

Caesarean Birth

Making Informed Choices



an initiative of

Birthrites

Healing After Caesarean Inc.



www.birthrites.org

Contents

Just as every woman is different, so is every pregnancy and birth. Birthrites supports all women towards making an informed birth choice in regard to caesarean birth, vaginal birth or vaginal birth after caesarean (VBAC).

Birthrites wishes to sincerely thank all the people who took the time to contribute their knowledge, time and expertise.

This information booklet was produced by a consumer group and is aimed at consumers. The content contributors included consumers, midwives, doulas, obstetric general practitioners and obstetricians.

Birthrites does not claim to have the qualifications to provide medical information, and any such information provided in this booklet has been proofread by medical practitioners to ensure accuracy.

Birthrites recommends that if you are experiencing a medical condition, especially if it may have an impact on the birth choices available to you, that you discuss your options with your chosen childbirth professional.

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Introduction

This booklet provides information to help you make informed choices about your baby's birth. It covers both caesarean birth and vaginal birth after caesarean (VBAC).

It is hoped that this book will be the light at the beginning, or even the end, of the tunnel that will enable women to experience empowered births.

Please use the blank page at the back of this booklet to make notes or jot down any questions you want answered.

Feelings about birth

Sometimes our expectations of birth can be very different from the actual event.

Some women may find that their initial emotional response is preoccupied with the safe arrival of their new baby. Other feelings associated with the birth experience may not surface for weeks, months or even years.

These feelings may be triggered by other events - such as a subsequent pregnancy or the pregnancy/birth experience of others. A woman may feel a range of emotions towards herself, her care providers and even her loved ones. These feelings may include frustration, anger, disappointment, disempowerment, sadness, grief, loss and/or failure.

Negative feelings are especially prevalent when mothers feel they are not 'involved' in the decisions surrounding their birth process.
(Waldenstrom et. al. 2004)

Do I have choices about how I give birth?

The answer is YES!

But it is important that you make "informed" choices.

The process of giving birth is different for every woman. Whilst it is impossible to predict what will actually happen 'on the day', there are ways you can improve your chances of having a positive and empowering birth experience - whether it is a caesarean birth or a vaginal birth.

A sense of empowerment during childbirth can be achieved by choosing a childbirth professional who values woman-centred care. These care providers involve the woman in all aspects of her care. They consider individual circumstances and needs, and provide information to help women make informed choices. Being part of the decision-making surrounding the childbirth experience is essential for a mother's positive involvement in the process of birthing her babies.

The basic strategy of providing child-bearing women with information about the risks, benefits and consequences of various choices can equip them to make their own judgments regarding birth choices. Enabling a mother to deliberate on her needs and reflect this information in her birth plan, well in advance of giving birth, helps in preparation for unexpected events - such as a caesarean or when other interventions are recommended.

**“With knowledge we can make choices
that lead to empowerment, and healing, through birth.”**

Birthrites' philosophy



Birthrites
Healing After Caesarean Inc.

Informed Birth Choice

It is important that women are aware of what 'making an informed choice' actually means.

Making an informed choice involves listening to your childbirth professional's advice, researching the options available to you in your own specific circumstances, and then following your own inner guidance to make an informed decision about how you want to birth your baby.

In order to make an informed choice it is important to seek out up-to-date information from a number of sources. These can include your primary care provider, independent midwifery associations, hospital libraries and community support groups.

Through becoming truly 'involved' in the making of decisions related to your pregnancy, labour and the birth of your child, you significantly increase your chances of having a positive birth experience.

When making choices about the way you want to birth your baby, it is important that you explore and acknowledge your own feelings and expectations around birth.

Choosing Your Care Provider

Your birthing outcome is influenced by your choice of where to birth your baby. Policies and attitudes vary between care providers. Intervention rates are generally higher in the private system (Gee & Godman 2006). It is important that you choose a care provider that meets your own needs.

The following information has been ADAPTED from the Maternity Coalition Infosheet, "Who Cares?" Choosing a Model of Care, July 2006:

Midwife primary care

Best for:

- Uncomplicated hospital births
- Birth centre
- Home birth
- Community midwifery programmes

The midwife's scope of practice allows her to work on her own authority where the mother and baby are well, and to work in collaboration with specialist medical and nursing providers when a complication or illness is detected.

As a primary carer, a midwife works to provide normal maternity care from early pregnancy through birth and early parenting. The midwife is available to provide advice and monitor progress throughout pregnancy, and to attend when labour has established, providing agreed services within the scope of midwifery practice.

A midwife will arrange appropriate back-up from another suitably skilled midwife to cover when she is not available.

Models of midwifery care:

- Community midwifery programmes
- Independent midwife
- Primary (first level) care from a known midwife
- Team midwifery care
- Primary (first level) care from a small team of known midwives
- Shared care (between a midwife and a GP)

Midwifery based NBAC clinic

NBAC = Next Birth After Caesarean (Not available in all states)

Best for:

- Low risk pregnancies after a previous caesarean

Midwives supportive of 'empowered birth after caesarean' work collaboratively with obstetric staff to provide care for women who have had a previous caesarean.

A dedicated team of midwives is able to advise on 'birth after caesarean' care for the mother throughout the pregnancy. Mothers have about two obstetric appointments during the pregnancy. VBAC and 'positive caesarean' planning is available.

Birth is hospital based with specialist obstetricians available when needed or if a caesarean is scheduled.

Continuity of care through pregnancy and birth may depend upon hospital policies.

These clinics are currently under trial. You are encouraged to seek out more information on these programmes in your area.

Specialist obstetric care

Best for:

- High risk pregnancies
- Difficult births

Specialist obstetricians are doctors who are experts in the treatment of the complications that can lead to poor outcomes in pregnancy and birth, and are skilled in surgical options for birth.

In the private system, antenatal care is usually provided in the doctor's private consulting rooms. In the public system, it is provided at the hospital.

Specialist obstetric care is appropriate for a complicated pregnancy or if you have a serious medical condition separate from your pregnancy.

Specialist obstetricians can provide continuity of care throughout pregnancy with access to either a private or public hospital for birth.

During labour, hospital midwives monitor your progress and call the obstetrician when they feel it is appropriate.

Your care after the birth will also be undertaken primarily by hospital midwives, with the obstetrician available should complications arise.

Shared care

Shared models of care involve midwives and either general practitioners or specialist obstetricians working together to provide care. This is often within a hospital based maternity service, with the doctor usually being the leading care provider.

Some midwife-managed models of care within birth centres or hospitals have medical supervision when the woman is required to be reviewed by a doctor at intervals throughout the care.

Women receiving shared care should be aware that it can lead to fragmentation and lack of continuity of care - as you may see different midwives and doctors during your pregnancy and birth.

"I searched everywhere for a doctor who would support my VBAC decision - my original doctor wasn't available because I had moved interstate. Then I read somewhere that the local hospital was supportive of VBACs but with certain condition - the VBAC policies had a lot more intervention than I originally wanted. After searching around for other alternatives I decided upon the continuity of care through the team midwife programme and negotiated with the obstetrician on some of the finer points about the VBAC in my birthing plan - like the continuous monitoring, water for pain relief and time limit requirements for different stages of my VBAC"

If you do not feel that the maternity care offered to you by your initial choice of childbirth professional is what you need, then you can always research other professionals within your locality to find someone better suited to your ideals of maternity care. It is best to be supported by a professional who is as comfortable with you as you are with them. But if this isn't possible, such as in rural areas of Australia, then you should try to negotiate your care with the childbirth professional that is available.

During the process of negotiation, your midwife or doctor may need reassurance that you are aware of the possible consequences of your decision/s. It is much better to negotiate your care (ie. give and take) than to demand the care you want. You will achieve more by working together than you will if you alienate each other by demanding care that the other can't provide or accept.

Caesarean Birth

The rising rate of caesarean section

Up until the 1970's, the caesarean rate worldwide remained low at around 5%. At that time a caesarean section was still considered a 'rescue' operation. Since then, Western countries have seen a dramatic rise in this rate due to a range of complex factors, including:

- The increasing safety of caesarean section (leading to complacency)
- Defensive practices resulting from fear of litigation

- Effects of the increasing use of epidurals, labour induction and electronic foetal monitoring
- Increasing rate of obesity
- Women being unaware of VBAC as a choice
- Increasing average age of first time mothers
- Breech babies largely delivered by caesarean
- Lifestyle factors
- Doctor's preference
- Increasing number of women with gestational diabetes
- More premature deliveries due to improved ante-natal screening and treatment for obstetric complications

The World Health Organisation recommends a caesarean rate of 10 - 15% (Dosa 2001). The caesarean rate in Australia in 1998 was 21.1%. By 2004 it had leapt to 28.5%, with the rate in Western Australia the highest in the country at 32.4%. Notably, the incidence was significantly higher for twin pregnancies (65.1%), and for preterm babies (47.4%).

(Gee & Godman 2006)

What does a caesarean involve?

A caesarean is an operation that involves an incision being made on your lower abdomen and through your uterus, through which your baby is delivered. An 'elective' caesarean, also known as 'planned' or 'scheduled', is one that is arranged during pregnancy. A non-elective or 'emergency' caesarean is an unexpected outcome resulting from events that take place usually after labour has commenced.

An anaesthetic is administered before the operation begins. Your birth partner may leave you at some time during this as they are dressed and prepared to join you in the theatre room.

Once the anaesthetic has taken effect a sterile drape is raised across your chest. A catheter is inserted into your urethra and your bladder is emptied - reducing it in size to protect it during the surgery (this catheter may remain in place until the morning after your caesarean). A drip is inserted in your arm, and heart monitoring dots are placed on your chest. Your abdomen is then washed down with an antiseptic solution and the

surgeon begins the operation. Within five to ten minutes you may hear some noise as the amniotic fluid is removed. You may feel some pressure on your abdomen and pulling or tugging as your baby is delivered.

Whilst your newborn is being cared for, and ideally nursed by you, the surgeon will begin suturing (stitching) your uterus and the overlying layers of muscle and skin of your abdomen. This procedure is considerably longer than the birthing component of a caesarean section and can take 30 minutes or longer.

After the operation you will be transferred to a recovery room where you will be monitored and observed. Once you are considered stable you will be transferred to your hospital room. Usually, if there are no complications, your baby can remain with you in recovery.

Why are caesareans performed?

The following are some medical, psychological, emotional and social reasons for an elective caesarean section:

Situations where a caesarean is the best option:

- Placental problems (eg. placenta praevia - where the placenta is situated low and partially or fully covers the cervix, or placental abruption - where the placenta starts to peel away from the uterus)
- Previous 'J' or 'T' type incision
- Umbilical cord compression (cord prolapse)
- Transverse lie (baby is lying sideways in the uterus)
- Active genital herpes simplex

Situations where a caesarean may be offered:

(Labour and/or vaginal birth may be possible)

- Previous caesarean/s – this is the most commonly-cited reason. For 83.5% of women in Australia in 2006, it was a repeat procedure (Laws 2008).
- Suspected cephalopelvic disproportion, or 'CPD' (the baby's head may be too big to fit through the mother's pelvis).
- Occipital posterior position (the baby is facing up towards the pubic bone).
- History of big babies/difficult past deliveries with/without shoulder dystocia and/or 3rd or 4th degree perineal tear involved.
- Gestational diabetes – which, if poorly controlled, may lead to extra large babies.
- Foetal distress - which may occur in late pregnancy or in labour.

- Foetal intra-uterine growth restriction (IUGR)
- Abnormal placental function/placental deterioration
- Intra-uterine infection
- Breech presentation (the baby is head up with their feet or bottom presenting first)
- Multiple births (ie. twins, triplets etc.)

Psychological and emotional reasons for a caesarean:

- Tokophobia (fear of childbirth)
- History of sexual abuse
- Previous traumatic birth experience

Social reasons for caesarean:

- Choice of baby's birth day
- A wish to avoid a certain date
- Work leave for mother or partner
- Convenience for woman and/or her care provider
- To avoid the pain and unpredictability of labour and vaginal birth
- To avoid perceived stretching/damage to the vagina or pelvic floor (in fact, the pelvic floor is stressed through late pregnancy not childbirth)

Common medical reasons for non-elective or emergency caesarean:

- Failed induction (labour does not start)
- Labour that is not progressing
- Foetal distress
- Maternal distress
- Placental problems (eg. bleeding, separations, etc.)
- Undiagnosed foetal malposition or malpresentation (eg. breech, brow, occipital posterior position)

Where psychological and emotional reasons prevail, good support and counselling in pregnancy has been shown as beneficial, and can improve a woman's confidence about labour sufficiently enough to facilitate a vaginal birth outcome instead of caesarean section.

(Saisto et. al. 2001)

Consequences and implications of caesareans

It is true that the caesarean procedure has become less dangerous over time.

However, giving birth via major surgery when it is not medically necessary is still not as safe as giving birth to your baby vaginally.

Research studies repeatedly find that there are many short-term and long-term risks associated with caesarean section - for mothers, babies and for the whole family. These may be physical, emotional, psychological, behavioural and/or social.

The following risks should be considered very carefully where a caesarean is an option rather than a necessity:

- Increased blood loss in the mother - which may lead to a need for a blood transfusion, or a hysterectomy.
- Wound or uterine infection - which will delay healing, lengthen your hospital stay and require antibiotics.
- Anaesthetic risks - these are explained in more detail further on in the booklet but may be related to the drugs used (type of drug and quantity) and result in possible side-effects experienced by the mother and/or baby.
- Damage to the bladder or intestines of the mother.
- Blood clots in the mother - these may form in the deep veins of the legs or pelvis. Rarely, these clots travel to the lungs causing life-threatening pulmonary embolus.
- Future difficulties becoming pregnant.
- Respiratory distress in the baby - where the baby retains amniotic fluid in their lungs. During labour, maternal and foetal hormones assist the baby to clear this fluid, which normally fills the lungs when the baby is still in the uterus. When the baby is born by caesarean this clearing may not happen efficiently. If the baby suffers from respiratory distress, they may need to go into a high oxygen environment (an incubator) for between a few hours to a few days soon after they are born. This likelihood is increased with an elective caesarean.
- Increased chance of placental problems in future pregnancies - these can be life threatening (Makoha et. al. 2004).
 - Placenta praevia - the placenta implants low in the uterus.
 - Placenta accreta - the placenta implants into the uterine scar.
- The risk of uterine scar separation.
- Increased chance of ectopic pregnancy - this is due to scarring in the uterus.
- Small risk of the baby being cut by the scalpel.
- Risk of maternal death - there is a three-fold increased risk of direct maternal death when compared to vaginal birth (Deneux-Tharaux 2006).

Benefits of caesareans

Caesarean birth provides an alternative for women and babies whose medical condition means vaginal birth would be dangerous or not possible.

For women who are so highly fearful of childbirth that their mental health is affected, planning to give birth by caesarean may reduce their anxiety.

Types of incision

The type of incision made on the skin usually indicates the type made on the uterus - but not always. A classical incision (explained below) on the uterus may have been done after a 'sideways' incision was done on the abdomen, and vice versa. The only way to be sure what type of internal incision was made is to check with your doctor.

Transverse - lower uterine segment caesarean section (LUSCS)

This is the most common type of incision. It is made on the lower part of the abdomen, just above the bikini-line and cuts through the lower, fibrous part of the uterus. Because this part of the uterus heals very well, and involves less blood loss, it is the preferred site on which to perform the incision.

Classical incision

This is a vertical incision through the uterus. A classical incision is rarely used because it is associated with greater blood loss and may not heal as strongly as a LUSCS. There is also an increased risk of uterine rupture with VBAC following a classical incision.

Possible reasons for using this type of incision include:

- The baby is pre-term (less than 37 weeks gestation)
- The uterus has not stretched enough to allow a LUSCS to be performed
- The baby is lying sideways in the uterus (transverse lie)
- The placenta is lying where a LUSCS incision would be performed

'T' or 'J' incision

Two other rarely used incisions are the 'T' or 'J' incisions, so called because of their shape. These incisions are the result of a LUSCS incision being unexpectedly inadequate to deliver the baby. Usually the baby is in an unusual position, such as a transverse lie (lying sideways in the uterus). The LUSCS incision is extended into a 'T' or 'J' shape to allow delivery.

There is also an increased risk of uterine rupture with VBAC following a 'T' or 'J' incision.

Anaesthetics for caesarean

If you are having a caesarean you will need to have an anaesthetic. Regional anaesthetics (spinal, epidural, or combined spinal/epidural) numb the lower half of the body. This means you can be awake for the birth of your baby. If you have a general anaesthetic (GA) you will be asleep during the birth.

Most women in Western Australia have either a spinal anaesthetic, an epidural or a combination of the two (Gee & Godman 2006).

Regional (spinal and/or epidural) anaesthetic

The most common type of anaesthetic used to control pain during a caesarean is a regional 'block'. This involves injecting anaesthetic drugs into either the spinal fluid or the epidural space which surrounds the spinal nerves and cord.

A spinal anaesthetic is faster acting than an epidural anaesthetic. However, it can result in a rapid drop in blood pressure (Ng, Parsons, Cyna & Middleton 2004), making you feel nauseous and faint. This is unpleasant, but can be treated quickly by the anaesthetist.

With an epidural anaesthetic, the catheter (a fine plastic hollow tube through which the anaesthetic is administered) may be left in place in your back for the first day or two after the caesarean. This can then be connected to a device which allows you to safely self-administer your own pain relief.

Some anaesthetists will use a combined spinal/epidural technique which gives fast action and allows for postoperative pain relief.

Complications of regional (spinal/epidural) anaesthesia

Both spinal and epidural anaesthetics carry some risk of complications.

These may include:

- Partial or complete failure (about 1 in 20)
Partial failure may still give satisfactory pain relief. However, if pain relief is inadequate another epidural may have to be performed.
- Bloody tap (about 1 in 30-50)
Injury of an epidural vein with the needle. Women with a coagulation disorder may be at risk of epidural haematoma (a blood-filled swelling) at the site of the puncture.
- Accidental dural puncture (about 1 in 100 insertions)
The epidural space in the adult spine is only 3-5mm deep, which means it is comparatively easy to cross it and accidentally puncture the next layers with the needle. This may cause cerebrospinal fluid (CSF) to leak out into the epidural

space, which may in turn cause a headache. This can be severe and last several days, and in some cases weeks. Most cases resolve spontaneously with time.

- Catheter misplaced into a vein (less than 1 in 300)
This results in all the anaesthetic being injected intravenously, where it can be toxic in large doses.
- High block (less than 1 in 500)
The catheter is misplaced into the subarachnoid space (rare, less than 1 in 1000) If this is not recognised, large doses of anaesthetic may be delivered directly into the cerebrospinal fluid. This may result in a high block or, more rarely, a total spinal block, where anaesthetic is delivered directly to the brainstem causing unconsciousness and sometimes seizures.
- Significant damage to a single nerve (very rare, less than 1 in 10,000)
- Epidural abscess formation (very rare, about 1 in 50,000-75,000)
The risk increases greatly with catheters left in place longer than 72 hours.
- Paraplegia (extremely rare, less than 1 in 100,000)
- Death (extremely rare, less than 1 in 100,000, (Leighton & Halpern 2002))

A study published in the International Breastfeeding Journal 1:24 Dec 2006, indicated that when compared to women who did not have an epidural containing the drug Fentanyl, those women who did have an epidural with Fentanyl were twice as likely to either not start breastfeeding, or they ceased breastfeeding within the first 24 weeks. The researchers suspect that as Fentanyl crossed the placenta and into the baby it stopped the baby knowing how to instinctively breastfeed.

(Torvaldsen et. al. 2006)

General anaesthetic

General anaesthesia, where you are actually 'put to sleep' during the caesarean, is usually only used when an extreme emergency occurs (eg. cord prolapse or uterine rupture). It is avoided, where possible, due to the additional risks and complications involved with general anaesthesia and the drug's ability to pass through to the baby and make them drowsy.

With a general anaesthetic, a drip is inserted in the arm and heart monitor dots are placed on the chest. An oxygen mask is placed over the mouth and nose to boost oxygen levels before proceeding with the surgery. A rapid-acting anaesthetic is injected through the drip in your arm. You may get a metallic taste in your mouth depending on

the drug used.

As you lose consciousness you may feel the nurse pressing on your neck, just below your Adam's apple. This blocks the oesophagus - to prevent vomiting. Another drug is then given to relax the muscles. A breathing-tube is placed in the throat, through which anaesthetic gases are given to keep you asleep. A longer-acting muscle relaxant is also administered.

After your baby has been born, a narcotic is often given to aid after-surgery pain relief. At the end of the operation a drug is given to reverse the muscle relaxation. The anaesthetic gases wear off quickly and the tube is removed when you start to wake up and begin to swallow or cough.

Antibiotics may be given to avoid infections, and a drug that thins the blood is given to help prevent the possibility of blood clots forming in your legs.

After a general anaesthetic, your partner and baby may be able to stay with you in recovery whilst you wake up fully. However, this may not always be possible.

You are strongly encouraged to discuss any concerns you have about anaesthetics for caesarean section with your anaesthetist.

Wound closure

Your obstetrician will probably have a preference for the method of stitching the skin wound.

This could be with a dozen or so individual stitches or metal clips (they look like staples) across the wound, or a single, continuous stitch running just under the skin. This latter type of stitch may be of absorbable material so that it dissolves over a few weeks. If it is non-absorbable it will need to be removed - usually around the fifth post-operative day. If you have your own preference for the type of skin suture, discuss it with your doctor beforehand.

What to Expect After a Caesarean

Physically

Straight after the surgery you will need to spend some time in the recovery area. This could be between one and several hours. This is to enable your vital signs to be monitored until they stabilise. Once you are stable you will be moved to your room.

It will take some hours for the effects of the anaesthetic to wear off. If you received a spinal or epidural anaesthetic, you may be numb and unable to move from the chest down. Being moved from the trolley to the bed can be a bit unnerving, as you may feel awkward with the lack of control.

You and your baby will be monitored very closely and frequently for the first few hours. Snuggle up with baby if you can. Skin-to-skin contact is important at this time as it helps to initiate the baby's breastfeeding responses and provides physical comfort and parental bonding.

Babies are born with the instinctive ability to make their own way to the breast, attach and start to suckle. This early sucking is important because it causes the release of the hormone oxytocin in the mother, which makes the uterus contract. This helps to control blood loss after birth and if frequent breastfeeding follows, the uterus will quickly return to its normal size. It will also help to establish your milk supply.

Your skin, especially on your face, may feel really itchy during the first few hours. This is a side effect of one of the spinal narcotics given during the surgery. The feeling will eventually fade as the drug leaves your system.

Sometimes women get the shakes during the surgery, to the point where their teeth chatter. This shaking may continue during the surgery and into the recovery phase but will disappear as the anaesthetic wears off. It occurs because the spinal/epidural anaesthetic dilates your skin blood vessels and you lose a lot of body heat. Your blood pressure may drop due to the epidural and you may feel nauseous upon recovery. Again, these are reactions to the drugs used and symptoms will soon fade.

You may also experience a sharp pain beneath your shoulder blades. This is due to air that has entered the abdominal cavity during surgery. The air pocket will gradually be absorbed by your body over the next day or so and the pain will disappear.

You may notice that your legs and feet become puffy and the skin feels tight due to fluid retention. This is a normal response that may not clear for a week to ten days. Elevating your legs and rotating and flexing your ankles can help to shift the fluid.

Rarely, when an epidural/spinal anaesthetic has been used, headaches or swelling at the

site of injection can occur. These symptoms should be picked up quickly as it is your midwife's responsibility to check you and the puncture site regularly. If you experience these symptoms in-between checks, then alert your care provider – the anaesthetist needs to know about this quickly.

Regardless of whether the caesarean was planned or unplanned, you are very likely to feel drained - if not exhausted. Take time to allow yourself to recover from the surgery and make sure you stay on top of your pain.

It is a good idea to limit visitors during the first few days. You can ask hospital staff to block phone-calls and restrict visitors. They can also provide tactfully worded signs if you feel that requesting this yourself may offend.

Pain relief

The need for pain relief varies greatly between women depending on individual pain tolerance and what happened during the caesarean and/or preceding it.

Women can feel traumatised (emotionally and/or physically) by their caesarean experience. It is well known that emotional fragility, and feeling upset or distressed, is linked with a reduced ability to cope with physical pain.

Your midwife, or anaesthetist, will recommend which drugs will help you best cope with any pain. If you continue to experience pain, you should alert your midwife to your condition so that she can revise the treatment.

It is far better to take pain relief medication regularly and 'stay on top' of the pain, as some of the drugs work best once they reach, and are maintained at, a certain level. You should not wait until you are in pain and need pain relief. If you do, it will be harder, and take longer, to control the pain because of the circulating adrenaline.

Research shows that a combination approach to pain relief is much more effective than a single medication. All three of the following types of pain relief work more effectively together than individually:

Narcotic (opiate) medication

These can be given by injection every 3 - 4 hours intramuscularly. They may also be given through an intravenous line in your arm or an epidural line into your lower back as a 'fixed dose infusion', or via a patient-controlled analgesia (PCA) pump. The PCA pump enables you to self-medicate as needed. Alternatively, the midwife may access these lines to administer your medication. Opiates may also be taken orally.

Non-steroidal anti-inflammatory drugs (NSAID's)

These may be given as a suppository (inserted into your rectum) or in tablet/capsule form. With the suppositories, a small number of women experience a mild burning sensation and, in a few, diarrhoea may occur. It is important to take the tablets with or after food as you may get indigestion or heartburn if you take them on an empty stomach.

'Simple' analgesia

For example, paracetamol (eg. Panadol) or a paracetamol/codeine combination. Be aware that codeine, pethidine and morphine (all narcotic drugs) can cause constipation.

Make sure you are informed about the possible side effects of any medication taken to manage pain after your caesarean. Discuss any concerns with a healthcare professional.

When pain relief is very effective, it may have the undesirable effect of making you feel more healed than you actually are. If you over-exert yourself and put your body under stress too soon after the caesarean, you may prolong the healing process.

Some women have reported feeling so disappointed and guilty about having a caesarean that they felt they didn't 'deserve' to be comfortable and that they should endure the pain. This is a sign of a need for help in coming to terms with your birth experience. You should not feel alone and it is important that you ask to speak to someone to express your feelings about the birth.

Eating and drinking

Before you can eat or drink you need to have 'bowel sounds' (tummy rumbles) and/or pass wind. This is because the bowel and intestines are handled during surgery.

You may be very hungry after surgery. However, a heavy meal can make you vomit - so until your intestines can handle normal food intake, a light diet is best.

It is also really important to keep up your fluid intake. Drinking 6 to 8 glasses of water a day will stop you becoming dehydrated and help replace any blood loss. It will also keep your bladder functioning well and help prevent constipation. Avoid caffeinated drinks (eg. tea, coffee, coke) as they are diuretics and can make you feel even thirstier and more dehydrated.

Urinating

When the urinary catheter is removed you may be asked to measure the amount of urine you pass.

Some women may experience physical trauma related to the urinary catheter. If you experience any burning pain upon urinating, especially if this persists, you need to let your doctor or midwife know of this problem.

To help prevent any bladder problems try to urinate at least every couple of hours during the first day or so. By doing this you will also avoid the pain created by a full bladder putting pressure on your caesarean wound.

If you experience a lack of sensation telling you that your bladder is full, then you need to tell a doctor or midwife.

It is not normal to experience incontinence (leaking urine) after having a baby. This may have begun during pregnancy, as a result of your growing pregnant belly continually applying pressure against your bladder, and/or the normal relaxing hormonal effects of pregnancy itself. If this happens you should seek advice from the midwife, or physiotherapist, about exercises to increase your ability to maintain bladder control (pelvic floor exercises etc.).

Bowel movements

Within the first couple of days of your caesarean you should feel the need to move your bowels. This can be a scary experience in itself, as you will feel unsure as to how much pushing your wound can withstand. It can be reassuring to apply gentle pressure, with the palm of your hand, over the wound area while you gently attempt to allow a bowel motion to occur.

It is important to avoid constipation by drinking lots of water and eating a high-fibre diet. Narcotic/opiate medication such as morphine, pethidine or codeine slows the bowel. If

you are taking any of these medications, consider taking a stool softener or stimulant, such as Senokot, at the same time.

Blood loss

Over the first few days your midwife may ask to view your sanitary pads to check the amount and colour of your blood loss. The flow may increase when you actually breastfeed your baby, as the hormones released by the stimulation of breastfeeding encourage uterine contractions to occur. When you stand up, and as a result of gravity, your flow may suddenly increase as well. You may also pass some clots, although they shouldn't be too big.

At first your blood loss will be bright red and slightly heavier than a normal period. The loss will decrease and the colour will alter to a paler red, then a brownish-red. The flow should stop after a week or so, although light blood loss may last for around 6 weeks after the birth.

If your blood loss tapers off and then becomes heavy again, or if your discharge has an offensive odour, this can indicate that a tiny piece of placental tissue is still inside your uterus. This is a cause for concern and needs to be brought to the attention of your midwife or doctor.

Wound care

A sterile dressing will cover the incision site and you may have received antibiotics while still in theatre. These safeguards should help reduce the likelihood of infection.

The wound may be covered by a white adhesive 'Mefix' or 'Fixomull' type dressing which can be removed within the first few days.

Some surgeons are now choosing to use a self-adhesive gel-like dressing like 'Duoderm' or 'Comfeel', which stays in place for five to seven days. There is good evidence to say these dressings improve wound healing, and strong evidence to suggest they may offer some benefit in reducing scarring.

Once your wound is exposed it should be gently washed with water (soap may irritate) then patted dry with a clean towel. If possible, allow the wound area to air-dry. You should maintain good hygiene and try to avoid getting very hot, as perspiration will aggravate the wound area.

A great way to protect the wound area is to place a sanitary pad, sticky side on your underpants, over the wound. Wear loose fitting clothes to help reduce any rubbing on

the wound area.

If you notice any swelling or redness, or if your wound weeps blood or other fluids, please tell your midwife or doctor ASAP - especially if these symptoms are associated with any pain.

A healthy diet will also encourage healing.

Mobility and exercise

Once feeling has returned to your lower body, you should begin to gently move and stretch your legs and feet. This encourages blood flow and discourages the formation of blood clots in your legs. When ready, you can try sitting up in bed.

You should try walking as soon as you feel ready, and definitely by the day after surgery. A midwife will probably encourage you to get up as soon as you are able, helping you to the toilet or shower. She will stay nearby during that first shower, just in case you should suddenly feel faint or weak.

Don't rush yourself - but do try to increase activity everyday. When walking, try to stand as straight as possible to strengthen your abdominal muscles and reduce the risk of backache.

If possible, attend at least one physiotherapy class prior to discharge. They will have advice on strengthening the abdominal muscles, alleviating back pain and improving your bladder and bowel control.

A physiotherapist can also advise you about when to return to sport, work or home duties. Swimming, yoga and walking are good choices until you are fully recovered.

Although light housework is all right in the first weeks, wait at least 6 - 8 weeks before beginning heavier work such as vacuuming and laundry. Take care with regard to any lifting. Straining may cause damage or hinder recovery.

Be aware that, with most motor insurance companies, you will not be insured to drive for between four and six weeks after major abdominal surgery – check with your insurer.

Rest

Some clear signs that you need to rest are:

- Your wound or your stitches ache
- You feel tired and unable to cope
- You notice an obvious increase in vaginal discharge (inform your midwife or doctor if your discharge increases suddenly)

Your body needs time to heal and it takes several weeks for internal healing to take place. Although it is important to resume physical activity, avoid pushing yourself too hard.

After the major surgery of a caesarean, your body has an increased need to rest, recover and regenerate. You should not feel guilty for resting, and if you deny yourself this rest it will only extend the length of time needed to achieve full healing. A feeling of tiredness may continue for months.

Breastfeeding

Babies are born with the instinctive ability to make their own way to the breast, attach and start to suckle. This instinctive behaviour is usually strongest immediately after birth. Increasingly, babies are being placed onto their mothers' chest immediately after birth. Where this is not possible, try to have at least a brief skin-to-skin moment with your baby - even if only cheek-to-cheek.

If your baby is sleepy from medications given to you during the caesarean, they may be content to just lick or nuzzle the breast for some time without feeding. This is valuable, as it is part of a series of instinctive actions that precede feeding. A sleepy baby usually just needs more skin-to-skin contact, and time, to get breastfeeding going.

A midwife can help find breastfeeding positions that suit you and that don't place your baby directly over your wound area - such as lying down on your side, sitting beside the bed on a chair with the baby lying on the bed, or using the 'football' hold.

For some women, giving birth by caesarean appears to set lactation back by a day or two when compared to women who have given birth vaginally. The physical and emotional stress of the operation, and any drugs you receive, may initially affect your milk supply or your let-down reflex. In addition, you may have a baby who is mucousy or also affected by the drugs and may, therefore, appear disinterested. These things can generally be overcome and many mothers go on to enjoy a wonderful breastfeeding relationship after a caesarean birth.

Some babies (particularly those born by scheduled caesarean) who are not particularly

interested in feeding are at a higher risk of their blood sugar level dropping. This in turn makes them even sleepier and less likely to feed, causing further problems if it is not corrected.

Formula or bottle feeding

If you are bottle-feeding your baby, the midwife can assist you in finding comfortable feeding positions that don't place your baby directly over your wound area.

What about sex?

The same rule applies to women who have experienced a caesarean birth as to those who birth vaginally - which is that you should not resume sexual relations with your partner until you feel ready.

Before resuming sexual activity, discuss with your doctor what sort of contraception you will be using. It is sensible to allow a reasonable amount of time for your body to heal from the caesarean before becoming pregnant again. Your childbirth professional will be able to advise you what time frame this involves, based on your individual health status and the latest research available.

Cease sexual activity if it causes pain or is uncomfortable.

Due to surgical trauma, the wound and surrounding area may remain numb for up to a year after surgery. Feeling should, but doesn't always, return. Explain this 'numbness' to your partner as it can be disturbing to be touched in this area. Pressure on this area may also cause nausea.

After a caesarean your body will be trying to heal physically and emotionally. On top of this, babies demand a lot of a mother's time and energy - day and night! It is normal to feel very tired and distracted. After expending so much energy caring for your baby, you may feel emotionally 'all out of nurturing' by the time you hop into bed at night. Resuming sexual activities may not feel like a priority and it is important that your partner understands these feelings.

Anxiety, trauma and/or depression may cause a loss of interest in sex, in both new mothers and/or their partners. These can be caused by:

- A chemical/hormonal imbalance - true postnatal depression (PND). This needs professional attention, so see your health care professional.
- Grief. If you did not wish the birth to be by caesarean, it is normal to grieve for the loss of your expected birth experience.

- Post traumatic stress. This can occur especially if the caesarean was an emergency situation, or in an emotionally/physically traumatic way where you were fearful for your own/your partner's or your baby's safety or life.

Additionally, women who feel low about having a caesarean or who feel a sense of failure about the birth, quite often report a decrease in self-esteem and their sense of how attractive they are. They may also feel a sense of being less deserving of someone else's attention and affection. This can have a strong, negative impact on relationships.

If any of these things are happening with you, it is important to seek out someone to talk to about it, so that you can start to come to terms with the birth and begin to feel better about yourself.

Feelings and emotions

The emotions felt after a caesarean will depend on what actually occurred during the birth, and whether to birth this way was your choice.

If you prepared yourself for a caesarean birth and everything went well on the day, then you may have no emotional issues connected to the caesarean at all. You may flow straight back into everyday life with very little difficulty apart from the normal physical healing needed.

When birth is different to how women imagined, or they are not given support or time to adjust to a change in expectation, they can have great difficulty coming to terms with the birth.

How you react emotionally to the surgery, whether you understand the need for and are ready for intervention, and the degree to which you accept the fact that your baby is to be born in this way, will all contribute to how well you cope afterwards.

It is quite normal to experience some regret and sadness, and this may be compounded by 'baby blues' about the time that your milk comes in on around day three. Women who have seemingly straightforward, uncomplicated births also experience this. However, if the feelings of depression don't become lighter over the next day or so, then speak to someone about it.

Many women find it helpful to tell their story over and over to make sense of it. Eventually the very powerful emotions diminish, and although the grief and sadness may always be there, they won't always dominate your thoughts and life. Other women may find the healing process to be more complex. Either way, talking about your feelings is an important first step of processing your experience.

Research is indicating that 1 in 3 women experience symptoms of trauma following childbirth (Creedy et. al. 2000). It is important that you speak to someone if you are

experiencing flashbacks, nightmares, intrusive recurring thoughts, difficulty sleeping or avoiding situations where you are reminded of the birth.

“In the future, I will be asking the hospital if there is a counsellor on staff that I can talk to. After the birth I was shell-shocked and I was not thinking straight. I really needed someone to explain what had happened and listen to me. My obstetrician visited me but it was all so brief and there was the baby to think of. I was just focusing on his well-being. I needed someone to ask about me, not the stitches or the pain but my mental well being.”

These feelings may not arise immediately after the birth of your baby. Initially you may be too busy being grateful for the safe arrival of your newborn. It may be weeks, months or years further on that you become aware of a feeling of loss.

Acknowledge your feelings. It is good to give yourself time in which you can remember the whole experience. During this time, you should just let the feelings ‘come and go’ as you think about the birth. Allow yourself to be sad and the grief to be released - it is a valid emotion when we lose someone or something. You may have been planning the birth for your whole pregnancy, visualising how it was going to be, and it is normal to experience some grief at the loss of such an important expected life experience.

A lovely suggestion for healing after a caesarean is:

“As soon as we were alone and the kids were busy I ran a lovely deep warm bath and sank into it, then my husband brought our naked little newborn in and placed him in the bath with me. It was wonderful and amazing. I had missed out on holding him, with us both naked and wet at the birth. I needed to do that, to feel his skin against mine and just look at him as he was born. We lay in the water together, I touched him and he had a feed. I thought about his birth and all the happy moments and just let all my feelings come and go as they needed to.”

Next Birth After a Caesarean

Giving birth by caesarean, especially when it is a repeat caesarean, can have some undesired physical effects, as outlined below.

Formation of scarring and adhesions will occur as a result of the surgical trauma. No matter how gently the surgery is performed, internal organs will develop some adhesions that may cause problems later in life. Adhesions may cause pain in future

pregnancies as the increasing size of the uterus pulls, stretches or breaks adhesions formed earlier between the uterus and surrounding organs or the abdominal wall. They can also cause pain in a non-pregnant woman, especially around the time of menstruation, when inflammation and contractions of smooth muscle (related to menstruation) may irritate adhesions and scarring.

For each subsequent caesarean birth the surgery becomes more complicated, as the surgeon must negotiate their way more carefully through the scarring and adhesions formed from previous surgery.

The risk of placental attachment occurring on the site of the uterine scar, causing problems with placental retention during third stage, increases with each caesarean a woman experiences (Makoha et. al. 2004). This problem may necessitate manual removal of the placenta after the birth and could cause pieces of the placenta to remain behind - causing uterine bleeding, possible infection and a risk of hysterectomy.

Caesarean birth also carries the risks normally associated with major surgery. That is, anaesthetic and other drug risks to mother and baby, the risk of excessive blood loss, and possible surgical damage to adjacent organs.

Making a Caesarean Birth Plan

A birth plan is a VITAL tool for making your wishes clear to ALL your care providers.

Doctors and nurses perform caesareans everyday and it can become routine for them. Remind them that this is a special event for you and your family and ask that they respect your wishes.

Your birth plan needs to be very clear and comprehensive, but it must also be concise and to the point so it is easily read and followed. Have several copies with you and give one to every person involved in your caesarean.

Make use of the many excellent resources and ideas available through pregnancy related websites and organisations.

Remember that a birth plan is a list of ‘wishes’. Although these wishes need to be respected they cannot always be followed exactly. A sense of empowerment through giving birth comes when women feel they have been totally involved in the birth process and the making of any decisions - not how closely the birth went to plan.

If you do not want to be separated from your baby, you should make this clear well in advance. Discuss your wishes with your care provider and support team, and document it in your birth plan.

Planning a Positive Caesarean

Below are some suggestions to help make your caesarean a positive experience:

- Acknowledge your feelings. Where possible, take the time to examine your own feelings, fears and expectations of a caesarean birth.
- Educate yourself on all aspects of caesarean birth, both positive and negative.
- Maintain a healthy pregnancy. Keeping yourself and your baby in good health will help you both recover more quickly.
- If an elective caesarean is necessary, then you could request that you be able to begin labour naturally before the caesarean is performed. This will help avoid any problems with prematurity and allow you and your baby to reap the benefits of labour hormones.
- Where possible you may choose to walk into theatre and not be wheeled in on a bed. This will allow you to see the reality of the room and not a distorted view from laying down looking up at the room and lights.
- You may choose to have a relaxation CD of your choice played quietly throughout the birth. This should be organised in advance.
- Although you may not wish to see the surgical incision, you may request that the drapes to be lowered enough to see your baby as it is born. You may also appreciate a verbal description as your baby is born.
- Consider being naked (without a gown) underneath the surgical drapes, and request your naked newborn is placed on your chest unwrapped, with a towel placed over both of you to keep you warm.
- Maternal Assisted Caesarean. The head and shoulders of the baby are delivered by the obstetrician. The mother then reaches down and pulls her baby from her abdomen. This gives some women a greater sense of being involved in the birth process. This is an innovative procedure that may not be available at all sites. Speak to your doctor or visit www.birthrites.org for more information.
- You may request that your baby's umbilical cord is left long to allow you or your

partner the chance to cut it.

- If an emergency caesarean under general anaesthetic is necessary, request that your baby be given to your partner as soon as possible after birth, and be held by them (hopefully next to their naked chest) until you are awake and can be told of the baby's sex and well-being by your partner.
- Breastfeed in theatre, or as soon as possible. Even a few seconds of sucking is a big positive step towards successful breastfeeding.
- You can request that, as long as your baby is well, they remain with you at all times. If your baby must go to the nursery, then send your partner and encourage them to have skin-to-skin contact. Your baby will benefit from this contact and should recognise your partner's voice.
- If you would like to see your placenta you will need to let the theatre staff know. You may like to take the placenta home - to plant under a tree, or even to eat. Please tell theatre staff your wishes so they can make the appropriate arrangements.

Please visit www.birthrites.org for examples of birth plans.

Baby Massage

Baby massage can be extremely enjoyable to both mum and baby. One school of thought is that it can imitate the stimulation a baby would have received from uterine contractions and passing through the birth canal.

Touch your baby - spend time massaging their skin. This is great, especially just before or just after a bath. Use a product like Sorbolene, which washes off in water, or a gentle essential oil blend.

Vaginal Birth After Caesarean – VBAC

AVBAC, especially after a lower uterine segment caesarean section (LUSCS), in the absence of medical complications associated with this pregnancy, is the safer choice for 85 to 90% of women (World Health Organisation).

Planning a VBAC

In a recent large Dutch study of 3,276 women who went into labour after a previous caesarean, 76% had a successful VBAC (Kwee et. al. 2007). This figure has been fairly consistent throughout the last five or so years. Therefore, roughly 7 in 10 women who choose vaginal birth after a previous caesarean section should expect to give birth vaginally.

The only way that a VBAC labour differs from other labours is the small increased risk of uterine rupture. This has been consistently reported as about 0.4% (one in 250) for women who have had one caesarean section and enter into spontaneous labour with no other complications (Landon et. al. 2004).

The risk of uterine rupture cannot be accurately predicted (Macones et al 2006), but the scar from a previous caesarean is very strong. While many people fear that the scar will rupture and cause the death of the mother and/or baby, medical studies have shown that this risk is greatly overstated. Consider that there is a 30 times higher risk of requiring a caesarean section for other emergency obstetric situations not related to a previous caesarean (Enkin et. al. 2000).

A long-term study of uterine rupture was carried out on Australian child-bearing women. This included both women who had not had a previous caesarean section and women who had. The study reported 27 ruptures over five years, and five babies died as a result of those ruptures. When put together with the 0.4% risk of uterine scar rupture after a caesarean, this study shows that in real terms there is, at most, about a 0.07% risk of a baby dying from a uterine scar rupture (Lynch & Pardy 1997).

Benefits of VBAC

A VBAC, where not medically advised against, has many advantages for both the mother and baby. The contractions of labour massage and stimulate the baby and prepare them for birth. Waiting until labour starts assures that the baby is ready to be born, rather than being immature and with lungs that may not be able to cope with life outside the womb.

Your baby is less likely to require assistance with breathing if born by successful VBAC (Green-top Guideline UK 2007). Women who have had a successful VBAC have fewer blood transfusions, fewer postpartum infections and shorter hospital stays after the birth than women having a repeat elective caesarean section (New Zealand Guidelines Group 2004).

There are many reasons why women choose VBAC. Whatever your reasons may be, you have the right to be supported. Educate yourself on all aspects of VBAC. There is a suggested reading list at the back of this booklet. You can also contact Birthrites, or a similar local support group.

"I didn't want another caesarean because I knew how long it took to recover and I had seen so many women give birth naturally and they were able to get up and do what they wanted almost straight after."

"Pregnant for the third time and, having had an empowering birth after caesarean last time, I was not plagued with thoughts of self-doubt in my body's ability to birth naturally. Instead I had a firm belief in myself to give birth with strength, courage and serenity, like countless women before me."

A birth plan is a VITAL tool for making your wishes clear to ALL your care providers.

Your birth plan needs to be very clear and comprehensive, but it must also be concise and to the point so it is easily read and followed. Have several copies with you and give one to every person involved in your labour and baby's birth.

Not all childbirth professionals are supportive of VBAC. Those that are will have their own requirements for a VBAC labour:

Some requirements that may be discussed with you are:

- Time limits on the duration of both the pregnancy itself and each stage of labour.
- Intravenous access - which is having either a drip (I/V fluids), or a bung (catheter, but not attached to a drip) in a vein in your arm - in case of emergency.
- Use of continuous, or intermittent monitoring - either using a CTG or a foetal stethoscope.
- Eating and drinking during labour: Some allow this, others worry about the risk of inhaling vomit should a caesarean become necessary.
- Use of labour inducing drugs to induce or augment labour: There is an increased risk of rupture involved with the use of these drugs and this needs to be taken into serious consideration.
- The use of pain relief in labour.

You may wish to discuss these details with your care provider during the pregnancy to decide what is best for you.

All women wanting a VBAC should be encouraged to find out as much as possible about reasons for interventions, and their possible consequences. Being well informed will enable you to negotiate an appropriate birth plan for your VBAC labour.

Choosing a birth environment for a VBAC

Options around where to labour and birth with a VBAC will depend on the facilities available within your local area. You may have the option of a midwifery-led birth centre, a hospital, or a homebirth with the support of an independent midwife - with or without a back-up GP or specialist obstetrician.

Some women choose a homebirth to avoid the intervention and/or fear experienced in their previous caesarean, or to avoid interventions that hospital VBAC policies may stipulate (eg. CTG, fasting, I/V access, etc.). Some women wish to regain faith in their body's ability to birth naturally, and feel that the most supportive environment for this is at home.

"My midwife had been with me for a marathon 29 hours. I did it! I had my VBAC at home in a pool to soft music and candle light. It was a dream come true."

Women choosing a homebirth VBAC with the support of a childbirth professional need to be aware that in the event of the very small - but very real - risk of uterine rupture occurring, the time delay in transferring to hospital for an emergency caesarean may have serious consequences for both mother and child.

Once a woman has researched her options and made an informed decision, then she should be supported to give birth in whichever environment she feels most at ease - comfortable and confident with the help of an experienced childbirth professional.

It is natural and quite likely that whatever you choose you will waver on occasion. If this becomes more than a 'wobble' and you seriously doubt your choice – change it. You will only have this birth experience once. It has to feel right. Only when your mind is at peace with your decision, and you accept what goes with it, will you give your body the best chance to labour effectively and give birth vaginally.

Choosing a childbirth professional for a VBAC

The choice of childbirth professionals available to women wishing to have a VBAC are the same for all birthing women (see the section Choosing Your Care Provider).

Remember - you do not have to go with the first childbirth professional you visit or are referred to. If your discussions leave you feeling uncomfortable or unsure about their belief in your ability to have a VBAC, then interview others until you find one you feel confident with.

The continuity of care that can be attained by hiring an independent midwife should be noted. The midwife may support you in either a homebirth VBAC, or a hospital VBAC - depending on what you want and how she feels about each birth environment.

"As well as the shared care between the hospital and my family GP, I now also had ante-natal visits with Dierdre (my midwife) - what a difference!"

Doulas

The other childbirth support person that you might like to employ is a doula. The Greek word 'doula' loosely translates as 'woman for woman'.

A doula can provide you with the emotional support you may need during pregnancy and labour. Generally, they will visit you 3-4 times during pregnancy (mainly in the couple of months prior to birth), and once or twice postnatally. During labour, a doula's role can vary from support person for you, your partner or child/ren - to taking photos, massaging your back, and affirming your ability to birth. She may suggest ways of easing labour or simply remind you of your birth plan.

Although doula training courses are available, a doula may not have any formal educational training in regard to childbirth. A doula should not replace the childbirth professional present at your VBAC, but she can enhance the whole experience with her presence and emotional support.

"My doula was WONDERFUL! I'm so glad that I had her there and encourage ANYONE to use a doula. She really kept my head on straight and didn't let me give up."

What to expect during a VBAC

A VBAC labour will progress the same way as a non-VBAC labour. The previous caesarean/s will not directly affect your body's ability to perform this natural function. If you have experienced labour previously, even if it ended in a caesarean, you may find that your VBAC labour progresses more quickly than your previous one.

Some women experience a 'stall' in their VBAC labour at the point they had reached during an earlier labour - usually at the stage where the decision to perform a caesarean was made (eg. at so many centimetres dilated). It is not known if there is a physical cause for this, but it is more likely to be a response to the emotions surrounding the memories of the previous experience, triggered by reaching the same stage in this labour. Fear is a powerful emotion. If this does happen, it doesn't mean you will not birth vaginally. Nearly all women are able to work past this point, especially with the right support, and have a wonderfully empowering birth experience.

Working through memories, and believing in your body's ability to birth naturally, will decrease the likelihood of your body stalling in this way.

"I could feel and see my baby moving down through my birth canal, and soon I felt his head crowning. What an amazing thing to feel! It was soft and hairy and squishy. I guided his head out, by massaging my perineum over and around it, and after about half an hour of pushing, James was born into his Daddy's hands."

After a VBAC

"Once the feeling came back into my feet (they were pretty numb from kneeling) I got up and showered then put on my silky nightie and hopped on the bed for some photos. Dom had a nice cuddle with Sabrina while I showered."

A vaginal birth is different for all women. Nearly all women who birth this way report feeling a mixture of emotions including:

- Relief
- Joy
- Exhaustion
- Love
- Exhilaration
- Accomplishment

Physical feelings after a vaginal birth vary depending on the individual experience. Some common physical feelings are:

- Abdominal soreness (like bruising)
- Perineal soreness (more so if you've had stitches, though the amount of bruising involved is also a factor)
- Sore tailbone
- Sore anus (bruised feeling)
- Sore arms/shoulders (from bracing against things)
- Tired legs (from standing, kneeling or squatting)
- Sore throat (if you have been very vocal in labour)

For perineal soreness some hospitals offer small ice packs, and these are great - especially for bruising.

A salt bath is very soothing and excellent for ensuring stitches stay clean and uninfected.

A sports bottle filled with warm water and a few drops of tea tree oil is useful when you urinate, if you have grazes, tears or stitches. Simply squirt the warm water onto the perineum whilst urinating to dilute the urine, therefore reducing stinging.

Panadol or Panadeine along with an anti-inflammatory such as diclofenac (eg. Voltaren) or ibuprofen (eg. Brufen or Nurofen) will usually alleviate any soreness.

"I cannot describe what I felt - It was relief, joy, tears and laughter, it was pride and satisfaction, and so, so right. It was tenderness, and surprise and love, and a tinge of sadness for my firstborn to no longer have me all to himself. And the most satisfying part of all ~ the tears and the laughter on Todd's face as he looked at our new son, and said "You did it - all by yourself. You're so clever, look what you did!"



To order this booklet please contact
booklets@birtherites.org

Obstetric Guidelines

You may wish to look at the following guidelines written for obstetricians:

1. The Royal College of Obstetricians and Gynaecologists UK Green Top Guidelines.

The Green Top Guidelines are adhered to by many Obstetric Colleges around the world. They are written for public viewing and are easy to read.
www.rcog.org.uk/resources/Public/pdf/green_top45_birthafter.pdf

2. The Society of Obstetricians and Gynaecologists of Canada
www.sogc.org/guidelines/public/155E-CPG-February2005.pdf

It is important to remember that every obstetrician will practice slightly differently. You should discuss your birth plan with your obstetrician to make sure he/she understands your wishes.

Other related websites:

1. www.childbirthconnection.org
2. www.vbac.com

To order this booklet please contact
booklets@birthrites.org

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Suggested Reading List

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You may be able to borrow the above books from your local libraries or midwifery centres, or you can order them through a book supplier, such as:

- CAPERS. Ph: (07) 3369 9200
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Birthrites

Healing After Caesarean Inc.

Birthrites: Healing After Caesarean Inc. was started in 1997 by a group of seven women committed to supporting others who had experienced, or would need to have, a caesarean section.

One of the ways in which they were able to support these women was to provide them with information regarding their future birth choices.

Birthrites has since grown into a nationally recognised group, serviced by volunteers.

Birthrites aims to provide emotional and physical support networks, as well as information for women who have had or will have a caesarean birth. Birthrites also aims to increase health care provider awareness of the specific needs of these women.

Birthrites does this by:

- Providing telephone contacts for further support and information.
- Facilitating monthly get-togethers for women who have had or are planning to have a caesarean section. These informal coffee mornings provide a safe environment for women to share their thoughts and feelings and allow for the exchange of information.
- Increasing women's awareness of birth choices through providing a suggested reading list, quarterly magazine, website, online discussion forum and list of local resources.
- Increasing public awareness of the rising caesarean rate and providing balanced, evidence based information about VBAC.
- Promoting childbirth as a significant but normal life event.

**“With knowledge we can make choices
that lead to empowerment, and healing, through birth.”**

Birthrites' philosophy

www.birthrites.org

To order this booklet please contact
booklets@birthrites.org