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Labour and birth

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, such as an 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, for example books, magazines, music.
- 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 your baby home.
- Green MHHR. Birth preferences.
- Any other letters or test results.



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.

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.



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.

- 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 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
- **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.**

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.

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 preferences, 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 preferences to record what you would like to happen in labour.

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 keep your energy levels up. You can also have a 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.





have agreed what you will do when labour starts.

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

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

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.





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 birth preferences, show your midwife so that she knows what kind of labour you want and can help you to achieve it.

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.


Pain relief


Option	Pros	Cons
Position and movement	<ul style="list-style-type: none"> • Maximises your body's ability to give birth. • No lasting side-effects for you or your baby. 	<ul style="list-style-type: none"> • Try not to overdo it; saving energy is also important. Lying on your side for a while or sitting up supported by lots of pillows can help your body to work really well while you conserve energy.


Option	Pros	Cons
Water and birthing pools 	<ul style="list-style-type: none"> • Water soothes pain and, in a large birthing pool, supports you, enabling you to glide into any position. • You can combine it with other options, such as Entonox (gas and air) and massage. • Women who labour in water need fewer interventions and are less likely to need other drugs. • No lasting side-effects. 	<ul style="list-style-type: none"> • Water can sometimes slow down labour, particularly if you get in too early. • You won't be able to use TENS (see below), injectable drugs or an epidural while you're in water. • Birthing pools might not be available or an option everywhere.

Option	Pros	Cons
TENS A TENS (Transcutaneous Electrical Nerve Stimulation) machine transmits mild electrical impulses to pads on your back. These block pain signals and help your body to produce endorphins.	<ul style="list-style-type: none"> • You can keep moving and it won't directly interfere with your labour. • You can use it for as long as you want. • There are no lasting side-effects for you or your baby. • It doesn't need an anaesthetist, doctor or midwife. • It can be used at a home birth and in hospital. 	<ul style="list-style-type: none"> • You'll probably need someone to help you to position the pads. • It may only help in the early stages of labour. • It may have to be removed if your baby's heart has to be monitored electronically. • You can use TENS before you get into water, but not when you're in the water. • It might make it more difficult for your birth partner to massage your back. • The clinical evidence in support of TENS is lacking though many women say that it helped them.

Option	Pros	Cons
Complementary therapies (including acupuncture, aromatherapy, reflexology, yoga, self-hypnosis and massage).	<ul style="list-style-type: none"> • Some studies show acupuncture is helpful. • Massage or pressure on the lower part of your back can help reduce levels of stress and ease discomfort, too. • You can learn self-hypnosis techniques for labour by attending a course or using CDs; you don't have to have a hypnotherapist with you in labour. 	<ul style="list-style-type: none"> • There is little research proving the effectiveness of these treatments though lots of women say that they found these techniques useful. • Apart from massage and self-hypnosis, you will need a registered practitioner to perform the therapies.

Option	Pros	Cons
<p>Gas and air (Entonox)</p> 	<ul style="list-style-type: none"> You can control it and the effects wear off very quickly once you stop inhaling. It's fast-acting (taking effect after 20 to 30 seconds). Your baby doesn't require extra monitoring while you're using it. You can use it in a birthing pool. It should be available wherever you give birth, including birth centres and at home. 	<ul style="list-style-type: none"> It may make you feel sick and light-headed initially but the nausea usually passes. It can dry your mouth out if you use it for long periods. Keeping hold of the mask or mouthpiece may stop you from moving around and getting into a comfortable position. It can take a few contractions to get the hang of it so that it's effective at the peak of contractions. If used with pethidine or diamorphine, it may make you feel even drowsier.

Option	Pros	Cons
<p>Painkilling drugs in labour Opioids such as diamorphine and remifentanyl are pain relieving drugs given by injection into the thigh. Some hospitals offer remifentanyl, which is a very strong, short-acting painkiller given via a drip that you can control yourself using a machine.</p> 	<ul style="list-style-type: none"> Opioids may help you to relax and get some rest; especially if your early labour has been long and uncomfortable. Diamorphine can be given by a midwife, so there's no need to wait for a doctor although they may have to prescribe the drug. Remifentanyl infusions are set up by an anaesthetist. These drugs don't appear to slow labour down, if you're already in established labour. They may help you to postpone or avoid having an epidural if you're finding your contractions hard to cope with. Not all opioids are available at a home birth so talk to your midwife about what you could have if you're planning to give birth at home. In some areas, drugs like these are prescribed in advance by a GP. Remifentanyl is not available at home or in a birth centre. It is possible to still use a birth pool or bath during labour, but not usually within two hours of a single dose of an opioid, or if you feel drowsy. Protocols vary so it's good to check with your midwife if you are considering using a painkilling drug in labour. 	<ul style="list-style-type: none"> Once you've had an injection of an opioid the effects last for up to four hours, so if you don't like the sensation you can't do anything about it. For instance, it may make you feel out of control, and feel sick. (This is not the case with remifentanyl, as the drip can be turned off and the effects fade away). All opioids pass through to a baby and can occasionally make them slower to breathe at birth. This is particularly true if your labour progresses more quickly than expected and your baby is born within two hours of you having the drug. (Effects on babies are less likely with a remifentanyl infusion than they are with other opioids because remifentanyl is active in the body for a much shorter amount of time.) Your baby may also stay sleepy for several days, making breastfeeding harder to establish.

Option	Pros	Cons
<p>Epidural</p> <p>Epidural analgesia is a local anaesthetic injected through a tube into the space between two vertebra in your back. It usually removes all pain and most feeling from the waist down. The combined spinal epidural (CSE) injection contains a low dose of pain-relieving drugs and works more quickly than an epidural alone. At the same time, the anaesthetist will insert a catheter into your bladder. When the CSE injection starts to wear off, your anaesthetist will pass the epidural solution through the tube to give ongoing pain relief.</p> 	<ul style="list-style-type: none"> • It gives total pain relief in 90% of cases; partial pain relief in the remainder. • Top-ups can usually be given by an experienced midwife once the epidural is in place so you don't need to wait for an anaesthetist. • You may still be aware of your contractions, and have a clear mind, but you'll feel no pain. 	<ul style="list-style-type: none"> • Epidurals are only available in obstetrician-led maternity units. • Labour may slow down as you'll be less able to move around. • It takes about 20 minutes to insert and set up and another 20 minutes to work once injected. • You may not feel contractions or – later on – the baby moving down so there is an increased chance of needing forceps or suction (ventouse) to help the baby out. • Having an epidural will mean increased monitoring for mum and baby. • A catheter might need to be inserted to empty the bladder (as you won't feel when you need to wee) and you may need a drip to help if your blood pressure drops. • Some low-dose (mobile) epidurals now contain less anaesthetic but include a small amount of fentanyl, an opioid drug. The fentanyl makes the epidural really effective without taking away all of your mobility but the fentanyl might cross the placenta and make the baby sleepy. It's hard to say how much of a problem this is but there have been studies showing different feeding behaviours in babies born after low-dose epidurals were used.

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.

- 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.

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.

She will tell you to try not to push until your cervix is fully open and the baby's head can be seen. 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.

Find a position

Find a position that you prefer. You can 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 if 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 your baby's breathing and heartbeat;
- release your 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.

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'. About one early baby in six is induced and about one early baby in five is delivered by caesarean section (see page 114).

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 can be started mechanically. A catheter with a balloon at the tip is inserted through the cervix. The balloon is filled with a sterile fluid and puts gentle pressure on the cervix to soften and open it. 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 vaginal delivery

What is an assisted vaginal delivery?

An assisted vaginal delivery involves using a ventouse (vacuum cup) or forceps (like large tongs) to guide your baby as you push with your contractions.

Your doctor may recommend that you have an assisted vaginal delivery if your baby needs to be delivered quickly.

This document will give you information about the benefits and risks to help you to make an informed decision. If you have any questions that this document does not answer, ask your obstetrician or the healthcare team.

Why may I need an assisted vaginal delivery?

The following are the more common reasons why an assisted vaginal delivery may be recommended.

- You have been pushing for too long.
- You may have run out of energy to deliver your baby safely.

- Your baby's heart rate may be going above or below normal levels or they may not be getting enough oxygen.

Sometimes, if you have high blood pressure, your obstetrician may recommend an assisted vaginal delivery if the second stage of labour goes beyond a certain time and your blood pressure goes higher.

On average, 10 to 15 in 100 deliveries are assisted vaginal deliveries. You are more likely to need an assisted vaginal delivery for your first baby. Your obstetrician will discuss with you why an assisted vaginal delivery is the safest method of delivery for both you and your baby.



Are there any alternatives to an assisted vaginal delivery?

You can continue pushing and try to deliver your baby without a ventouse or forceps.

Another option is to have a caesarean section (procedure to deliver a baby by a surgical operation).

If you are worried or have any questions about why an assisted vaginal delivery has been recommended for you, you should discuss this carefully with your obstetrician.

What does an assisted vaginal delivery involve?

Before the procedure

Your obstetrician will examine your abdomen to find out how large your baby is. They will perform an internal examination to check the position of your baby and how dilated your cervix is. Your obstetrician will also want to check that your pelvis is large enough for an assisted vaginal delivery.

If you are already having an epidural and there is enough time, you will be given more anaesthetic through the epidural. Otherwise, local anaesthetic may be injected either into the skin at the opening of your vagina or through your vagina to block the pudendal nerve that supplies your lower vagina and perineum (the area between your vagina

and back passage).

You may need to have a spinal, which involves injecting anaesthetic into the subarachnoid space (an area near your spinal cord).

Your legs will be put in 'stirrups' (the lithotomy position).

Your obstetrician may place a catheter (tube) in your bladder to help you to pass urine.

Forceps delivery

Your obstetrician will place metal forceps either side of your baby's head. When the forceps are in position, your obstetrician will hold them together.

If your baby's head is not facing towards your spine, your obstetrician will need to turn the head using the forceps.

They will pull gently as you push with your contractions to guide your baby's head out. This can take several pulls and usually involves an episiotomy to help reduce the risk of you tearing.

Ventouse delivery

Your obstetrician will place the ventouse cup onto your baby's head. The cup may be attached to a special vacuum machine or to a hand-held suction pump that creates a vacuum seal between the cup and your baby's head.

Your obstetrician will make sure that none of your vaginal skin is caught in the vacuum seal.

Your obstetrician will guide your baby out, as you push with your contractions. This can take several pulls and you may need an episiotomy.

Listen carefully to your obstetrician and midwife during the delivery so you know when to push and when to pant.

Once your baby's head is delivered, your obstetrician will remove the forceps or ventouse from your baby's head and your baby will be delivered onto your abdomen, 'skin-to-skin'. Once the cord has been cut, your baby will be covered to keep them warm.

Your obstetrician will close an episiotomy or any tears with dissolvable stitches.

What complications can happen?

The healthcare team will try to make the procedure as safe as possible but complications can happen. The possible complications of an assisted vaginal delivery are listed below. Any numbers which relate to risk are from studies of women who have had this procedure. Your doctor may be able to tell you if the risk of a complication is higher or lower for you.

- Pain, once the local anaesthetic or epidural wears off. You will usually be given a painkilling



suppository (tablet placed in your back passage) to keep you comfortable. You may get pain in your abdomen or, more usually, around the stitches. However, an episiotomy or any tears usually heal quickly and if any pain continues it can be controlled with simple painkillers such as paracetamol.

- Bleeding. On average, women lose less than half a litre of blood. You may be given medication through a drip (small tube) in a vein in your arm or by an injection to help your uterus (womb) to contract. This will help to reduce any bleeding. If you bleed heavily, you may need a blood transfusion. You may need to take iron tablets.
- Tears (risk of a major tear: 1 in 5 for forceps delivery, 1 in 10 for ventouse delivery). Minor tears are common. Tears are closed with stitches.
- Damage to your back passage caused when a major tear or episiotomy extends to the muscle around your anus or to your anus itself (risk: less than 3 in 100 for a ventouse, less than 7 in 100 for forceps).
- Healing problems. Sometimes an episiotomy or tear will open slightly. However, this usually does not need any treatment and still heals well.
- Difficulty passing urine. You may need a catheter for one to two days.
- Infection. This is easily treated with antibiotics.
- Marks and bruises on your baby (risk of serious damage: less than 2 in 1,000). A ventouse can leave a suction mark and the forceps can bruise your baby's face. These do not usually cause any problems and settle in one to two days. Sometimes a ventouse can bruise one of the bones of your baby's skull (risk 1 to 2 in 100). This does not cause any problems and gets better within a few weeks. A paediatrician (doctor who specialises in babies and children) will be present at the birth if they are needed.
- Shoulder dystocia, where your baby's shoulders get

stuck for a short while on the way out (risk: 1 in 50, compared to 1 in 100 for normal deliveries).

- Your baby having jaundice (they eyes and skin turning yellow) (risk: 5 to 15 in 100) and having bloodshot eyes (risk: 17 to 38 in 100) after birth. This is only a small increase compared to normal deliveries and does not cause any long-term problems.
- You should discuss these possible complications with your doctor if there is anything you do not understand.

How soon will I recover?

In hospital

You will stay in the delivery room for one to two hours while all the routine checks on your baby are carried out. You will then be transferred to the ward.

The midwives will give you advice about your postnatal care, including how to look after your stitches. The healthcare team will tell you about abdominal and pelvic-floor exercises to help you to recover.

You will be able to go home when you can walk around without any help and are able to care for your baby. If you go home the same day, a responsible adult should take you home in a car or taxi and



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

Emergency caesarean section

Your obstetrician can recommend an emergency caesarean section to deliver your baby safely. However, it is your decision to go ahead with the operation or not.

They will give you information about the benefits and risks to help you to make an informed decision. Ask your obstetrician, anaesthetist or midwife if there is anything you do not understand.

stay with you for at least 24 hours. Be near a telephone in case of an emergency.

Do not drive, operate machinery or do any potentially dangerous activities (this includes cooking) for at least 24 hours and not until you have fully recovered feeling, movement and co-ordination. If you had a general anaesthetic or sedation, you should also not sign legal documents or drink alcohol for at least 24 hours.

If you are worried about anything, in hospital or at home, contact the healthcare team. They should be able to reassure you or identify and treat any complications.

Returning to normal activities

The healthcare team will tell you when you can return to normal activities. It is important to have plenty of help at home in the first few days so that you have time to recover and to spend with your new baby.

An episiotomy or any tears should heal quickly. If you have any concerns, ask your midwife

when they visit you at home, or contact your GP.

The future

You should make a full recovery. An assisted vaginal delivery should not affect your ability to become pregnant or deliver a baby in the future.

Summary

An assisted vaginal delivery is a common procedure and is usually a safe method of delivery for you and your baby.

However, complications can happen. You need to know about them to help you to make an informed decision about the procedure. Knowing about them will help to detect and treat any problems early.

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

What does the operation involve?

A caesarean section can usually be performed under a spinal or epidural anaesthetic. You will be awake so you can see your baby and have 'skin-to-skin' contact as soon as your baby is born. Your birth partner will also be able to be with you. However, this will not be possible if you need a general anaesthetic.

Your obstetrician will make a horizontal cut on your 'bikini' line. They will separate the muscles of your abdominal wall and open your uterus (womb). They will deliver your baby through the cut and repair your womb and abdomen.

A midwife will be with you and a paediatrician (doctor who specialises in babies and children) may also attend to your baby when it is born.

What complications can happen?

A caesarean section is usually safe and your obstetrician believes it is the safest way to deliver your baby. However, complications can happen. Some of these can be serious and can even cause death.

Complications of anaesthesia

Your anaesthetist will be able to discuss with you the possible complications of having an anaesthetic.

What complications can happen?

- Pain. The healthcare team will make sure you are given enough pain relief.
- Bleeding during or after the operation. If you bleed heavily (risk: less than 8 in 100), you may need a blood transfusion.
- Blood clots in your legs (deep-vein thrombosis – DVT) (risk: 7 in 1,000) or, more rarely, in your lungs (pulmonary embolism). The healthcare team will take measures to reduce this risk.
- Infection of the surgical site (wound) or in your womb (endometritis), which usually settles with antibiotics.
- Developing a hernia in the scar caused by the deep muscle layers failing to heal.
- Bladder damage. The risk is higher if you have had previous caesarean sections.
- Small scratch on your baby's skin, when your obstetrician makes the cut on your womb. Sometimes the scratch can be on your baby's face (risk: 2 in 100). This usually does not need any treatment.
- Breathing difficulties for your baby, where your baby takes longer than normal to clear the fluid from their lungs (risk: 6 in 1,000).





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

How soon will I recover?

You should be able to go home after one to three days. However, your doctor may recommend that you stay a little longer.

If you are worried about anything, in hospital or at home, contact the healthcare team. They should be able to reassure you or identify and treat any complications.

It is important to have plenty of help at home in the first few days so that you have time to recover and to spend with your new baby.

For the first two weeks do little other than care for your baby. You can then gradually increase the amount you do. Bleeding usually lasts for 2 to 4 weeks. Use sanitary pads rather than tampons.

Do not lift anything heavy or do strenuous exercise, such as vacuuming or ironing, for 6 weeks. Do not push, pull or carry anything heavier than your baby during this time.

Do not have sex until you feel comfortable.

Most women take at least three months to recover. You should wait until you are physically and emotionally ready before trying for another baby.

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. 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

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 116). Discuss your hopes and plans for any other deliveries with your doctor or midwife.

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.

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. 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.

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

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 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.
- 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.

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.