Brighton and Sussex University Hospitals NHS Trust

How will my baby be born?

Different types of birth

A Parent Information Leaflet

Your baby's day of birth

When your labour starts you may experience a range of emotions from excitement to nervous anticipation as well as joy and apprehension. This is true whether you are having your first or fifth baby.

No two labours are the same but the result will change your life. When childbirth starts naturally and continues without interference a vaginal birth is more likely. The majority of babies are born this way. However the caesarean section rate has risen over the past 30 years and may be associated with increased rates of intervention such as induction of labour (see page 2 for further explanation). If labour starts between 37 and 42 weeks your baby is said to be full term and before 37 weeks is considered to be pre-term.

What type of birth will I have?

It is not always possible to know exactly how your baby will be born but it will be one of the following:

- normal birth – also called vaginal, spontaneous or normal delivery
- instrumental delivery: forceps or ventouse (suction/vacuum) delivery
- caesarean section.

What is a normal labour?

Both midwives and doctors agree that it is better for you and your baby if your labour is normal and spontaneous as it is more likely that you will give birth to your baby without the need for interventions such as having your waters broken or your labour started artificially.

A normal labour starts on its own, with naturally occurring hormones causing contractions and dilating your cervix (neck of the womb) over a gradual period of time. Your waters will break naturally during labour and you will respond to the natural urges in your body to push your baby out.

Although some women need help to start or induce their labour, labour can still progress normally and result in a spontaneous vaginal birth.

What is medical intervention?

- Induction – starting labour artificially with hormones
- augmentation – keeping labour going artificially with intravenous hormones
- amniotomy/artificial rupture of the membranes – breaking the waters.

The aim of these interventions is to increase the likelihood of a vaginal birth.

A labour that leads to a normal vaginal birth has been shown by research to be better for women and their babies.

The need for interventions does not necessarily mean that your labour will be complicated.

Some women may need assistance to aid the birth of their baby and it is important to have a safe outcome for both mother and baby.

To enable you to make choices and be fully involved with decisions about your labour and birth, you and your partner need to have information about normal labour and why some interventions may be necessary.

How will I know if I'm in labour?

Labour contractions (or pains) are different to the Braxton Hicks (practice contractions) that you may have experienced in your pregnancy. Labour contractions begin around the time your baby is due and come in a regular pattern and get increasingly painful.

There are a number of factors that influence the way your labour progresses:

- the length of contractions, their regularity and strength
- the way your baby is lying inside the uterus (womb)
- being active. Standing, walking about, sitting upright or being in a squatting position can help your labour to progress. On the other hand lying down especially being quite flat on your back is more likely to slow down the labour
- food, environment and birth support.

What position is my baby in?

When labour begins most babies have their head down, 'engaged' in the pelvis with their feet under the rib cage (called cephalic presentation). When your baby is in this position it is more likely to lead to a vaginal birth.

About three to four percent of babies have their bottom down first in the pelvis and the head under the rib cage (this is called breech presentation). Labour and birth can be complicated with the baby in this position. It is therefore usual for the obstetrician to offer to try to turn the baby (external cephalic version or ECV) before labour begins at around the 37th week of pregnancy. This has been shown to be successful in about 50% of cases and may avoid the need for Caesarean section. Further information is

available about ECV, please ask your midwife for a leaflet if you want need it.

If your baby is in the breech position close to when your baby is due to be born or when labour starts an obstetrician may recommend that you have a section, but you still have the option of a vaginal birth. We advise you to get find out more about this so that you can make an informed choice.

You may want to visit www.nice.org.uk for more information.

Occasionally the baby will not be head or bottom down, but may be lying across the uterus (your womb). This is called a transverse or oblique lie. This may occur for a number of reasons:

- when a mother has had a number of pregnancies the walls of the uterus become weaker which allows the baby to move around more easily
- multiple pregnancies, for example, twins
- when something is preventing the head or bottom entering the pelvis. This could be the placenta (or afterbirth) or a fibroid (swelling in the wall of the uterus) or an abnormality in the upper part of the uterus.

In these situations the midwife and doctor will discuss the most appropriate and safest way for you to give birth to your baby.

What happens when I'm in labour?

When you are in labour your midwife will carry out a full assessment of you and your baby. This will include observing how often, long and strong your contractions are. She/he will also regularly listen into your baby's heart beat; every 15 minutes in the first stage of your labour, to ensure that your baby is coping

with the effect of the contractions. Part of the assessment will include palpating or feeling your abdomen and an internal (vaginal) examination which will be offered about every four hours during your labour. This will give you and the midwife information about how dilated your cervix is and the position of the baby's head in the vagina or birth canal. We will discuss all care fully with you and give you explanations and choices to help you make an informed choice about your labour and birth.

Can I have a waterbirth? (see seperate leaflet)

You can use water during your labour and may continue to use it to give birth. Both maternity units have a birthing pool for your use and pools can be hired or bought to be used at home.

The use of water has been shown to reduce the need for other pain relief, help women to feel calm and relaxed and may slightly shorten your labour. If you are full term, healthy and have a straightforward pregnancy the use of water during labour and birth is as safe for you and your baby as a land birth. If the midwife identifies any complications that may put you or your baby at risk she will advise you about using the pool. If complications arise whilst using the pool the midwife may ask you to get out. It is most useful to use the pool when you are in strong active labour, although the midwife will guide you with this decision based on your individual needs.

Can I choose where I have my baby?

The decision about where to have your baby and what issues are important to you need to be discussed in detail with your midwife or an obstetrician. You can leave the final decision for when you are in labour. You may choose to have your baby at home, in the hospital or at Crowborough Birthing Centre. Visit our website www.mypregnancymatters.org.uk for more information.

How will I be supported in labour?

Women who give birth in a positive and supportive environment that encourages their involvement in choices and decisions about their care are more likely to have a positive birth experience whether this is in hospital or at home.

Some women will not be able to give birth without medical assistance despite having problem-free pregnancies. In these situations the midwife will continue to give support and encouragement and ensure that you understand what is happening and communicate why certain interventions are required for example you may need an artifical hormone in order to start your labour if your if your baby has not arrived a week after your due date. It is possible you may need assistance from a doctor when you are giving birth to your baby by either ventouse or forceps.

Why might I need a ventouse or forceps birth?

If the midwife is worried or concerned about either you or your baby during the labour or birth she/he will refer to a doctor for further assistance. You and your baby's well-being will be carefully assessed by the doctor who will then discuss with you any concerns about your progress in labour or your baby's health. The doctor may recommend delivering your baby by ventouse or forceps for the following reasons:

- because you have become exhausted or distressed during the final stages of your labour
- there are concerns about your baby's well-being and the baby needs to be born quickly
- there is a medical reason why you should avoid the exertion of pushing e.g. certain heart conditions.

What is a ventouse birth?

This is an assisted vaginal birth using a silicone rubber or metal cup placed on the baby's head. Suction (vacuum) is then created between the cup and the baby's head to hold it firmly in place. You will be encouraged to continue pushing and at the same time the doctor will guide you whilst gently pulling on the cup to help the baby to be born vaginally. The suction is then released and the cup removed from your baby's head. This will leave some swelling which will usually disappear within 24 hours and bruising on your baby's head which may last for a week. Very occasionally the baby's head may have a small cut on its head from the ventouse cup.

What is a forceps birth?

Forceps are sometimes described as being similar to a pair of salad servers that cup the baby's head and follow the shape of your pelvis. The doctor positions these around the baby's head and gently pulls whilst encouraging you to push with the contractions. The doctor will make a cut into the vaginal skin and muscles (an episiotomy) to allow for the extra space that the forceps take and reduce the risks of tearing through the back passage (rectum). Usually prior to a forceps delivery an anaesthetic doctor will administer pain relief to enable a pain-free birth.

Ventouse versus forceps – what are the risks, benefits and recovery period?

- Women who have a ventouse birth experience less trauma to the muscles and skin of the birth canal, and also report less severe pain postnatal than forceps births.

- Babies born by ventouse tend to have more bruising on their heads while babies born by forceps can have more facial marks or bruising.

- The position of the baby's head and the clinical judgement of the doctor will decide the method of birth.

- Women who have a forceps birth will have an episiotomy (this involves the doctor using some scissors to cut the perineum to make room for the forceps. Without the cut it is possible you could tear badly and would need extensive repair work. The cut is recommended as it causes less damage to the perineum) and may have more discomfort in the first few days after the birth.

- Both ventouse and forceps deliveries enable a vaginal birth and reduce the need for caesarean section.

- Recovery period for a ventouse birth is similar to a spontaneous vaginal birth, forceps births may have more discomfort due to the episiotomy, but are both quicker than a caesarean section.

What is a caesarean birth? (see separate leaflet)

A caesarean section means your baby is born by an operation involving a cut through the skin on your abdomen (usually along the bikini line) and into the lower part of your uterus. The baby is then born through this opening and you will have the opportunity to cuddle your baby as soon as the midwife has checked that your baby is well.

The midwife can help you to have skin to skin contact and breastfeed your baby if you would like (if your baby needs to go to the Special Care Baby Unit you can decide if your partner stays with you or goes with the baby). The caesarean section will take place in the operating theatre of the labour ward and you will be looked after by the midwife, the obstetrician, an anaesthetist and a team of theatre support staff. This team is of about seven people.

Why might I need a caesarean section?

Some women may need to give birth to their baby by caesarean section for different medical reasons including:

- low lying placenta
- sometimes previous caesarean section – see vaginal birth after caesarean section (VBAC) leaflet
- medical indications in the mother, for example high blood pressure, some heart problems
- baby's well being, for example concerns with your baby's heart rate during labour, premature birth or breech (bottom first) position.

If a problem has been identified during your pregnancy your obstetrician will discuss with you the best way for your baby to be born. You may be advised to have a planned or elective caesarean section; this is usually done during the 39th week of your pregnancy. You will be offered a hospital appointment a few days before the date of your caesarean section to prepare you and enable you and your partner to ask any further questions you may have.

Caesarean sections can also be done at any stage during your labour if the midwife and obstetrician are concerned about you or your baby's health. This is called a non– elective operation that you may hear referred to as urgent or an emergency caesarean section.

What are the benefits, risks and recovery period?

Benefits are:

- safe outcome for mother and baby when immediate or urgent complications are identified
- no labour contractions for planned caesarean sections.

Risks are:

- haemorrhage (bleeding) that, if it cannot be controlled can lead to a hysterectomy (surgical removal of the uterus)
- infection of the uterus, wound or bladder
- injury to the bladder or bowel
- thrombosis (blood clots) usually in the legs
- scar tissue – internally which may need further operations
- baby – cuts on the face and breathing problems
- recovery from a caesarean section takes about six weeks.

How can I find out more?

Having read through this leaflet we hope that you have a better understanding of the events surrounding the birth of your baby. If any of this information has made you worried or you have any questions about how your baby will be born please talk to your midwife or obstetrician.

If you would like to speak to a midwife about the information in this leaflet, please contact your named community midwife. Alternatively a midwife on the labour ward will be happy to advise you.

Royal Sussex County Hospital
Eastern Road
Brighton
BN2 5BE
Tel: 01273 694793

Princess Royal Hospital
Lewes Road
Haywards Heath
RH16 4EX
Tel: 01444 448669

Useful Addresses:

AIMS – Association for Improvements in Maternity Services

5 Ann's Court, Grove Road, Surbiton, Surrey KT6 4BE
Telephone: 0870 7651433 www.aims.org.uk

National Childbirth Trust

Alexandra House, Oldham Terrace, Acton, London W3 6NH
Telephone: 0870 4448707 www.nct.org.uk

Other sources of information:

Nursing and Midwifery Council

www.nmc-uk.org

Royal College of Obstetricians and Gynaecologists

www.rcog.org.uk

'Understanding NICE guidance: Care of women and their babies during labour.'

www.nice.org.uk/CG055

If you do not understand this leaflet, we can arrange for an interpreter.

إذا كنت لا تستطيع فهم محتويات هذه النشرة فبامكاننا عمل الترتيبات لتوفير مترجم شفوي لك.

এই প্রচারপুস্তিকাটি যদি আপনি বুঝতে না পারেন, তবে আপনার জন্য আমরা একজন অনুবাদকের ব্যবস্থা করে দিতে পারি

如你不明白本單張的內容，我們可安排口譯員服務。

如你不明白本传单的内容，我们可安排口译员服务。

اگر مندرجات این جزوه را نمی‌فهمید، ما می‌توانیم مترجم در اختیارتان بگذاریم.

Jeśli masz trudności w zrozumieniu tej ulotki, możemy zorganizować tłumacza.

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The information in this leaflet is for guidance purposes only and is in no way intended to replace professional clinical advice by a qualified practitioner.

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