# Planning for the birth

## Introduction

Most babies are born vaginally and without assistance. Most babies are born in hospitals and are not born on their expected date. The following information describes:

- things to consider when preparing for your labour
- what labour involves
- various aspects of care during labour
- an overview of other events that may happen.

You are encouraged to seek out further information through services including Women's Health Victoria or the Women's Health Information Centre (WHIC).

## Birth plan

During your pregnancy there are opportunities to plan your labour and birth in such a way that lets your carers know your preferences. It is important that birth plans are flexible in case events do not go according to plan.

If you have particular requests for your labour and birth, it is recommended these are:

- discussed with your doctor/midwife prior to labour
- documented to ensure everyone caring for you is aware of your choices
- given to the midwife caring for you either before or at the commencement of labour.

Ask your doctor/midwife for a birth plan form that you can complete (the Victorian Maternity Record [VMR] contains a useful birth plan template), or a guide to writing a birth plan that you can follow.

## Support in labour

It is important to have at least one supportive companion during labour, preferably someone who can stay with you throughout. The right support in labour can make a difference to your labour and how you feel. Research has found that a support person who is present throughout labour reduces the necessity for:

- pain relief
- assisted vaginal birth
- caesarean birth.

Length of labour has also been found to be reduced to some extent when a support person is present.[1]

Support is more than just being present. Support should involve physical, emotional and social support and be available throughout your labour. During labour, a midwife will provide your clinical care, and some support. However, if you decide to have your baby in hospital, and depending on the type of care offered at the hospital, change of shifts means the same midwife may not be there for the duration of your labour.

You can choose who you would like to have with you. For example, you may decide to have one or some of these support people present during your labour:

- your partner
- your mother, sister(s) and friends
- you may employ someone to stay with you throughout your labour.

If you are planning to have your other child/children with you during labour, you will need someone in addition to your support, to look after their needs throughout. It is advisable that children attend 'child specific' education classes prior to attending the birth.

## When to notify your doctor/midwife/hospital

During your pregnancy visits, you should discuss when it is best for you to contact your doctor/midwife or hospital. If you are having your baby in a hospital, also discuss when you should come into hospital. The circumstances which will influence the decision(s) include:

- distance from hospital
- number of previous pregnancies
- any significant problems you have had during your pregnancy



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- previous birth experience
- how your labour appears to be progressing.

It can be difficult to tell when labour has started or becomes established. Your doctor/midwife or hospital staff will advise and assess you to determine whether your labour has established. If it has, some hospitals will recommend you go home to 'await events'.

It is recommended that irrespective of when your baby is due, you contact your hospital or carer if you have any of the following:

- any vaginal bleeding
- less movement of your baby than usual
- any pain that doesn't go away
- waters break (membranes rupture)
- a concern your waters may have broken
- a high temperature
- vomiting that will not stop
- an unrelenting headache
- visibility loss  or blurred vision
- widespread itching of the skin
- sudden swelling of face, hands and feet
- any worries.

## Preparing for your hospital stay

In Victoria, the majority of births take place in hospitals. For many women arriving at the hospital, meeting unfamiliar people in an unfamiliar environment can be quite stressful. It is recommended that you ask what you need to bring to hospital and visit the hospital (including birthing suite) prior to admission. Then on admission you may:

- be accompanied by your partner and/or support person(s)
- give a copy of your birth plan (if you have one) to the midwife caring for you
- ask questions or clarify any outstanding issues.

## Stages of labour

There are three stages of labour commonly referred to as:

- *First stage* - when regular, usually painful contractions cause the thinning and dilatation of the cervix
- *Second stage* - from when the cervix is fully dilated (completely open), until the birth of the baby.
- *Third stage* - from the birth of the baby until after the delivery of the placenta and membranes.[1]

### First stage

You will recognise the onset of labour when you have painful (intermittent or regular) uterine contractions. The contractions may be associated with a 'show' of mucus or blood and/or waters breaking (membranes rupture).[1] These painful contractions come and go, usually at regular intervals increasing in frequency and intensity, and therefore differ from the irregular, painless tightenings (Braxton Hicks contractions) that some women experience during pregnancy.

During the first stage of labour, careful monitoring and recording of your and your baby's wellbeing and the progress of your labour is important to ensure:

- that labour is progressing normally
- any problems are recognised early
- relevant information is communicated readily.[1]

### Second stage

As the cervix gets closer to full dilatation (completely open), you may feel an urge to push or bear down. The second stage of labour is shorter than the first stage if you are having your first baby, and is even shorter for subsequent births. Monitoring of your and your baby's condition is increased during the second stage of labour. A prolonged second stage of labour can result in risks for you and your baby. There is no good evidence that suggests the doctor/midwife should tell you when and how to push all through the second stage of labour.[1]

If your labour is not progressing, it is important that the reason is worked out, and your management changes accordingly.

At the time of birth, a doctor/midwife may guide your pushing to enable a gentle, unhurried birth of your baby's head. Sometimes the umbilical cord is wound around the baby's neck. If possible, the doctor/midwife will loosen it to enable your baby to pass through, loop it over your baby's head, or clamp and cut it to allow your baby to be born safely.

Care of your baby immediately following the birth is described in the "Early days after you have your baby" section.

### Third stage

After the birth of your baby the placenta (or afterbirth) separates and is delivered. The muscles of the uterus continue to contract to stop the bleeding. However, this process is always associated with a moderate blood loss, up to 500mL. The amount of blood loss is dependent on the time it takes for the placenta to come out and how effectively your uterus contracts afterwards.[1]

In the third stage, one of the potential problems is excessive bleeding (postpartum haemorrhage) which can result in anaemia and fatigue. This is why the third stage is carefully supervised.

There are two approaches to managing the third stage:

- *'Active management'* where the midwife/doctor administers an injection (oxytocin) to you after the birth of your baby, clamps and cuts the cord, and then carefully pulls on the umbilical cord to speed up placental separation and delivery.
- *'Expectant management'* where the placenta is allowed to deliver spontaneously, aided by gravity or nipple stimulation only. In this approach the baby is able to stay connected to the umbilical cord until it has stopped pulsating.

When these approaches are compared, active management has been found to reduce the incidence of excessive blood loss and other serious complications. In Australia, active management is the common practice and recommended for women expecting to give birth normally in hospital.[1]

It is recommended oxytcin be used for the third stage.[1]

## Monitoring your baby during labour

It is essential to monitor your baby's wellbeing during labour, to ensure all is going well and to initiate appropriate action when necessary.[2] During labour, your baby's heart rate will be checked regularly and may involve more than one approach.

If you have had a low risk pregnancy and there are no problems at the onset of labour, your baby's heart will be listened to every 15-30 minutes using a small hand held Doppler ultrasound device or Pinard (fetal stethoscope). This equipment can be used regardless of the position you are in. Your baby's heart will be listened to more frequently during the second stage of labour, up to and after every contraction when you are pushing.

However, continuous electronic fetal monitoring of your baby's heart during labour will be recommended by your doctor/midwife if you develop complications during pregnancy or there are problems arising during your labour.[2] This cardiotocograph (CTG) involves two plastic disks (receivers) on your abdomen held in place by two belts. The receivers are attached to a machine, which may limit your movement. These are usually applied when you are sitting, lying down or standing. Some hospitals have machines that allow you to be monitored but still able to move around freely (telemetry).

Electronic fetal monitoring for 20-30 minutes on admission to the birth suite or intermittently during your labour may be recommended by your doctor/midwife when clinically indicated.

## Positions for labour and giving birth

It is important for you to choose a position for labour and birth which is most comfortable for you. You will change your position many times during labour. To help prepare for labour, you might practice a number of different positions. Also, if you are having your baby in hospital, check what is available for labour, including baths, showers, birth balls, bean bags and floor mats.

During the first stage of labour, you may find that being on your side or upright (standing, walking, sitting upright, kneeling) compared with lying down in labour, improves the feeling of being 'in control'. In addition, you may find you have more efficient contractions.

During the second stage of labour, being on your back may

- increase pain
- increase problems with the baby's heart rate
- increase vaginal instrumental births.[1]

You may consider immersion in water to help you relax during labour and as a strategy for pain relief during the first stage of labour. Some hospitals offer the option of water birth although there is insufficient evidence to either support or discourage the practice.[1]

## Pain relief during labour and birth

Your experience and response to pain in labour can be influenced by a number of factors, including the environment in which you give birth, the support you receive, the position of the baby and the method of pain relief used. It is important that you know about the options of pain relief available prior to labour and that your care givers know your preferences.

There are a number of non-medical and medical methods available for you to use in labour. Although some of the non-medical methods have not been subjected to rigorous research, you may find them helpful and these are unlikely to cause harm.

Non-medical methods include:

- reduce painful stimuli by changing position, moving to help how your body perceives the pain, applying heat and cold, use of baths and showers, touch, massage, acupuncture, acupressure, transcutaneous electrical nerve stimulation (tens)
- using other things that distract you such as music, attention focus, distraction
- continuous support in labour by a known person.[1]

Medical methods include:

- gas (nitrous oxide mixed with oxygen) given by mask or mouth piece
- pethidine injection may reduce the pain
- epidural and spinal injections into the back that make you numb from the top of the uterus down.[1]

Epidural injections are the most effective pain relief available and are especially useful for women experiencing:

- long first and second stages of labour
- baby in the wrong position (posterior or "back pain labour")
- induced labour
- an assisted vaginal birth.[1]

However, epidurals also have some disadvantages for you to consider, including:

- possible longer second stage of labour
- your position will probably be restricted to staying on the bed
- you may need a tube inserted into your bladder (catheter) for passing urine
- you will need an intravenous line
- you may experience a complication, such as a headache
- your baby's heart will be monitored continuously
- you have a greater likelihood of an vaginal instrumental birth[1]

An epidural does not:

- increase the length of the first stage of labour
- increase the need for a caesarean section
- cause long term backache.[1]

## Care of the perineum during birth

During birth the perineum may be injured either by tearing or by cutting the perineum to enlarge the vaginal opening.

If this is your first baby, you may help prevent these types of trauma by massaging the perineum during the weeks prior to the birth.[3] However, massaging the perineum during the second stage of labour has not been shown to stretch tissues and therefore does not reduce perineal injury.[1]

An episiotomy may be needed during the last part of the second stage of labour if:

- the birth needs to be quicker if you or your baby show signs of distress
- you need an assisted vaginal birth, or
- if you are showing clinical signs that you may sustain a severe tear.[1]

Episiotomies should be performed only if needed. They should not be 'routine' as they do not reduce the risk of severe perineal injury, urinary stress incontinence, trauma to the baby or improve perineal healing.[1]

## References

[1] National Institute for Health and Clinical Excellence (NICE) (2008) Clinical Guideline: Intrapartum, http://www.nice.org.uk/Guidance/CG55

[2] Royal Australian and New Zealand College of Obstetricians and Gynaecologists. (2006) Clinical Guidelines: Intrapartum Fetal Surveillance

[3] Beckmann MM, Garrett AJ. Antenatal perineal massage for reducing perineal trauma. Cochrane Database of Systematic Reviews 2006, Issue 1.