctor will check the position of the second baby by feeling your abdomen and doing a vaginal examination.

If the second baby is in a good position to be born, the waters surrounding the baby will be broken, and the second baby should be born very soon after the first because the cervix is already fully dilated. If contractions stop after the first birth, hormones will be added to the drip to restart them.

Triplets or more are almost always delivered by elective caesarean section.

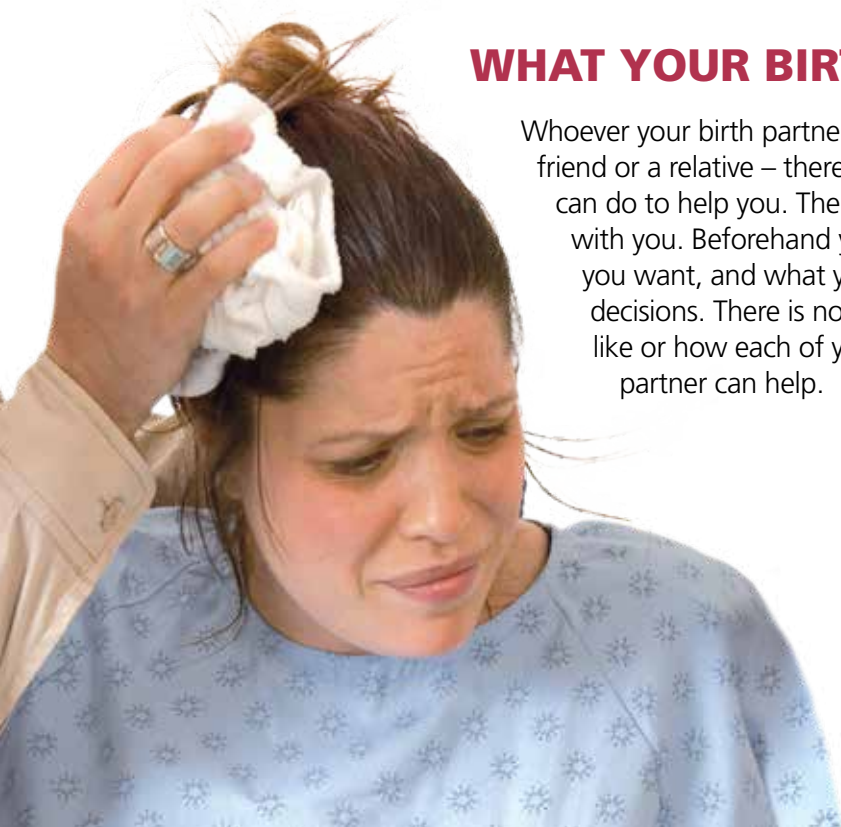
Help and support

Contact the Multiple Births Foundation (MBF) or Twins and Multiple Births Association (Tamba) for advice and support (see pages 181 and 186).



WHAT YOUR BIRTH PARTNER CAN DO

Whoever your birth partner is – your partner, your baby's father, a close friend or a relative – there are quite a few practical things that he or she can do to help you. The most important thing will probably be just being with you. Beforehand you should talk about your birth plan, what you want, and what you don't want, so that they can support your decisions. There is no way of knowing what your labour is going to be like or how each of you will cope, but there are many ways in which a partner can help.



They can:

- Keep you company and help to pass the time in the early stages.
- Hold your hand, wipe your face, give you sips of water, massage your back and shoulders
- Help you to discuss your options with the midwife or doctor. This can help you to feel much more in control of the situation.
- Tell you what is happening as your baby is being born if you cannot see what is going on for yourself.
- Help you move about or change position, or to get more comfortable.
- Encourage you as your labour progresses and your contractions get stronger.
- Remind you how to use relaxation and breathing techniques, perhaps breathing with you if it helps.
- Support your decisions about pain relief.



For many couples, being together during labour and welcoming their baby together is a wonderful experience that they will never forget.

Many partners who have seen their baby born and who have played a part themselves say they feel much closer to the child from the very start.

