

Medical Interventions & Caesarean Birth



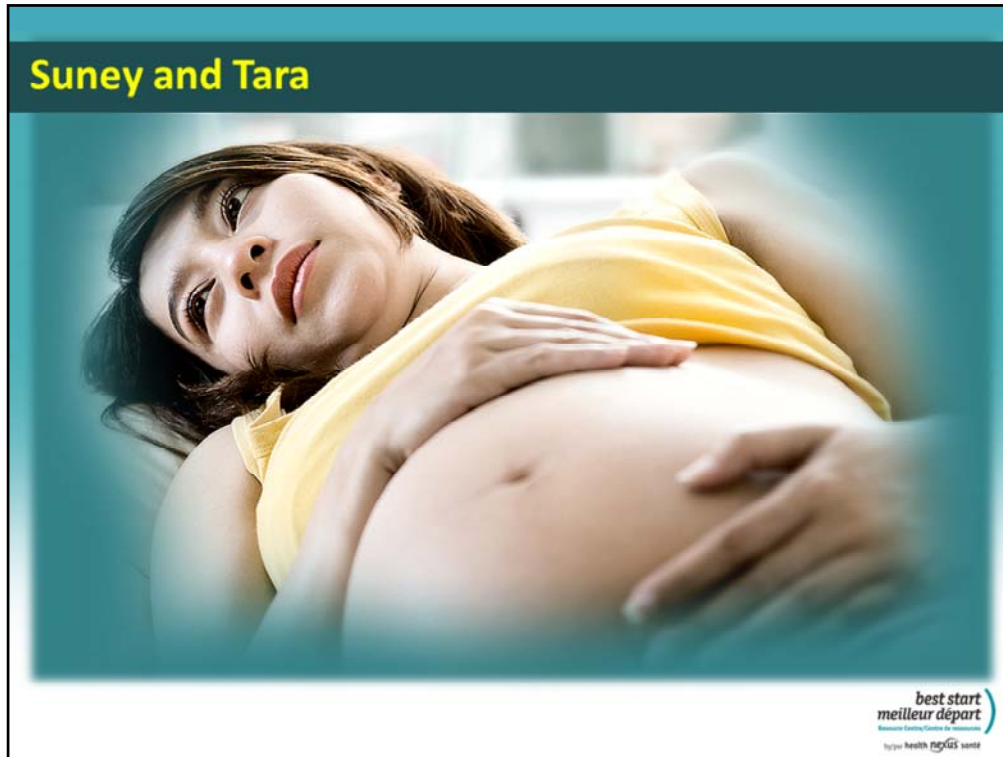
NOTE: Refer to module outline for goal, objectives, class outline, equipment, resources required and references.

If this is the first class:

- Welcome participants to class.
- Housekeeping: bathroom, breaks, length of session, ground rules/respect.
- Have each couple or individual pair up with another couple or individual and introduce themselves to each other. (Consider including name, due date, HCP, something they are looking forward to, something they are nervous about and/or anything they would like to share about the pregnancy). Then have the pairs or individuals introduce each other to the rest of the group.
- Provide the choice of prenatal handout (depending on your organization, this may be *Healthy Beginnings* or *A Healthy Start for Baby and Me*) for each expectant mother.
- Provide a list of community resources.
- It is best to advise participants during the first session that you have a duty to report any concerns about the safety or well-being of a child (including the witnessing of abuse of the mother) to child protective services. (This is only applicable if there are children in the home already.)

Suggestions for Facilitator: On a flip chart, list the topics to be discussed in this session:

- Informed decision making and consent
- Common assessments
- Induction and augmentation of labour
- Pain medications: analgesics, nitrous oxide, epidural
- Assisted birth
- Caesarean birth
- Birth plans



Read story:

Suney has been in active labour for more than eight hours and has not progressed past 6 cm dilation. During this time, she has assumed different labour positions such as walking, sitting on a birthing ball, and forward leaning on hands and knees to encourage dilation. Her labour partner Tara has helped Suney by giving her back massages, offering her ice chips, and advocating her birth plan preferences to the staff. To assist with labour progress, her health care provider recommends rupturing her membranes. Even though her contractions increased in intensity, her cervix remains unchanged. Suney and Tara review their birth plan with their health care provider and discuss options to encourage labour progress. An intravenous oxytocin drip is started and the contractions and the baby's well-being are assessed using continuous external electronic fetal monitoring. Their health care provider reviews the benefits and risks to having an epidural. As Suney's contractions become more difficult to manage, she makes an informed decision, with her partner's support, that an epidural would be a good choice for pain management.

Points to highlight:

- Positions used to encourage progression of labour.
- Has a supportive birth partner who advocates on Suney's behalf.
- Use the birth plan throughout the labour.
- Each intervention, including benefits, risks and alternatives, are discussed with the health care provider.
- Suney makes informed decisions about interventions.

A variety of assessments offered during labour and birth are common and considered to be a routine part of your care. They are offered to ensure the well-being of you and your baby and to assess how your labour is progressing.

Medical interventions may arise out of necessity because of an issue due to the pregnancy or the progress of labour. They are not "routinely done".

Informed Decision Making and Consent

- B - Benefits
- R - Risks
- A - Alternatives
- I - Intuition
- N – No/Not right now



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Speaker's Notes:

Understanding why assessments and interventions may be needed during your labour and birth can help you make decisions that are best for you and your baby.

If your health care provider suggests medical interventions, it may be helpful to use the acronym BRAIN when asking questions (use your BRAIN when making a decision):

- **B** - What are the **b**enefits?
- **R** - What are the risks?
- **A** - Are there any **a**lternatives?
- **I** - What is your **i**ntuition or **i**nnner voice telling you?
- **N** - What if you say **n**o or **n**ot right now?

Informed consent occurs when the pregnant woman understands the nature of the procedure, risks, benefits, alternatives, possible complications, and she has the opportunity to ask questions. It also includes the right to informed refusal. Without this right, informed consent would not exist.

Common Assessments During Labour

Assessment of:

- Vital signs
- Baby's heart rate
- Contractions
- Dilation of cervix



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Speaker's notes:


Some common assessments during labour include:

- Regular checks of your temperature, blood pressure, heart rate, and breathing rate.
- Regular checks of your baby's heart rate.
- Regular checks of the strength, length, and frequency of your contractions.
- Vaginal examinations of your cervix as needed to assess progress and make decisions regarding care.


Some additional assessments and interventions may be needed. Note that these will be discussed in more detail in the upcoming slides.

- A sample of blood may be taken.
- You may need an IV (intravenous) line.
- You may need continuous monitoring of your baby's heart rate.
- You may need medical ways to help your labour start.
- You may need medical ways to help your labour progress.
- You may need medical ways to help you give birth to your baby.
- You may need help to birth your placenta.

Listening to Baby's Heartbeat



- Intermittent monitoring using a handheld ultrasound
- Continuous monitoring using an Electronic Fetal Monitor


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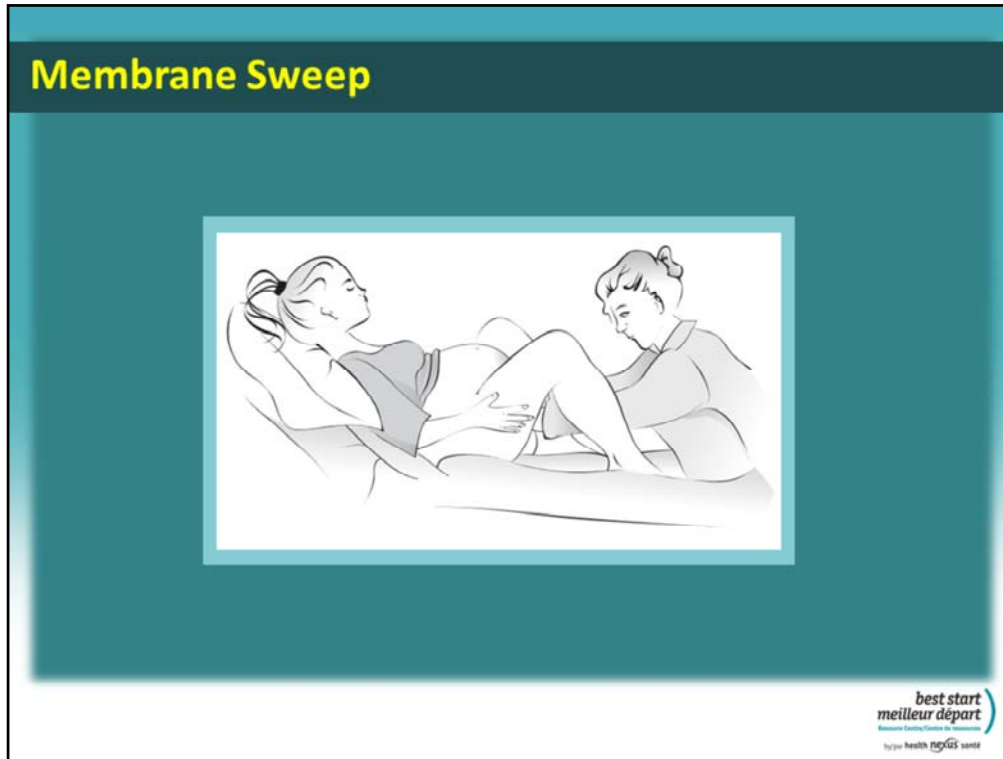
Speaker's Notes:

Monitoring the baby's heart rate is one way to determine baby's well-being during labour and birth. Intermittent monitoring done using a Doppler, a handheld ultrasound device, is the best practice for low-risk pregnancies. You can expect the fetal heart rate to be assessed:

- Every hour during the early phase of labour or if any change occurs in labour, such as the rupture of membranes.
- Every 15 to 30 minutes in active labour and the transition phase.
- Every five minutes during pushing in the second stage of labour.
- If there is a concern for you or your baby, are receiving intravenous oxytocin, or have other circumstance such as a previous cesarean birth, continuous monitoring of the baby's heart rate may be required because this intervention can have an impact on the baby's well being. This is done with a continuous electronic fetal monitor (EFM)
- With continuous external EFM, soft belts will hold two small, flat monitors in separate places on your abdomen. One monitor will record your baby's heart rate, and the other one will record when you have a contraction. When your baby's heart rate is being monitored this way, your ability to walk around may be limited unless your hospital has a wireless monitoring system.
- EFM is used to determine how the baby is responding to labour. The normal range for a baby's heart rate is between 110-160 beats per minute. The heart rate varies depending on your labour positions, contractions, medications, and other factors.
- If it is hard to monitor your baby's heart rate with an external monitor, an internal monitor may be used. A small probe will be placed inside your vagina and attached to the top of your baby's head to do this. Rarely, uterine contractions are monitored internally with a small catheter that accurately measures the pressure changes in the uterus during contractions. In order to use internal fetal monitoring, your membranes will need to be ruptured if they are not already. *(Note: This would be a good place to discuss the cascade of interventions and why each informed decision is important. Also important to know how that specific intervention may impact need for future interventions.)*

Encourage class participants to ask their health care provider or hospital/birthing centre staff the following questions:

- How often is EFM done? EFM can take about 30 minutes or can be for the entire length of the labour (e.g. if the woman is on intravenous oxytocin).
- Can I walk or be out of bed during the assessment (wireless/telemetry EFM)?
- Can it be removed to allow for other comfort measures to be used such as a bath, shower, or massage?



Speaker's Notes:

Sweeping the membranes

Around the time of your expected due date, to help your labour to start and to possibly prevent an induction, your health care provider may offer to do a membrane sweep during a vaginal examination. A membrane sweep involves your health care provider using a gloved finger to separate the amniotic sac away from the wall of the lower part of your uterus. This can cause your body to release hormones that can cause your labour to begin.

A membrane sweep is safe, but may cause:

- Discomfort and pain.
- Bleeding.
- Accidental rupture of membranes.

A membrane sweep can be repeated after a few days if your labour does not begin.


Clarify that this is a medical intervention to induce labour and there should be an informed consent discussion before this is done about the benefits and risks.

Home remedies to help labour begin may not be safe for you or your baby. Check with your health care provider first before trying a home remedy.

Induction of Labour



- Cervical ripening
- Intravenous oxytocin
- Amniotomy



Speaker's Notes:

Induction of labour is the process of medically starting your labour. If you do not go into labour on your own by 41 weeks or if there is a concern about you or your baby, your health care provider may recommend inducing your labour. If you choose to wait for labour to begin naturally, your health care provider will recommend increased monitoring of your baby's well-being. An induction will be needed if monitoring suggests your baby is no longer thriving.

If your cervix is not ready for labour and needs to be softened, your health care provider can do this by:

- Inserting a soft, flexible (Foley) catheter through your cervix into the lower part of your uterus and inflating a small balloon with saline fluid. This puts pressure on the cervix to release hormones.
- Inserting a prostaglandin medicated fabric ribbon such as Cervidil into your vagina.
- Inserting prostaglandin gel into your vagina.
- Giving you oral prostaglandin tablets called misoprostol.

With any of the prostaglandin methods, you may start to feel labour contractions within hours. If not, it may need to be repeated a few times before your labour begins. Learn about the signs to call or return to your birth setting if you leave for a period of time after any of these interventions.

If your cervix is ready for labour, your health care provider can induce your labour:

- If your cervix isn't open enough to break your water, by giving you oxytocin medication via an IV pump in very small, gradually increasing amounts.
- By breaking your water (called an amniotomy) with a plastic hook and encouraging you to walk for four hours. If your contractions haven't begun after this time, then giving you oxytocin medication.

Improving Labour Progress

- Urinate often
- Walk
- Change position often



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Speaker's Notes:

Your health care provider may suggest ways to improve your labour progress. Natural ways to help your labour progress include:

- Urinating often.
- Walking.
- Changing your position often.

Medical ways to help your labour progress (augmentation) are similar to methods of labour induction and include:

- If your cervix isn't open enough to break your water, giving you oxytocin medication via an IV pump in small, gradually increasing amounts.
- Breaking your water for you, called an amniotomy, and encouraging you to walk for four hours. If your contractions haven't begun after this time, then giving you oxytocin medication.

Intravenous Infusion

Used for:

- Medication delivery
- Epidural
- Rehydration



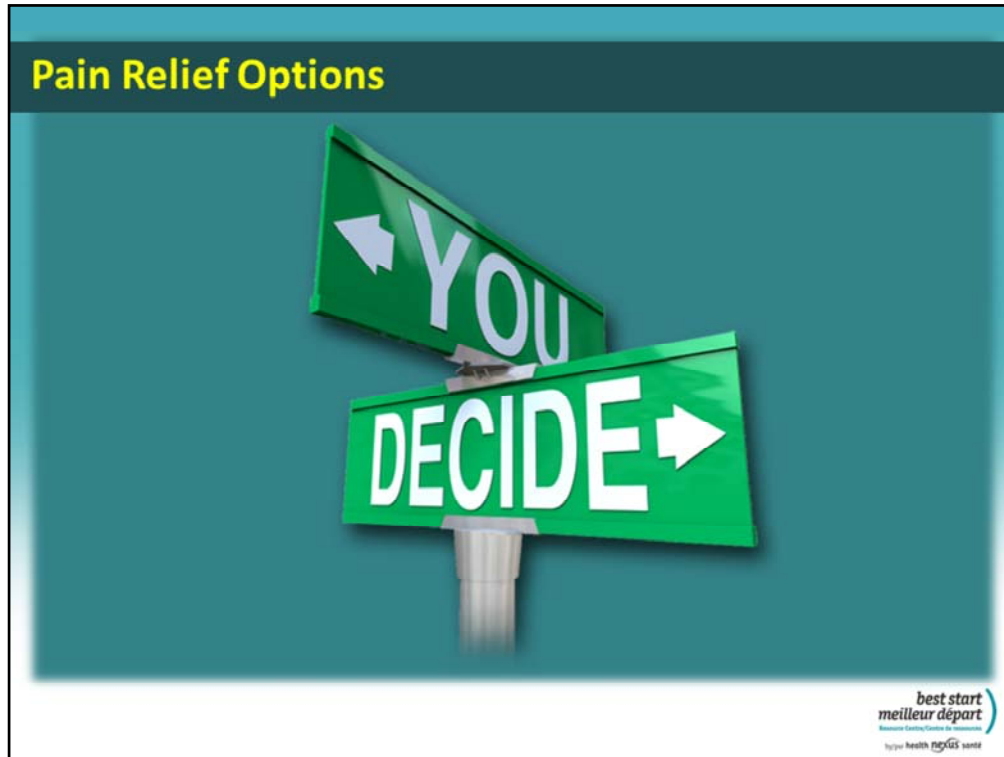
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Speaker's Notes:

Intravenous infusion (IV or IV line)

IV's are used when medically necessary. You may need an IV line during labour if you:

- Are Group B Streptococcus (GBS) positive so that you can receive antibiotics. You can request a saline lock, if IV antibiotics are the only reason for the IV line. A saline lock allows you to freely move during your labour as well as prevents you from receiving unnecessary fluids from the IV.
- Desire certain pain medications such as an epidural.
- Need oxytocin medication to assist with your labour progress.
- Are unable to drink fluids because you feel nausea and/or are vomiting excessively.
- Depending on your other circumstances in your pregnancy.



Speaker's Notes:

Sometimes labour pain is difficult to manage despite using numerous comfort measures. There are several medication alternatives for managing pain during labour and birth, although not all options may be available in every birth setting. It is important that the pregnant woman discuss pain relief choices and any preferences with her health care provider and her support person before labour begins. Labour is an unpredictable process and there is no way of knowing how her experience will unfold. However, if the pregnant woman is aware of the benefits, risks and alternatives of each option, she will be better prepared and empowered to make informed decisions to manage her labour as it progresses.

Remind participants of the BRAIN acronym. Other questions to ask their health care provider when considering pain medication may include:

- What is the medication and how is it given?
- What are the risks for me and my baby?
- How quickly will it work and how long does it last?
- Will I be able to walk around or be confined to bed?
- What are the effects on breastfeeding?
- What other procedures might be done along with the pain option chosen?

Many women are surprised to know that if they ask for an epidural, they will automatically get bloodwork drawn and an intravenous, they may also be given oxytocin, and have continuous electronic fetal monitoring.

Pain Relief Options

- Non-opioid analgesics
- Opioid analgesics
- Anesthetics




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Speaker's notes:

Pain medications used in labour can be divided into several categories:

- Non-opioid analgesics, which can provide mild-to-moderate pain relief. They are usually taken orally.
- Opioid analgesics, which can provide moderate-to-strong pain relief. They can be given by injection or intravenously.
- Anesthetics, which can provide a range of pain relief including almost complete pain relief. Nitrous oxide (i.e., laughing gas), epidurals, and pudendal nerve blocks are examples of anesthetics.

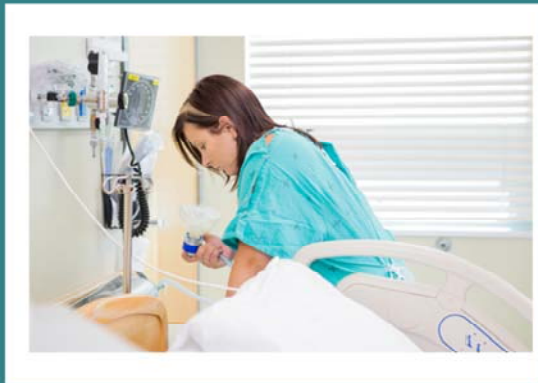
Pain medications have risks and side effects. Learn about the risks and side effects of any medication you are considering. Some risks and side effects might include:

- Nausea and/or vomiting.
- Dizziness and/or weakness.
- Decreased ability to walk and/or change positions.
- Itchiness.
- Headaches.
- Concerns for the baby during labour or at birth.
- Increased risk of assisted vaginal birth.

Note that all these risks and side effects do not apply to each medications.

If you are close to giving birth, the type of pain medication you can safely have may change. You and your baby will be monitored more closely if you use pain medication in labour.

Nitrous Oxide



- Self-administered
- Only used during contractions
- Often used during transition, early pushing or while waiting for other pain relief

Speaker's notes:

- Nitrous Oxide, commonly known as laughing gas, is made up of 50% nitrous oxide and 50% oxygen.
- This medication is usually offered during transition and early pushing stages or while the labouring woman is waiting for alternative pain relief such as an epidural.
- The labouring woman self-administers this medication by inhaling it through a mask when her contraction begins.
- She continues to breathe in and out with the mask until the peak of her contraction ends.
- It takes about one minute for the effects to clear.
- It crosses the placenta, but it is eliminated fairly quickly from fetal circulation in comparison to narcotics.
- It is not used in between contractions.
- Nitrous oxide provides short term relief by taking the 'edge' off the pain and helping the labouring woman to relax.
- Side effects from this medication may include: nausea, dizziness, sleepiness and rapid breathing. Since it is self-administered, the labouring woman can stop the medication at any time.
- It is not available in every hospital as it requires special ventilation systems.

Epidurals and Spinals - Description

- Provide temporary pain relief
- Block sensation to uterus, abdominal area and lower back
- Can be used during labour and for Caesarean birth



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Speaker's notes:

- Epidural or spinal anaesthesia are done to relieve pain temporarily.
- They work by blocking the set of nerves responsible for sensation to the uterus, abdominal area, and lower back (possibly from the chest to the toes), thereby reducing or eliminating labour pain.
- Only an anesthesiologist or other health care provider specifically trained in this technique may perform an epidural or spinal.
- When the medication is delivered into the *epidural space* in the spine, it is called an **epidural** anaesthetic.
- When the medication is delivered directly into the fluid that surrounds the spinal cord (cerebrospinal fluid), it is called a **spinal** anaesthetic. A spinal is **usually** done for a Caesarean birth (not always).

Epidurals and Spinals - Procedure




- IV needed
- Lie on side or sit with back curved outward
- Area numbed with local anesthetic
- Test dose followed by full dose
- Best when connected to pump for continuous infusion

Speaker's notes:

- The procedure for epidural and spinals is similar except for the placement of the catheter, the medication combination, and the dosage.
- The fetal heart rate is checked prior to the initiation of an epidural to ensure that it is normal.
- An intravenous is started to provide extra fluids to compensate for the drop in blood pressure that occurs from the anaesthetic.
- The support person may be able to stay, but will need to wear a hat and mask.
- The pregnant woman is asked to lie on her side or sit upright with her lower back curved outward.
- The anaesthesiologist cleans the lower back with an antiseptic and injects a small amount of local anaesthetic to numb the area. This usually stings.
- The epidural or spinal needle will be inserted between contractions. A woman typically feels only pressure when this done. The insertion may need to be done more than once to find the correct space.
- After inserting the catheter (through the needle) in the epidural space, a test dose of the medication is given to ensure there are no adverse effects, followed by a full dose. There is no catheter inserted for spinals, so this test dose is given directly via the needle.
- The needle is removed, and the catheter is taped to the woman's back and shoulder and an external fetal monitor will be used to assess the baby's well-being.
- Epidural catheters are usually connected to a pump that can provide continuous infusion. Tingling and numbing occurs within minutes and effects last until the medication is allowed to wear off. The dose is usually enough for the woman to feel pressure but not pain at the beginning of the second stage of labour. If a Caesarean birth is required, the dose is increased.
- Spinal anaesthesia is a single injection (used for Caesarean birth) that lasts for several hours and has a higher level of anaesthetic block than the epidural.
- At times a combined spinal-epidural (CSE) is considered to provide both rapid pain relief (spinal) and continuous relief (epidural). A CSE can be referred to as a "walking epidural." Not all women with a CSE are able to walk. If a woman wants to walk and hospital policy permits it, she should first perform a step-test to ensure that she is able to walk steadily.

Epidurals and Spinals - Benefits and Risks

<h3>Benefits</h3> <ul style="list-style-type: none"> • Most effective method of pain relief • Allows the labouring woman to rest • Allows her to be awake and alert • Less risk of side effects for baby compared to narcotics 	<h3>Risks/Side Effects</h3> <ul style="list-style-type: none"> • Possible effects on the baby • Breastfeeding challenges • Decrease in blood pressure, possibly decreasing fetal heart rate • Limited mobility • Incomplete pain relief • Headache • Shivering • Slowed labour • Decreased ability to effectively push • Etc.
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Speaker's notes:

The pregnant women should discuss benefits, risks and contraindications of having an epidural with her health care provider prior to labour starting.

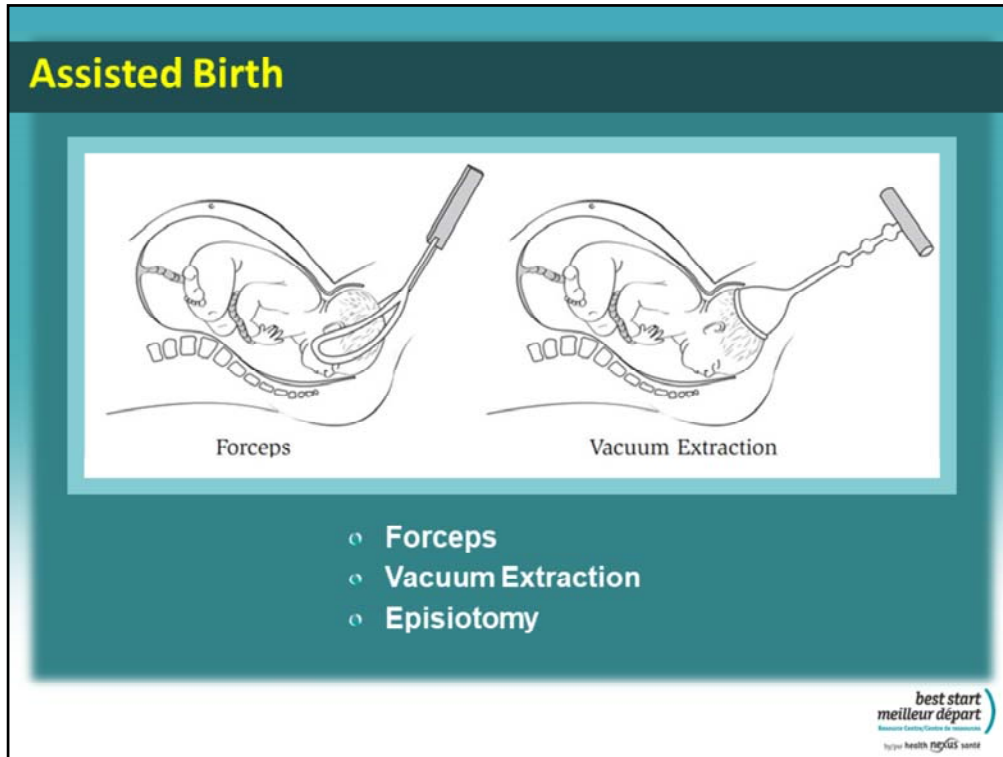
Benefits

- For many women, they offer significant pain relief.
- Epidurals allow the labouring woman to be awake, alert and able to rest.
- The baby is at less risk of respiratory depression at birth as compared to systemic narcotics.

Risks

- Epidurals can have effects on the baby. They may change the baby's heart rate, slow the baby's breathing at birth and may affect sucking behaviour. This can lead to difficulties initiating breastfeeding and could impact milk production.
- Some women experience incomplete or patchy relief. Because of the limited mobility when using the epidural, if it is incomplete or patchy with breakthrough pain, women can't resume previous comfort positions that have been helping, such as standing, swaying of hands and knees, or use of water for comfort.
- You may have nausea & vomiting and/or feel itchy, depending on which medication is used.
- You will need a catheter to empty your bladder when necessary as you won't feel the urge to pee. This procedure increases the risk of a bladder infection.
- You may develop a fever. This may make your baby at risk of needing antibiotics and closer observation in the NICU.
- Lower back pain from the insertion of an epidural needle. Sometimes multiple attempts are needed to find the epidural space.
- The need for additional medical interventions (cascade of interventions) may increase (e.g., assisted vaginal birth).
- Need for continuous monitoring of your vital signs, contractions, and baby's heart rate contribute to the feeling that childbirth is a 'medical' rather than a natural process.
- Epidurals often decrease the sensation for pushing, leading to a prolonged second stage that may require forceps or vacuum extraction to assist with birth.
- You may develop a severe headache that may require the epidural be repeated and a sample of your own blood to be drawn and inserted into the epidural space to patch a leak of spinal fluid.
- There is a very small risk of nerve damage that may leave a numb patch on your lower body, leg or foot. This is usually temporary.
- Extremely rarely, infection.
- Extremely rarely, maternal respiratory depression or arrest.

Note: Many women are concerned that they cannot have an epidural if they have a back tattoo. In most cases, the anaesthesiologist will insert the catheter into an area of the skin that isn't tattooed. The pregnant woman should discuss this with her health care provider prior to labour starting.



Speaker's notes:

Your health care provider may suggest assisting you with the birth of your baby if you become too tired to push any longer or if there is a concern about your baby's well-being. These can only be used if your baby is low enough in the pelvis to be born through the vagina. The pregnant women should discuss risks, benefits, and alternatives to assisted birth with her health care provider prior to labour starting.

Your health care provider may discuss with you options to assist you to give birth. Remember to ask about the benefits, risks and alternatives:

- Place a small suction cup on your baby head's and, when you push, apply traction. This is called a vacuum-assisted birth. The vacuum extractor method can leave red marks or a bruise on the top of your baby's head. These will slowly fade after birth.
- Place two metal, spoon-like instruments on either side of your baby's head and gently but firmly pull with them when you feel the urge to push. This is called a forceps-assisted birth. Forceps may leave red marks or bruises on the sides of your baby's face or head. They will slowly fade after birth. There is a risk when using forceps that your baby may have challenges starting breastfeeding because of the tenderness to their face and head. There is also a small risk that your baby may have an injury to their facial nerves.
- Make a small cut in the tissue to the side of the vaginal opening. This is called an episiotomy. It is offered as a option if there is a need to give birth quickly. Sometimes it is offered when the tissue between your vagina and anus (the perineum) does not stretch to allow the birth of the baby's head. When making an informed decision, it's important to know that a tear heals better and more quickly than an episiotomy and there is less long term pain with a tear than an episiotomy.

Alternatives: Different positions may facilitate you giving birth more easily. Listen to your body and use gravity, i.e., squatting to open the pelvis, hands and knees dangling or leaning over the back of the bed.

Note to facilitators: you may want to share local statistics around use of forceps, vacuum extraction, and other procedures such as epidurals, Caesarean birth, etc.

Caesarean Birth - Why it may be needed



- Position of baby
- Placenta covering cervix
- Placenta not functioning well
- Multiple babies
- Genital herpes with symptoms
- HIV with high viral load
- High blood pressure or blood sugar
- Previous Caesarean birth


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Speaker's notes:

- A Caesarean birth occurs when the baby is born through a surgical opening in the lower abdominal area.
- In Canada, about one in four births is by Caesarean section. In Ontario, the overall Caesarean birth rate is 28.4% (Canadian Institute for Health Information-CIHI).
- Sometimes, a Caesarean birth is medically needed to have a healthy baby and mother. This surgery may be planned in advance as advised by the health care provider or unplanned as a result of events of labour.
- If a previous baby was delivered by Caesarean, a vaginal birth after Caesarean (VBAC) may be an option. The possibility of a vaginal birth after Caesarean (VBAC) should be discussed with the health care provider.

Reasons for Caesarean birth may include:

- Your baby is in a position where it would not be possible for you to give birth vaginally.
- Your placenta is covering the opening to your cervix.
- Your placenta is not functioning well and would not manage the stress of labour.
- You are going to give birth to multiple babies. (Though giving birth vaginally with twins may be an option).
- You have active genital herpes.
- You are HIV positive and have a high viral load.
- Your blood pressure or blood sugar is too high for the process of labour.
- You had a previous Caesarean birth, and you have made an informed decision that you will not try vaginal birth after Caesarean (VBAC).
- You had a Caesarean birth less than 18 months before your current due date.

You may need to have a Caesarean birth after your labour begins if:

- The health of your baby is at risk.
- Your health is at risk.
- Your labour is not progressing.
- Your baby is unable to be born vaginally.

Caesarean Birth - Risks



- Risks for mother
- Risks for baby
- Ways to reduce risk


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Speaker's notes:

Surgery risks associated with a Caesarean birth may include:

- Accidental cuts to your bladder or bowel.
- Complications from the anesthetic.
- Bleeding. If uncontrollable, in rare circumstances your uterus may need to be removed.
- Death (extremely rare with today's advanced technology and care processes).

Post-partum risks associated with a Caesarean birth may include:

- Nausea and vomiting after the surgery.
- Difficulty moving around easily after the surgery.
- Developing blood clots that could travel to your lungs or brain.
- Pain that may last days to weeks after the birth.
- Re-opening of the surgical wound.
- Infection.
- Scarring of the uterus, which can cause complications in future pregnancies and births.

Risks associated with a Caesarean birth for babies include:


- Delay in being placed skin-to-skin with mother immediately after the birth if mother or baby are not medically stable. Baby can be placed skin-to-skin with partner of mother's choosing if mother unavailable and baby is medically stable.
- Difficulty breastfeeding related to late initiation or difficulty with positioning.
- Accidental surgical injury.
- An increased need for ventilation or resuscitation at the time of birth.

You can take the following steps to reduce your chances of having a Caesarean birth by:

- Attempting to have a breech baby turned.
- Making sure your body is ready for labour.
- Delaying hospital admission until your labour is well underway.
- Being patient with labour.
- Having continuous labour support.
- Changing positions often and moving around during labour.

Caesarean Birth - Preparations

- Bloodwork
- Nothing to eat or drink
- Intravenous
- Anesthesia
- Urinary catheter



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Speaker's notes:

Before a Caesarean birth, you will:


- Meet with the doctor doing the operation and possibly the doctor who will be managing your anesthesia. You will be able to ask them questions about the risks and benefits of the operation and give them your informed consent.
- Have a sample of blood taken. This is done to check your blood type (to determine if you require RH Immune Globulin after the birth and to have blood on hand in case you need a transfusion during the surgery), hemoglobin level, and platelet level (to ensure that it's safe to do an epidural/spinal anaesthesia for the birth). Other blood tests might be done depending on your health. If your Caesarean birth is planned, this may be done on a day before the birth.
- Not eat or drink for six to eight hours before if it is a planned Caesarean birth.

Right before the operation you will likely:

- Need to remove any jewelry or nail polish and put on a hospital gown and hair covering.
- Have an intravenous (IV) line inserted. Antibiotics and medications for nausea and pain may be given through the IV.
- Drink a liquid antacid. This will be at the request of the anesthetist.
- Be taken to an operating room and asked to sit or lie on an operating table.
- Be given a spinal or epidural anesthetic to numb the lower part of your body. Both are inserted by a needle in your lower back. When these methods are used, you are awake and can see your baby right after the birth. If you already have an epidural, this can be used.
- Have a catheter inserted into your bladder to keep it empty.

Spinal or epidural anesthetic is used more often as you can stay awake for the birth, and it is better for breastfeeding. If your Caesarean birth is urgent, or if you cannot have spinal or epidural anesthesia, you may be given a general anesthetic that puts you to sleep.

Caesarean Birth - What to Expect During Surgery



You may:

- Have your partner or support person present
- Be pain free
- Feel tugging or pressure
- Be in surgery for 1-2 hrs.
- Feel sleepy or shivery

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Speaker's notes:

- Your partner and/or support person may be with you for the birth if you have spinal or epidural anesthesia. He or she will sit beside you at the head of the operating table. A team of doctors and nurses will work together to keep you and your baby safe during the operation. One doctor will take care of the anesthesia. If you have a midwife, she can also be part of this team.
- During the surgery a sheet is held in front of you so you do not see what is happening. You can ask that the sheet be dropped to see the birth of your baby. This has to be planned well ahead of the surgery.
- The incision made for a Caesarean birth is normally made across the lower part of your abdomen and then your uterus. You should not feel pain when the incision is made.
- You may feel some tugging or pressure when the baby is born. Use breathing techniques, visualization, hold hands, talk gently, and focus on your baby's birth if you, or your partner, are feeling anxious.
- Usually, the baby is out in the first few minutes of a Caesarean birth. You can request delayed cord clamping and immediate skin to skin with your baby, but this has to be planned well ahead of the surgery and you and your baby need to be medically stable. The rest of the time is used to remove the placenta, to make sure everything is well, and to repair the incisions in your uterus and abdomen. Your uterus will be closed with dissolvable sutures. Either staples or dissolvable sutures will be used to close your skin incision.
- You may feel sleepy or start shivering during the repair. Both are normal reactions to surgery. The nurse caring for you will warm you up with blankets.

Caesarean Birth - What to Expect After Surgery

For baby

- Physical assessment
- Skin-to-skin
- Breastfeeding

For mother

- Physical assessment
- Transfer from operating room
- Return to regular diet
- Pain management
- Removal of catheter
- Gradual return to normal activities




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Speaker's notes:

After your baby is born

- Your baby will be assessed by a health care provider right after birth. After this assessment, the best place for your baby to be is skin-to-skin with you. If you are not able to hold your baby skin-to-skin, your partner or support person can do this. If your baby needs medical care, or if you are not awake, you will be able to hold your baby skin-to-skin once you are both stable. Many of the benefits of skin-to-skin can still occur later and are especially important to counter the impact of the surgery on the hormonal physiology of birth transitions related to breastfeeding and attachment for both mother and baby.
- Following a Caesarean birth, you and your baby will be transferred out of the operating room to a recovery room, or to your postpartum care room, on a stretcher. Nurses will help you move from the stretcher to your bed as you may not be able to move your legs right after the birth if you've had an epidural/spinal anaesthesia.
- Your vital signs (i.e., blood pressure, heart rate, breathing rate, temperature, and oxygen level), your uterus and your bleeding will be checked regularly.
- Tell your health care provider if you notice any increase in bleeding from your vagina or incision.
- Your nurse will help you feed your baby as soon as possible after birth. You may find some breastfeeding positions more helpful than others after having a Caesarean birth.
- Your catheter will be removed approximately 12 – 24 hours after birth.
- You will be able to drink and eat small amounts of food after the birth if you had spinal or epidural anesthetic. Eating small amounts of food at a time and gradually increasing the amount will help prevent nausea and excessive gas.
- You will be encouraged to get out of bed as soon as you are able. Your nurse will help you the first time you are up. Walking around can help reduce the risk of blood clots, help you move gas and have a bowel movement, and help you feel better.
- After giving birth, expect to stay in the hospital for longer than if you had a vaginal birth.
- The incision in your abdominal area will be sore for at least a few days. Pain management varies and you should discuss this with your health care provider.
- Give yourself the time to heal by taking it slowly and avoiding strenuous activities. Abstain from sexual intercourse and do not place anything in your vagina for a few weeks. During recovery, it is common to experience mild cramping, bleeding or discharge for 4-6 weeks. But if you experience heavy bleeding, a fever, the pain gets worse, or your incision gets red, go to the emergency department of the nearest hospital.

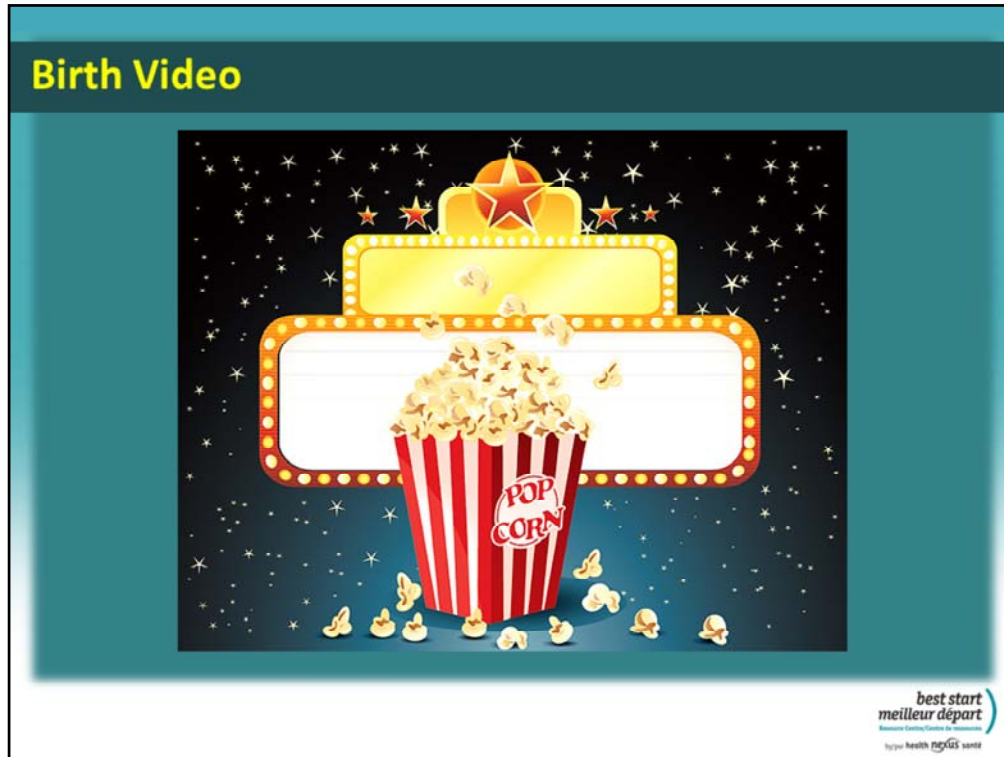


Speaker's notes:

- Newborns are most alert for the first hour or so after birth. Uninterrupted, skin-to-skin contact with the baby immediately after birth and for at least the first hour or until after the first feed improves the success of breastfeeding. Research suggests that labour medications, such as those used for pain relief or for Caesarean birth, can interrupt the hormonal physiology for both the mother and baby, sometimes making the initiation of breastfeeding more challenging. In this case, the new mother may require extra support to get started.
- It is important that the pregnant woman discusses potential effects of labour medications on breastfeeding with her health care provider prior to the birth. It is also recommended that she and her partner attend a prenatal breastfeeding class to learn about how milk is made, position and latch, and where to get help after the baby is born.
- Many mothers who have Caesarean births successfully breastfeed, but additional assistance and support in the beginning might be needed. It is recommended that breastfeeding be initiated within the first hour of life, starting with skin-to-skin contact in the operating room and in the recovery room. Directly following Caesarean birth, women may need more support with breastfeeding from a nurse or other support person than following vaginal birth.

Suggested video: Peel Region Public Health and Trillium Health Partners (2014). Breastfeeding Your Baby after a Caesarean Birth. Available from Parenting in Peel.

<http://www.peelregion.ca/health/family-health/breastfeeding/resources/video/index.htm>



Show a birth video that describes medical procedures and interventions to complement information presented in the session.

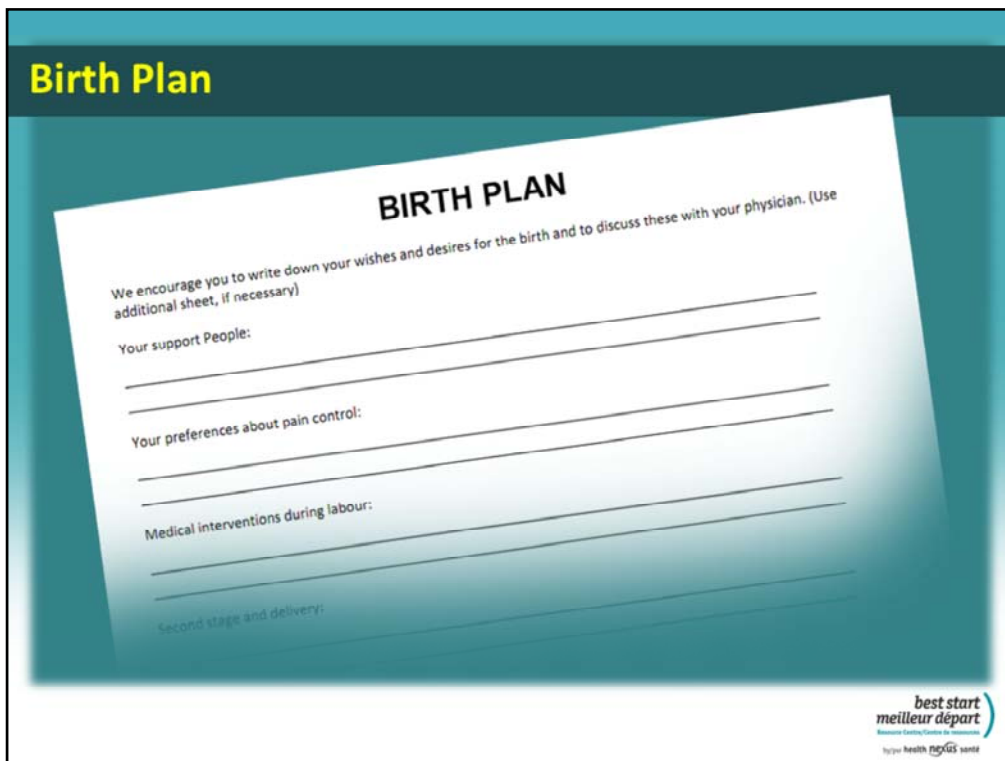
Suggested videos

- *Healthy Steps for Teen Parents*, 2nd Edition, Volume 2: Labour & Delivery, InJoy Health Education, 2010
- *How an epidural is given during childbirth*, Bupa Health UK, 2013
https://www.youtube.com/watch?v=7eaFn8GmY_0
- *Pain Management for Childbirth, Volume 2: Analgesics and Epidurals*, InJoy Health Education, 2011
- *The Miracle of Birth 4: Five Birth Stories*, InJoy Health Education, 2014.
- *Stages of Labour 3rd Edition: A Visual Guide*, InJoy Health Education, 2013
- *Stages of Labour 2nd Edition: A Visual Guide for Teens*, InJoy Health Education, 2007.
- *Understanding Birth 3rd Edition: A Comprehensive Guide*, InJoy Health Education, 2015.
- *Understanding Cesarean Birth*, InJoy Health Education, 2016.

May also want to consider the following videos for a lighter moment:

Dancing in labour:

- <https://www.youtube.com/watch?v=6bcFhZA2uR0>
- <https://www.youtube.com/watch?v=tuyRhYl4j1o>
- <https://www.youtube.com/watch?v=q3H8opbRj5E>



Speaker’s notes:

A birth plan is a written guide that communicates your preferences around childbirth and the care of your newborn to your health care provider and support team. It is best to be realistic, simple, and flexible when writing your birth plan. Labour and birth is a dynamic and unpredictable process so it is important to leave room for change as the situation develops. Remember that the goal is a healthy mother and a healthy baby.

- Before writing a birth plan, it is important that the family explores what limitations there may be because of hospital policies. For example, you may want a water birth but the facility does not have a bathtub, or you want to use a lit candle and the fire code of the hospital doesn’t permit it. It is important to determine how important that this is for you and what your options may exist. It may mean a change of provider and birth location to make it happen.
- The best time to write a birth plan is after you have attended prenatal classes, participated in a hospital tour, and discussed the various options with your health care provider.
- Try to write your birth plan in a way that indicates what you do want vs. what you don’t want and identify the things that are most important to you and those that you can be more flexible with.
- Avoid using lengthy birth plans that may not be relevant to the health care services available to you.

Points to consider when writing your birth plan:

- Members of your labour support team and their role.
- Specific and realistic ways the partner can provide support.
- Labour positions and comfort measures.
- Pain relief options.
- Medical interventions/procedures.
- Religious or cultural beliefs.
- Unexpected events.
- Infant feeding.
- Fears and concerns for both you and your partner.
- Postpartum care.
- Newborn care.
- Overall goal for the labour experience.



Suggested Activity: Birth Plan

Purpose: To write a sample birth plan.

Materials:

- Pens or pencils
- Blank paper OR
- Printed copy of the sample birth plan found at
 - <http://pregnancy.sogc.org/wp-content/uploads/2014/05/Birth-Plan.pdf> OR
 - <http://www.lamaze.org/page/planning-for-a-safe-and-healthy-birth>

Instructions:

- Using either a printed birth plan that participants can customize, or blank paper to create their own, encourage them to think about the following topics and write down what is important to them. Remind them that their place of birth may have a standardized birth plan for them, and that is perfectly acceptable to create their own.
- Have them take it home to talk about with their partner, and share it with their health care provider when they are ready to share it.

Your support people

- Who do I want with me during labour and birth? Examples may include partner, family, doula, children. What is important to me?

Your preferences about coping with contractions

- What non-medical options are available and which am I most comfortable with? Examples may include the ability to move freely, use of water (shower or tub), massage, birthing ball, etc.
- What medical options are available and which am I most comfortable with? Examples may include analgesics, epidurals/spinals, nitrous oxide, general anesthesia.
- What is important to me?

Medical interventions during labour

- What are the routine procedures and what additional procedures may be necessary? Examples may include fetal monitoring, intravenous, rupture of membranes, induction/augmentation, episiotomy.
- What is important to me?

Second stage and birth

- What are my options for birthing positions and breathing during pushing?
- Examples of positions may include sitting upright, forward leaning, side lying, or squatting. Examples of breathing may be breathing and pushing when and how your body tells you to, or directed pushing. What is important to me?

(continued on next slide)

Birth Plan



- Most important issues
- Concerns or fears
- Infant feeding
- Newborn procedures



Suggested Activity (continued):

Most important issues:

- What is your overall goal for your birthing experience?
- Examples may include having an un-medicated labour and birth, skin-to-skin contact following the birth, delayed cord clamping, partner cutting the umbilical cord.

Concerns or fears

- What are your concerns or fears about the birth experience? By including these in the birth plan, your support team is more likely to provide care based on your identified issues.
- Examples may include fear of needles, fear of pain, concerns about the health of the baby.

Infant feeding

- What is your infant feeding plan?
- Examples may include immediate and uninterrupted skin-to-skin contact for at least an hour or until first feed, supplementation only if medically indicated, use of hand expression to obtain mother's own milk if baby needs to be supplemented.

Newborn procedures

- What are the common procedures (e.g., vitamin K injection, eye ointment) done to newborn after the first hour of uninterrupted skin-to-skin after birth?
- Examples may include partner cutting the umbilical cord, baby placed on chest immediately after birth.

Care providers during labour

- You have chosen your health care provider, but it is important to discuss who will be there when you go into labour, nights, weekends and holidays, and if there is a complication or an emergency.

Additional Resources

- Hospital or birthing centre tour
- Health care provider
- Certified Doula
- Local public health unit
- Society of Obstetricians and Gynaecologists of Canada
- Childbirth Connection (U.S.A)
- Childbirth and Postpartum Professional Association (CAPPA)
- International Caesarean Awareness Network (ICAN)
- Lamaze International
- International Childbirth Education Association (ICEA)
- 40 reasons to go to the full 40
www.health4mom.org/zones/go-the-full-40

The information represents the
best practice guidelines at the time of publication.
The content is not officially endorsed by the Government of Ontario.
Consult your health care provider for information specific to your pregnancy.



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