Handbook for the Helper

A Guide for the Support Person

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1. INTRODUCTION

Welcome! First let me begin by congratulating you on your choice to become an informed support person for this upcoming birth. As you will discover, having support people at a birth is undoubtedly one of the most important things a woman can have present for the birth of her babe. So please don't underestimate the importance of your presence!

This guide is designed to help people who have been asked to be present at a birth. You may be the father of the unborn baby, or perhaps a close friend or relative of the birthing mother. Perhaps you have been to births before, have birthed yourself, or maybe this is the first time you will have been at a birth.

Traditionally in childbirth women were attended by other women who provided continuous support to the laboring woman, from the earlier stages of labor right up until mom & new bub are happily settled. In recent decades it has become popular for the father to be present & supportive during labor & birth. As a support person you have an extremely important role to play, as having a caring & supportive person whose role is to be there offering the mother continuous support can hugely improve the 'shape' of her birth experience.

A recent study by the Cochrane Library involving more than 15,000 women in 15 different countries looked at the effects of having continuous care on labor outcomes. Continuous care means a support person (or people) who are with the birthing mother constantly. While an obstetrician or midwife provides care for the laboring woman they are not with them constantly, & are often unable to provide support on the numerous levels that can be of profound help. It found that women who had continuous support during their labor:

- Had slightly shorter labors
- Were more likely to give birth spontaneously (without caesarean, forceps or vacuum interventions)

- Were less likely to use pain medication
- Had babies who were less likely to have low 5-minute Apgar Scores (Apgar scores are a method of measuring the wellness of a baby at birth).
- Were moms who were more likely to be satisfied with their birth experience.

(http://onlinelibrary.wiley.com/o/cochrane/clsysrev/articles/CD003766/frame.html)

As you can see you have been asked to perform a very important job! In order to understand how best to do your job it's necessary to have an understanding of what happens in a normal labor, so you are aware of what the birthing mother will likely experience. So let's look at the stages of labor.

2. THE STAGES OF LABOR

Following is an outline of what occurs during a 'normal' labor & birth. Remember though, there is a huge variety in what can be considered normal. For first time moms who are at least 37 weeks pregnant labor averages between 10 & 20 hours, but for some women it may last much longer, & for others it may be over much sooner. If a woman has given birth vaginally before labor will often progress much more quickly for subsequent births.

The process of childbirth can be divided into pre-labor, first, second & third stages. Let's get an idea of what 'normally' occurs during these stages.

PRE-LABOR

Pre-labor can last for hours, days or weeks before labor becomes fully established. During pre-labor the woman's cervix, which is normally 3-5cm long (0% effaced) thins, or effaces, to become paper thin (100% effaced). This effacement can also occur simultaneously with dilation of the cervix, particularly with subsequent births. The symptoms of pre-labor include-

- **A dull ache or period-like pain** in the lower abdomen, lower back or upper thighs.
- **Contractions** that may be mild or strong (though generally not strong enough for the mother to need to stop what she is doing) that may come every 5 to 15 minutes & last 20 to 40 seconds. It is not necessary to time all contractions, just every hour or so, or if they intensify.
- **A mucus plug, or 'show'** may be seen as it comes away from the cervix. A show may be noticed days or weeks before labor begins.
- **Waters breaking.** The sac around the baby can break before contractions start, or at any time during labor. The amniotic fluid, or waters, ought to be clear or pink. If there is any green this indicates meconium (the baby's first poo) & the caregiver ought to be contacted immediately.

- **Diarrhea** will often occur as the mothers bowels are stimulated as her cervix thins.
- **Vomiting or nausea** can occur in pre-labor, but is more common as labor intensifies.

FIRST STAGE

The first stage of labor is when the cervix opens to full dilation (10cm). This is when things really start rolling, with contractions coming more frequent, longer & stronger, & the mother will probably no longer be able to talk through them. Contractions shorten the uterine muscles, making the womb smaller & pushing the baby's head down. First stage lasts on average 4 to 8 hours for a first-time mom. Artificial oxytocin (Pitocin / Syntocinon) generally speeds up first stage, but makes it more intense. Epidurals tend to slow it down.

First stage of labor can be divided into 3 stages: Early first phase, Active first phase, & Transition.

Early first phase

The cervix has often completely effaced during pre-labor, & now dilates to 3-4cm. Contractions during this time will vary in strength & pattern from woman to woman. They may be 3 to 7 minutes apart & last 40 to 60 seconds with a pain that builds to a peak & then fades away. They may be mild or painful & irregular, becoming more regular, more frequent & lasting longer. Or they may be strong from the beginning, or become stronger once the waters break. This is the time to contact the caregiver to let them know labor has begun. The beginning of early first phase is when the caregiver will record as the start of the woman's labor.

To time a contraction use a clock with a seconds hand. Time a contraction from the beginning of one contraction to the beginning of the next. So if a contraction begins at 4.05pm, lasts for 20 seconds, then the next begins at 4.11pm the contractions are 6 minutes apart. Another option is to download the 'Contraction Master' if you have

an iphone or ipod touch. It can help you track the duration & strength of contractions. Remember though, it is not necessary to time every contraction, just regularly enough to keep an idea on how they are progressing- every half to one hour, or if there is a marked change in the timing or intensity of contractions.

Active first phase- established labor

Active first stage is when the cervix opens from 3 to 4cm to 7 to 8cm. Caregivers call this strong established labor- this is when the woman's body really starts working hard at birthing the baby. Contractions may come as frequently as every 2½ to 3 minutes, or may stay at around 5 minute intervals, lasting 45 to 70 seconds. These contractions may be very painful, taking the birthing woman's full attention, & they may alternate with milder contractions. When (or if) you all move from home to a birthing place it is common for the mother's contractions to slow or stop for a period of time.

Generally speaking for first babies once the mother has had regular, painful contractions, coming every 5 minutes for 60 seconds or more for an hour it is time to contact the caregiver & head to the chosen place for birthing. For second or subsequent babies you'll all need to get to your place of birthing sooner as first stage of labor will probably not last that long.

Active first phase lasts on average four to eight hours for a first labor.

Transition

Transition is the bridge between first & second stage of labor. It is when the mother's cervix opens from 8cm to 10cm (full dilation). It is the most intense time of labor, when the cervix completes dilation, but the woman is not yet at the bearing down stage. Contractions come every 1 to 3 minutes, lasting from 50 to 70 seconds, or they may appear like one continuous contraction. It may be extremely difficult for the woman to talk or change positions during this time. Often women feel rectal pressure with a strong urge to open their bowels, they may feel nauseous & vomit, & may feel

hot & cold & shake. Baby may start to descend into the pelvis & the urge to push may be present. Women often feel strong urges to make a lot of sounds (curses, moans, deep groans etc) & breathe more heavily in this time, & they may start thinking "I can't take this anymore!!!!" The mother's body will often produce a burst of adrenalin, causing great thirst & giving the woman a much needed burst of energy to help with the bearing down of second stage.

Transition may last for 1 or 2 contractions, or up to one hour or more.

SECOND STAGE- BIRTHING BABY

Second stage of labor goes from when the cervix is fully dilated to the time baby is birthed. It is not as intense as transition, as the contractions become more expulsive & slow down a bit, coming perhaps every 4 to 10 minutes.

Sometimes there is a resting phase where contractions may fade away completely, or become milder with longer periods between them. This time is best used for everyone to rest & gather their energy. This resting time may last for 5 or 10 minutes, or up to an hour or more. As long as there are no sign of fetal distress this is fine- *there is no need for the woman to push until the urge to push comes*. If transition was very long the uterus may need this time to rest (& so may the rest of you!).

The contractions of second stage usually come with an immense urge to push. There is a new rush of energy. Baby's head is out of the womb & each contraction helps baby descend the birth canal, rotating as it navigates the pelvis. The uterus contracts & pushes from above. Each contraction brings baby further down the birth canal, & between contractions baby's head moves a little back up, but not as far as before the last contraction.

As baby continues to move down the birth canal the pressure of baby's head on the woman's perineum (the tissues between the opening of the vagina & the anus) creates an intense burning sensation. The pressure helps to stretch the perineum. This

process is meant to be slow & gentle to allow the tissues to stretch & to minimize tearing. Generally speaking, *there is no need to rush this phase.*

As baby's head engages in the vaginal opening it does not recede between contractions. Once the back of their head to their forehead is free of the vagina this is called 'crowning'. Very soon baby's face & head emerges. Baby turns & first one, then another shoulder is born, & then the whole body slips out. Baby is born! As baby emerges & immediately after birth it is normal for baby to be a bluish color until they begin breathing. They are still getting oxygen & nutrients from the placenta until breathing is completely established. In a vaginal delivery all the fluid is squeezed out of baby's lungs, so they are able to start breathing easily & will turn a pink color very quickly.

For first time mom's without an epidural the second stage lasts on average an hour (but sometimes only minutes), or around 20 minutes with previous vaginal deliveries. An epidural will cause the second stage to last longer.

THIRD STAGE

Third stage is birthing of the placenta. There are two options for the third stage of labor- natural management or active management. In a hospital setting it is normal for an injection of Pitocin / Syntocinon (artificial oxytocin) to be given in the woman's thigh as baby is being birthed. This causes the uterus to contract, & with the midwife gently pulling on the umbilical cord the placenta & membranes separate from the uterine wall, & are birthed quite soon afterwards.

In natural management the uterus stops contracting for 10 to 20 minutes (or up to 1 hour). The mother (& father/ support people) use this time to rest, recover & greet the new baby. Meeting baby for the first time creates a rush of emotions, & a rush of oxytocin in the mother. A baby's suckling at the breast also releases hormones. Both cause the uterus to contract & the placenta to come away from the uterine wall. A

strong contraction, usually one push (especially if the mother is upright) & the afterbirth comes out.

The main benefit of an actively managed third stage is a reduction of blood loss by the mother. Excess blood loss (a post partum hemorrhage) can be life threatening, can increase the chances of anemia, & the need for blood transfusions. The arguments for natural management are more philosophical; birth being a natural process & preferring to avoid interventions.

The umbilical cord continues to pulsate for some time after the birth, & baby continues to receive nutrients & oxygen. Once the cord stops pulsating it is time for it to be cut. The midwife places a clamp 1-2cm from baby's belly button & another a little further up, allowing room for the mother, partner or midwife to cut the cord. It is common practice for caregivers to clamp the cord within moments of baby being born, however waiting until the placenta has separated allows baby to receive extra blood from the umbilical cord & can help to create a more relaxed atmosphere in those minutes after baby's birth. The extra blood can reduce the risk of baby becoming anemic as an infant, & gives an extra immediate supply of oxygen until baby's breathing becomes established. The extra blood from the umbilical cord may lead to jaundice for a week or so after birth, which can be alleviated with some sun therapy (sitting in the sun with bub, preferably the morning sun, with at least some of baby's skin exposed. Even indirect sun is effective).

AFTER THE BIRTH

At 1 & 5 minutes after birth the midwife does an APGAR score for baby, which is a universal measurement of the overall health of baby. It stands for Appearance (color of skin), Pulse rate, Grimace (basically, how well do they cry?), Activity (movement of arms & legs) & Respiration (breathing). The APGAR score is out of 10.

The midwife or obstetrician will perform an examination of the placenta & membranes to ensure they are intact & none has been retained in the uterus, & a vaginal examination to assess whether stitches are required.

Hopefully you now understand the basics of what happens physically during a 'normal' birth. Now let's look at what is happening on a hormonal level during this process.

3. POWER TO THE PRIMAL!

As a support person you may feel reassured to learn that a woman's body is naturally equipped with essential tools required for childbirth. These tools are the hormones she produces that orchestrate labor & birth.

When in labor the part of the brain which ought to be the most active is the more primal part- the pituitary & hypothalamus- the part of the brain which stimulates oxytocin & endorphin production. When the intellect, otherwise known as the higher brain or neocortex is stimulated this reduces the activity of the helpful hormones, & can increase unwanted adrenalin. It is so important that you as a support person understands this, so that you can help create an ideal birthing environment.

When a laboring woman begins to feel stress it can throw her into an unfortunate series of events known as the 'Fear Tension Pain Cycle'. It looks like this. A woman's preconceived ideas on the pain of labor can make her feel tense (worry, fear, anxiety, physical tension- it's all a form of stress or tension). This stress can heighten the perception of pain during contractions. The pain makes her tense up & confirms her worries about the pain of labor, which makes her more fearful, tenser, & in more pain. The cycle continues itself, causing a long, painful & unproductive labor. In essence this cycle has taken the woman out of her primal brain.

There are numerous techniques the birthing mother can use to help her stay in her primal brain during labor. All of them revolve around relaxation, of both her body & particularly her mind. Practicing various relaxation techniques in the months or weeks leading up to the birth is VERY important. The more experienced she is in achieving a relaxed state the easier she'll find it during her labor. As a support person you can think of your primary job being to help keep the laboring woman in her primal brain.

4. THE HELPFUL HORMONES FOR LABOR & BIRTH

A laboring woman's body produces a cocktail of hormones that work together to create the birth experience. What this experience is has *a lot* to do with the combination of hormones produced. The main hormones involved in labor & birth include endorphins, oxytocin, adrenalin & prolactin. Let's look at what these hormones do, & how to optimize their levels.

Endorphins are produced in response to pain & stress. Levels increase towards the end of pregnancy & peak during an un-medicated labor.

Endorphins main actions are to calm mother & baby & to give pain relief. They are also amnesic, which is why a woman's memories of her birthing experience is often hazy. Endorphins strengthen the mother-baby bond & are passed to baby through the placenta & breast milk.

Low levels of endorphins can increase the perception of pain, prolong labor & increase the likelihood of interventions due to a prolonged labor or the heightened pain perception.

You can help the birthing mother to increase her body's endorphin production during labor by helping her feeling calm, comfortable & confident; helping to create a safe, comfortable & low lit environment; & by helping her avoid opioid or epidural pain relief.

Whilst pregnant the pregnant mother can stimulate her endorphin production, which trains her body to be more sensitive to endorphins when in childbirth. In the book Prepare for Childbirth she has learnt how to do this. You can help by reminding her to be helping her endorphin levels during pregnancy!

Oxytocin (often known as the 'hormone of love') is another key hormone in labor & childbirth. The woman's body's sensitivity to this hormone increases during pregnancy, & then sharply during labor. Its production peaks during labor & birth.

Oxytocin helps stimulate contractions & aids dilation of the cervix. It helps push baby down the birth canal & also aids the rapid birthing of the placenta- which reduces bleeding time at the placenta site. Oxytocin supports nurturing behavior & strengthens the mother-baby bond.

If baby's head is not in the ideal position it does not push on the cervix completely & this will decrease the amount of oxytocin produced. Also having low essential fatty acid levels can lower oxytocin production.

Low levels of oxytocin will decrease contractions, thereby lengthening the labor time. Low oxytocin also increases the bleeding time at the placenta site, & can increase the likelihood of interventions to respond to these issues.

To maximize the levels of oxytocin her body produces it is important that baby is in the ideal fetal position. Everyone present needs to stay calm, & help the birthing mother to be comfortable & confident during labor. She needs to avoid disturbances such as unnecessary fetal monitoring, logical questions & moving from place to place (of course sometimes these are unavoidable). It is also best for her to maintain an upright position during labor so baby's weight is pushing on her cervix. Nipple or clitoral stimulation will also increase oxytocin production. After birth a suckling baby stimulates oxytocin production, which helps her uterus to contract back towards its original size.

Adrenalin is produced by the adrenal glands in response to stress. This is called the 'fight or flight response'. Adrenalin increases alertness, heart rate & blood flow to the extremities. With adrenalin the sense of panic increases, as well as the perception of pain. Some adrenalin is helpful in transition; it increases energy levels, helps bring

the birthing mother out of the altered state of first stage, & in combination with oxytocin helps baby to be birthed quickly & easily. That extra energy also helps with the initial bonding with baby.

However excess adrenalin is not so helpful. It can be produced from fear or pain, from being disturbed, bright lights, noise, intrusive or disruptive procedures & from not feeling safe & nurtured. High adrenalin levels can cause contractions to slow or stop, thus lengthening labor. Adrenalin can cause distress to the unborn baby, & increases the likelihood of interventions to respond to these problems.

To minimize the amount of adrenalin produced during labor help the birthing woman to stay calm, in her centre, confident & relaxed. To do this it is helpful for her to have confidence & trust in her caregivers & place of birthing; for the environment to be peaceful, private, & lowly lit; & for you to be confident in your abilities as a support person so you can create a supportive, positive & calm environment.

Labor will go smoothest if the birthing mother is able to stay in her 'primal brain'. To do this will be much easier if everyone feels prepared for the birth experience & there are forms of relaxation you are practiced in helping the birthing mother with to help her through the first stage of labor.

Prolactin is another hormone that peaks at the time of birth. It is the hormone of mothering- enhancing tender, loving feelings towards baby. Prolactin is required for breast milk production & is thought to be necessary for baby's optimal brain development. It is an integral hormone for childbirth & breastfeeding; however does not get affected by the birthing environment or mindset, as the other hormones do.

5. WHAT IS THE ROLE OF A SUPPORT PERSON?

Being a support person at a birth is an extremely important job when you realize the benefits that result from having continuous care (remember- shorter labors, less interventions & pain medications, healthier babies & happier moms). There are numerous ways you can be a helpful support person. They can be divided into four main categories: Emotional support, comfort measures, information & advocacy. Let's have a look at these areas.

Emotional support

This means empathy, not sympathy. It means encouraging the birthing mother & supporting her throughout the stages of labor, even when everyone is exhausted. Some ways to provide emotional support include:

- Assure her that whatever she is feeling, whether emotionally or physically, that it is a normal & natural part of labor.
- Encourage her to follow her intuition. If she feels like walking, or resting, or rocking, or moaning, then encourage her to do so.
- Use words of encouragement, such as "you can do this, you are doing wonderfully", "I'm so proud of you", "or "everything's going well, you are doing so well" etc. There is no doubt that labor can be a huge challenge, & your encouragement can sometimes mean all the difference to the laboring woman.
- Simply being there as a loving, caring & attentive presence can be a huge emotional support.
- Holding her hand, maintaining eye contact to help keep her in her centre, or holding her feet to help her feel grounded.
- Assisting her with relaxation & breathing techniques (we'll go more into these shortly).
- Encourage her to stay at home for as long as possible as this can improve the labor outcome. That said, when she feels it's time to go, then it probably is time to go.
- Encourage her to rest in between contractions to help conserve her energy.

In order to support her emotionally you will need to be aware of what emotional state she is in. If she wants to be in her own world then just being a quiet presence will be helpful. However if she is feeling overwhelmed with pain then vocalizing your encouragement will be important, or taking a more active role & assisting her with changing positions or using a relaxation technique. Always notice how your efforts are received & use this as your gauge- if she appreciates it, great, if not then try a different tactic!

One more thing to remember… in order to be an emotional support it is essential to not react emotionally to anything she may say/ do to you. Just remember, you are the support person, so turn your reactive brain off for the course of the labor. Also, this will not be the time for jokes. I remember during transition with my first child the only place I wanted to be was in the shower, waiting for the bath to fill. My husband said something about me draining the town's water supply- needless to say this was less than helpful! Always consider the birthing mothers emotional needs before blurting anything out.

No matter how well prepared a woman is, there is always a chance that the birth will not go according to 'plan'. This can be very hard on the new mom emotionally, & many women can blame themselves, or think less of themselves for this. As her birth support person it is also your role to discourage this way of thinking- the simple fact is that sometimes things happen in childbirth that no-one can alter. Remind her of how amazingly she dealt with a difficult birth & that she did the very best she could under challenging circumstances. Help her to believe in herself, so she can have confidence in her self as she focus's on being a mom to her newborn babe.

Comfort measures

Helping the birthing mother to be as comfortable as possible is very important, as this will minimize the amount of pain she experiences, which will help keep her in her primal brain so the childbirth can happen smoothly. Providing comfort may mean:

- Holding a hot water bottle to her lower back, perhaps for hours on end.
- Massaging any aches & pains. Generally the most helpful forms of massage are gently firm, smoothly gliding stokes (known as effleurage).
- Helping her into comfortable positions. Sometimes these positions will require you to stay there, such as a supported squat.
- Walking with her, & supporting her during contractions.
- Assisting her with breathing & relaxation techniques
- Bringing her drinks of water or food when needed.

You cannot expect the birthing mother to be able to tell you when she is needing these comfort measures- she is not meant to be in her rational mind where she may know a massage would be very helpful right now (although she will likely tell you if that is *not* what she wants!). So it will be up to you to pre-empt these needs. Pay close attention to her- how is she holding her body? How is her breathing? What is she saying? How long has she been in that position? Is she drinking enough fluids? How regular & long & intense are her contractions coming?

In between contractions she ought to be basically pain free, but when she is in a contraction whatever comfort measures is helpful to her will be especially useful. Watch for signs that a contraction is coming, halt any conversation that may be happening, & give her your undivided focus.

Information

Informational support means providing helpful information to the birthing mother, & also to the caregivers, as they will be coming & going from the room. As a support person you may want to keep track of the length of contractions, & relay this information to the mother if it seems appropriate & to the caregiver when they come along. Providing information may also mean reminding her to breathe, or to change position, or coaching her in a relaxation exercise, or telling you what is happening, or reminding her that transition means she is nearly there.

If the caregiver begins to suggest a form of intervention or pain relief as a support person it may be more helpful for this information to get communicated to you, so you can ask the relevant questions, such as:

- Why are they suggesting this?
- What are the **b**enefits?
- What are the **r**isks?
- Are there any **a**lternatives?
- What is likely to happen if you all decide **n**ot to use the intervention etc? (You can remember these 4 questions by the BRAN acronym.

Once you have gathered all the relative information you can relay this to the birthing mother & help her reach a decision. If you have the role of information collector it means the birthing mother does not need to get into her rational brain to ask all the relevant questions, so she is more able to focus on her job of birthing.

Advocacy

This means speaking up for the birthing mothers needs or wants. You ought to have a copy of her Birth Plan (as ought the caregiver) which will outline her wishes, & you will be in close communication with the laboring woman & will know what her needs & wants are throughout her labor. If she knows she has support people who will advocate for her this is going to increase her confidence & sense of safety, so she will be better able to relax & get on with the job of birthing. Advocacy follows on from gathering information. Once you know the information your job is ensuring the best care for the birthing mother.

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To sum up, your role as a support person is to 'mother the mother' by:

- Listening to or pre-empting the needs of the laboring woman.
- Providing care for her in as many ways as you can & she needs.

- ✦ Helping to ensure her environment feels safe, give her confidence & help her remain calm.
- ✦ Being the person who does the thinking, talking & standing up for her needs.
- ✦ Help her believe in herself & to accept the way her birth unfolds.

All this aims to help her birthing hormones work at their best, with the aim of creating a smooth labor & birth.

Remember, the better support she has, chances are the better outcome for her, her baby & her birth experience.

6. SPECIFIC TOOLS TO HELP THE LABORING MOTHER

As a birth support person there is nothing more daunting than not knowing how to support the laboring woman. To help ensure this doesn't happen for you following is a list of support strategies that may be useful.

BREATH

The single most important tool the laboring woman has to help her through labor is her breath. As her support person one of your jobs is to keep an eye on how she is breathing. If she is starting to panic & letting the experience overwhelm her then her breathing will become shorter & shallower, her shoulders may tense up & her labor pain will be heightened. If you see this happen it is essential you help her get back into slow, deep breaths, where her abdomen is rising & falling with her breath, her jaw & shoulders are relaxed. To do this she may only need a reminder to slow her breath down & breathe deeply, or perhaps she will need more help. First, make sure you use a calm, relaxed & supportive tone (you may want to take a few deep, relaxing breaths yourself). You could then try:

- Be where she can see you & give her a visual cue to breathe in… & out…, such as raising or lowering your hand, or nodding your head.
- Try combining physical touch, such as embracing her, either from behind or in front, so she can relax into you, & breathe in & out loudly. She will begin to match her breathing to yours.
- Add an element of distraction to the rhythmic breathing by counting her inhales during the contraction, or counting the seconds on inhalation & exhalation.
- Be sure to praise & encourage her as she gets her breathing into a slower, more relaxed rhythm.
- You will probably find that if the mother is panicking you will have to start with a faster breathing pattern, such as one second in, one second out. As she

matches this begin to slow the pattern down to around 5 or more seconds per in or out breath.

MENTAL RELAXATION

Once she has her breathing back to a slower, more relaxed state try implementing some other forms of relaxation. Being able to relax her mind is the most important skill to have to help her birthing hormones do their job, so hopefully she has been practicing relaxation techniques & you are aware of what techniques she has practiced & found useful. Relaxation techniques can be divided into visualization, positive words, music, visual focus, vocalization & distractions techniques.

VISUALIZATION

This is a great tool for maintaining her centre & focus. Visualization means imagining a visual image inside ones' head. It may be a scene in nature, it may be an image of her holding her baby, or her cervix opening like a flower. Preferably you will know what her visualization is beforehand, but if you don't you could try asking her to paint an image in her head. Ask her to fill in the details, the colors, sounds, textures, how she feels in this scene. Don't expect her to verbalize what she is creating, but she may if she finds it helpful.

Another option is to create a scene for her. Make sure she is in a comfortable position, then have her close her eyes & describe a scene to her, such as a time you shared together, like a holiday or a favorite place to go. Be as detailed as possible, including what's happening around her, the colors, sounds, activities, any animals, tastes, smells etc. One of the most common visualizations is a day at the beach. Describe the feel of the sand on her skin, the sound of the waves and the sea gulls in the air. Describe the smells, and the heat from the sun.

POSITIVE WORDS

Positive words, or affirmations, are an excellent way to get into a positive mindset & can be used as a form of meditation or relaxation. She may have developed some positive affirmations during pregnancy, such as "I birth with ease" or "I have a smooth labor & childbirth". You can remind her to use an affirmation, by saying it either in her head or out loud. Or you can use words to help her create a positive mindset, such as "you are birthing so well", "I am so very proud of you", "I love you", or whatever it is you think she needs to hear.

MUSIC

You may have brought some relaxing music with you, & using it may be just what she needs to help her get into a relaxed state of mind. Or you could use a few words & sing them like a chant, or hum together. Use whatever is going to help her maintain her calm. If you are playing music then instrumental tends to be better than music with words, as her rational brain won't be trying to listen & understand the words.

VISUAL FOCUS

Having something to focus her vision on can be a form of meditation. It can be anything she likes- a candle, a picture, a flower, or your face. Maintaining eye contact can be a very powerful way to give her your non-verbal support- she will be able to sense your love & encouragement & this will give her strength.

VOCALIZATION

Being vocal will no doubt come very naturally to her at some times during her labor, & it is a natural way to release tension from stress, fears, & pain, without slowing down her labor progress. However, there are more & less useful sounds for her to make, as some sounds enhance relaxation & can only be made from a relaxed body, while other sounds increase tension & she needs to be tense to make them.

Sounds such as moans, groans, deep sighs or hums are low toned sounds, & her mouth, jaw & chest muscles need to be relaxed to make them. They help to create a relaxed environment. While her body needs to be tense to make a screech, a yell or a high pitched wail, & they will create a much more stressful environment. If your laboring woman is making these sounds it's a sign that she is feeling tense & letting the pain of contractions overwhelm her. To help her make more relaxed sounds once she is through a contraction help her get her breathing into a slow, relaxed pattern, then when the next contraction starts you could try making a more relaxed sound, such as a groan to encourage her to use a similar sound. Or ask her to open her mouth, as this will help relax her jaw & bring the sound lower.

DISTRACTION TECHNIQUES

Distraction techniques help the laboring mother to keep her mind focused on one thing & can help to reduce the amount of fear or pain she is experiencing. An excellent example of a distraction technique is called the 'Rainbow technique'. It's a bit like a guided meditation you can talk her through. Begin by helping her into a comfortable position, then ask her to close her eyes & imagine something red say a red apple, then orange, such as a glossy orange, then yellow, such as a yellow lemon, then green, say a bunch of green grapes, then blue, maybe blueberries, then purple, perhaps purple grapes. As you go through each color try to imagine as much detail as possible- the shape, texture, smell, even the taste. The more she is able to focus on theses details the less intense her labor will be feeling, & the more she will be staying in her centre.

REDUCE PHYSICAL TENSION

If the laboring woman is holding a lot of tension in her body then this can increase her perception of pain. Signs of physical tension include hunching over, stiff, jerky movements, higher pitch noises, her telling you of a pain, or the pain of contractions overwhelming her. There are several things you can do to help, including:

- Massage the areas of tension.

- Get her to really tighten those areas, while holding her breath, for a count of five, then let go (preferably do this in between contractions).
- Use a hot water bottle.
- Movement, such as taking a walk
- Any of the breathing & mental relaxation techniques.
- Help her change positions.
- Encourage her to rock or sway her hips.
- A warm bath or shower can help to loosen muscles as well.

7. POSITIONS FOR LABOR & BIRTH

As a support person it's important for you to have knowledge of good positions for labor & birth so you can encourage & help the laboring woman to use them. Rather than lying on her back, upright or active positions have been shown to:

- Decrease the amount of pain experienced
- Create more regular & effective uterine contractions
- Enables the mother to relax more between contractions
- Shorten the 1st & 2nd staged of labor by up to 40%

This said, the next most important thing to remember is the best position is whatever she finds most comfortable. Labor is about movement, so encourage her to change positions as she feels the need. If she has been in the one position for a long time & labor is not progressing much (contractions remain more than 5 minutes apart & are not really strong) then a change in position may be a really good idea. Encourage her to loosen up her hips by rocking or rotating them, as this will help loosen up her muscles & ligaments & help baby pass through the pelvis.

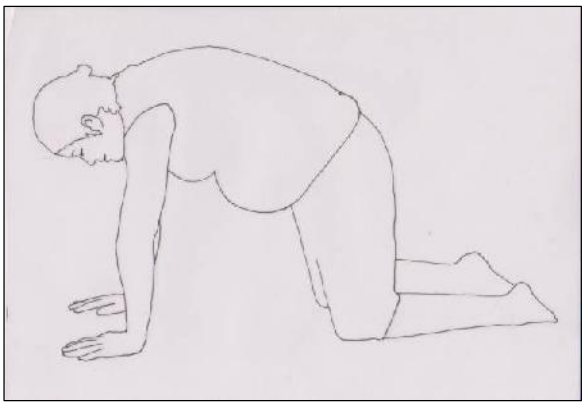
Active positions can be divided into the following groups.

STANDING

Standing includes walking, & supported standing, with her feet a comfortable width apart & you assisting from behind or in front of her. Alternatively she can support herself on a wall or other piece of furniture. Standing is great for utilizing gravity, it helps to open up the pelvis, is good for back pain, & can speed up a stalled labor. If pushing in a standing position care needs to be taken to not tear the perineum (make sure she takes her time pushing).

Standing can also speed up second stage, but can make it hard to relax between contractions.

KNEELING



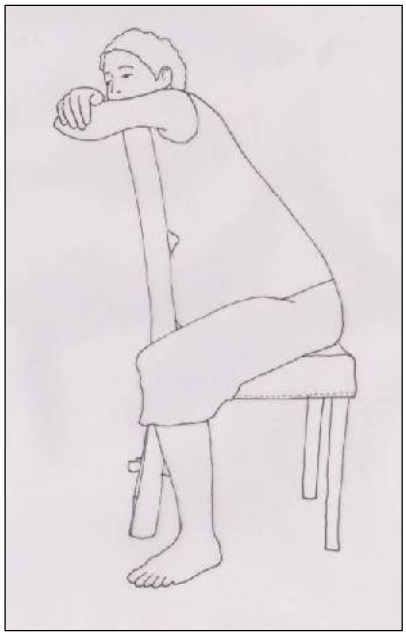
Kneeling can be on all fours, or resting over a bean bag, chair, pillows or yourself as a support person. This is a great position if she is having back pain or if baby is lying posterior. Kneeling can be used in the shower, & is a good position to be able to doze in between contractions. Kneeling will help to slow a rapid second stage & reduces the chance of tearing the perineum. If second stage is happening too quickly she can use an exaggerated kneel, with her head down & bottom up in the air to slow down the progress. If she has an epidural she may still be able to kneel, but she'll need help getting into position, & will need support people on either side to make sure she doesn't lose her balance. Make sure she has something soft under her knees, such as a folded towel so she can stay in this position without soon getting painful knees. It's a perfect position for swaying her hips, & gives you easy access to her lower back to provide heat or massage.

SQUATTING

Squatting is the best position for opening her pelvis up- giving 1-2cm more room in the pelvic outlet compared to reclining back. It is great for if baby is posterior or is not coming down the birth canal- making a long second stage. Squatting utilizes gravity & can give her a greater sense of control, but it can increase the chance of tearing because of the

pressure on the perineum. Most of us are not used to squatting for long periods of time, so is best saved for second stage & she can stand or sit back in between contractions. She can use a birth stool, or a supported squat with you holding her under the arms, or she can straddle your legs, allowing her to rest but still maintain a type of squat to open her pelvis.

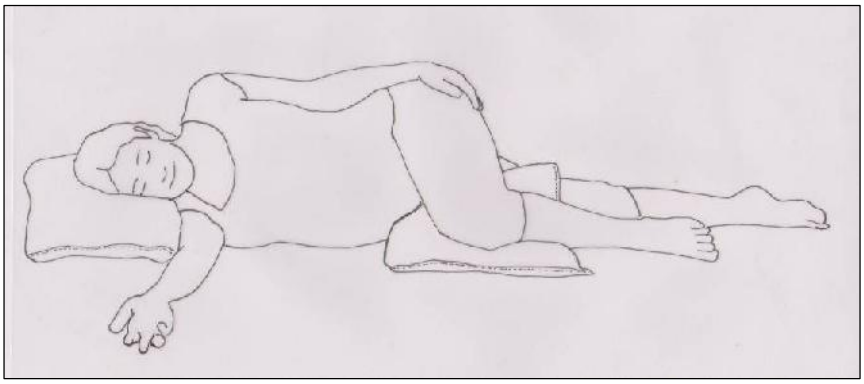
SITTING



Sitting is a good position to help her body let go as it feels so familiar. There a numerous sitting positions, including the laboring woman sitting between your legs so she is supported by you, or sitting with her back against a wall or bed-head; here she has good back support & can hold on to her knees & pull them towards her shoulders during contractions. This position gives the carer (& the birthing mother with a mirror) a good view of baby crowning & her or her carer can slow the crowning phase with a hand to decrease tearing.

Asymmetrical sitting, such as with one leg raised is good in the early stages of labor as it changes the shape & enlarges the pelvis, allowing baby to find the best position for birth. Straddling a chair allows her to lean forwards & rest, while sitting on a birthing ball lets her rock rhythmically with the contractions. Both these positions give good access to her lower back for hot packs or massage. Sitting still aids gravity, & can easily be used in between other positions, such as squatting or all fours. Just make sure she doesn't recline back too far, as this decrease's the space between her pelvis, which slows the birth progress.

LYING ON HER SIDE



There is no doubt that labor can be tiring, & if she is feeling exhausted lying on her side is the most restful position to use. This position can slow labor down, so it's best not to use it early on, unless labor is progressing too quickly. Lying on her side allows room for her sacrum & coccyx to move back as baby descends, & lying on her left side can take pressure off the uterus & improve baby's heart rate. If she is using this position for pushing it can be helpful for you to hold her higher leg up, as this gives her something to bear down against.

Lying on her side is also a position she can use if an epidural is in place, but she would require help rolling onto her side. This is possibly the best position for her to avoid perineal tearing.

WATERBIRTH

Birthing in water has some wonderful benefits. Being free from gravity allows easier mobility to the birthing mother. Being submersed in warm water positively changes her sensory stimulation & is extremely relaxing; creating a decrease in stress hormones & increasing endorphins & oxytocin. The birthing pool is filled with water the same temperature as the human body, & ideally deep enough that the birthing mother can submerse herself up to her chest, as this deep emersion appears to

increase the sense of relaxation. Not only does birthing in water allow the mother a more peaceful birth experience, it also has been observed that babies born in water cry less, are more relaxed, & are more eager to have eye contact with their mothers & to suckle than babies born in air. This is thought to be due to the warm water being a more similar environment to the womb, creating a gentle transition into the outside world.

Both my children were born in a birth pool, & I found it an incredibly nurturing experience. With my first my husband came into the bath as well, & held me as I labored, creating a wonderfully connected, loving experience.

Generally caregivers suggest the laboring mother not to get into the birthing pool until she is 5cm dilated or more, as the bath can slow or stop the labor progressing if used too early. However if there are strong contractions with no dilation a bath can help the mother to relax & speed up labor.

All the birthing positions talked about above can be used in a birth pool, except of course the side lying positions. Some, such as squatting are actually easier in a pool. Other positions such as reclining that are not recommended normally can be used in a pool as gravity has less impact.

A bath can be used either just during labor, or for the birthing of baby as well. Check what the policy is of the birth place for whether they allow waterbirths. In a waterbirth once baby is born they are gently brought to the surface. They continue to receive oxygen from the placenta & have natural reflexes that ensure they do not take a breath until their faces come in contact with air. After this their faces are not re-immersed.

8. HOMEOPATHICS FOR LABOR & BIRTH

Homeopathic remedies can be an invaluable, safe & easy to use treatment option for during & after childbirth. They can be bought in liquid or pill form. Some natural therapists will make up 'homeopathic birthing kits' & provide instructions for their use. Below is a list of potential homeopathics you may want in a kit. As a support person having an idea of homeopathics that can be useful in childbirth is a great way for you to feel like you have more to offer to aid the laboring mother- you can be an even greater support.

Arnica is the most important remedy to have handy for during & after labor. It reduces painful bruising & swelling, & can help keep energy levels high. It can also help to minimize blood loss. Arnica 200 can be used prophylactically (that is, to prevent bruising & swelling) in pre-labor, during & after birth.

During labor…

- Caulophyllum 200 can be used if labor is slow & contractions stop
- Pulsatilla 200 is useful if she feels helpless & weepy
- Sepia 200 if she feels indifferent & exhausted
- Arnica 200 if labor is long, slow, exhausting & painful
- Aconite 200 if labor is too fast or violent
- Kali Carb 200 if she has intense backache (such as from a posterior presentation)

After labor there are also a number of homeopathics that can be used.

After pains (from the uterus contracting back into position) are not often talked about, but can be debilitating, especially for births after her first. For after pains…

- That last a long time or occur after the birthing many children, use Secale 200
- That are intense in the groin area, use Cimicifuga 200
- That extend into the hips, buttock & legs, use Kali Carb 200

- That are worse when baby feeds, use Arnica 200, Chamomilla 200, Pulsatilla 200 or Secale 200
- With a sore bruised feeling, use Arnica 200
- With weepiness, use Pulsatilla 200
- That feel unbearable use Chamomilla 200, or Cimicifuga 200

If she feels anger (often suppressed) about the birth, use Staphisagria 200.

For the after effects of a…

- Caesarean she can use Arnica 200, Bellis Per 200, Calendula 200 or Hypericum 200.
- Catheter she can use Staphisagria 200
- Epidural she can use Arnica 200 or Hypericum 200 (Hypericum especially of there is any nerve pain)
- Episiotomy she can use Calendula 200, Hypericum 200 or Staphis 200
- Forceps delivery she can use Arnica 200, Bellis Per 200, Calendula 200 or Staphisagria 200

For the after effects of drugs such as…

- Morphine or Pethidine, where it's disturbed her sleep & made her irritable use Chamomilla 200
- Syntometrine she can use Secale 200, taken ASAP afterwards as an antidote
- General anesthetic, phosphorus 200 can be used, especially if it's caused vomiting

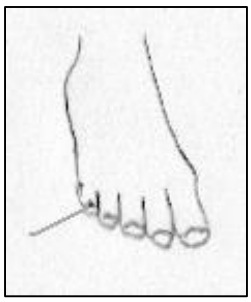
For retained placenta…

- With a bearing down sensation she can use Secale 200 or Sepia 200
- After a long & exhausting labor use Arnica 200
- Where contractions are weak or non-existent use Pulsatilla 200
- With bleeding she can use Ipecac 200

As you can see a good homeopathic kit can be invaluable for treating a great range of problems that may arise in the course of labor & birth. Homeopathics are a great modality as they do not interfere with any drugs, there are no real side-effects, & they can work very speedily. To take a homeopathic remedy she holds the liquid or pill in her mouth for as long as possible, & tries to not have any other flavors in her mouth at the same time. When purchasing homeopathic remedies the Natural Therapist will give more directions on dosage.

9. WHAT CAN I DO IF BABY IS BREECH?

If her baby is laying breech there are several things you can do to help the baby turn into the vertex position (head down). If the baby is breech at 34 weeks the following techniques may be used with your help. Make sure she talks to her caregiver first, so you are all working together & to see if there is any reason why you should not use these techniques. If she feels like baby has turned then stop using the baby turning techniques & the pregnant mother ought to visit her caregiver to confirm this. Once baby has turned vertex then she can start using deep squats to encourage baby to engage in this position.

- There is an acupressure point that can be useful for turning a breech baby.  This point is on the outside edge of the little toes, near the toenail. You can use an index finger or thumb, applying pressure to both little toes at once. This acupressure point can be used during the last weeks of labor, in pre-labor & first stage of labor as the contraction begins, then releasing as the contraction ends.

- Have the pregnant mother lay on the floor with a towel under her hips. Hold the ends of the towel & move your hands up & down so that her belly wiggles from side to side. This should be small movements that she finds very relaxing. Do this for about 5 minutes. Then have her kneel above a few steps & support her as she walks her hands down 2 or 3 steps. Have her stay like this for 5 minutes or as long as is comfortable. Do this exercise when she has an empty stomach to allow more room for baby to turn.

10. WHAT CAN I DO IF SHE IS IN TOO MUCH PAIN?

There is no doubt that for most women childbirth is an extremely challenging experience, with many women finding the sheer pain of contractions too much to bear. Many women will have put much thought into how they are going to cope with the pain of childbirth, & most will have some idea on whether they would like to avoid medical pain relief or if they are happy to use the drugs if needed. While having medical pain relief can be a huge relief & there are certainly times when it becomes necessary it's important to remember that any form of intervention does increase the chances of further interventions becoming necessary (the cascade of interventions) & that all interventions have their risks & drawbacks (much more on this in chapter 12). So while interventions do have their place it is very important that they are not used unnecessarily. As a support person there is much you can do to help minimize the pain the laboring woman experiences, & thus reduce the need for interventions.

Remember the 'fear tension pain cycle'? Being a supportive support person who soothes any fears or tension that arises can help minimize the pain the laboring woman experiences. To do this stay aware of any verbal or non-verbal signs that she is entering this cycle: What is she saying? How is she holding herself? How is her breathing? Has anyone said or done anything that may increase her fear or tension? If you notice her entering this cycle you have two options:

1. Respond verbally- ask her to talk about what's going on for her. Simply talking about it can help to relieve her fears. Provide verbal support- tell her how wonderfully she is doing, or whatever it is she needs to hear.
2. Respond non-verbally- ease her fears or tension through physical touch, eye contact, or utilizing any of the mental relaxation techniques. Start with her breath & get her breathing in a slow, deep rhythm, then use your intuition & move on from there.

The Gate Control Theory explains how the body has different types of nerve fibers for different sensations. The sensation messages from heat, touch, vibration &

massage get to a person's brain faster than the sensation messages from sharp cramping pain. So during labor utilizing the above forms of sensations will decrease the amount of pain the laboring woman is experiencing. That's why touch, massage, or a hot water bottle can be so helpful. If you combine this with relaxation techniques, such as using the breath & forms of mental relaxation then the birthing woman can really start to feel on top of her laboring experience.

There are also nerve endings called Merkel's Discs that are found particularly on ones palms, soles & lips that convey messages to the brain faster than contraction pain messages. So during a contraction you could help the laboring woman stimulate these nerve endings by holding her hands or feet, kiss her lips, or have her stand up & put her hands on a flat surface, or hum, or stimulate her fingertips by touching your face or rubbing her fingers on a surface etc.

What position she is in will have a huge impact on how much pain she is experiencing. Reclining positions, such as lying on her back or leaning back in a couch etc will generally be more painful than upright positions, such as standing, leaning forwards over a chair or a birthing ball. So helping her into a different position can be extremely effective.

Homeopathics can be useful for labor pains, such as Arnica 200 or Kali Carb 200. Have a close look at the Homeopathics for labor & birth section. The dose for homeopathics depends on the severity of the symptoms, so if in intense situations they can be given every 15 minute for up 3 hours. Remember to get dose guidelines from your natural therapist.

If you have tried numerous techniques & nothing is improving your laboring woman's experience she will likely be quite clear on wanting medicated pain relief. Hopefully she has outlined in her birth plan what her preferred option is, & when you read Chapter 12 you will get a good idea of the pro's & con's of each. The caregivers will need to be talked to & together you can help the laboring woman get

the necessary pain relief. It will depend on how dilated she is & possible other factors such as when the anesthetist can come.

11. WHAT IF LABOR DOESN'T PROGRESS?

If labor has begun but the contractions don't increase in speed, length & intensity this is known by many names, such as dysfunctional labor, failure to progress, protracted labor, or labor dystocia, just to name a few. The actual diagnosis of dysfunctional labor will depend upon the philosophy of the caregiver, but could be defined as dilating less than 1cm per 2 hours of labor, once active labor has been established.

There are many reasons why labor may become dysfunctional, such as:

- **Fetal dystocia**, from malposition, not being engaged fully, or a large head.
- **Uterine dystocia**, meaning that the uterus is not contracting sufficiently. This may be due to fear (increasing her stress hormones), being dehydrated or lacking food, laboring lying down, structural anomalies, or cephalopelvic disproportion (CPD- which means the baby's head being large compared to the mothers pelvis).
- **Cervical dystocia** may be caused by the cervix being scarred (from a biopsy), damaged from disease or structurally abnormal, which could cause the cervix to not dilate properly.
- **Pelvic dystocia** may occur if her pelvis is not the gynecoid shape (the ideal shape for birth), if it is malformed or very small. Using upright & active birthing positions can increase pelvic dimensions.
- **Emotional dystocia** relates to fear, exhaustion & severe pain, all of which increases stress hormones & reduces contractions.
- **Other causes of labor dystocia** include the mother being immobile, being dehydrated, 1st stage of labor being misdiagnosed (that is, she's not really in labor yet), being disturbed & inappropriate use of interventions such as Syntocinon.

As you can see for some of these reasons for labor not progressing there is very little you can do about, while others can be minimized or avoided altogether. As a support person you can help avoid these complications by helping the birthing mother

remain calm, helping with methods to cope with the pain of contractions, assist her with upright positions for labor, being a supportive support person & creating a safe environment will all help to ensure that labor progresses at a healthy speed. It is also crucial to remember to offer her plenty of fluids to drink (preferably water or diluted fruit juice) & nutritious snacks. Something as simple as becoming dehydrated can make the difference between a normal labor & one where interventions become necessary.

The natural remedies for induction can be used at this time, such as diluted jasmine oil rubbed into her feet or lower back, the homeopathic remedy Caulophyllum 200, or herbs to help reduce anxiety, such as skullcap, valerian or passionflower. There are also a number of acupressure points you can use.

When it comes to the pushing phase of labor (second stage) sometimes the birthing mother may feel like baby gets 'stuck'. Sometimes this may be the case, however there is also a normal stage of birthing where baby's head is 'shaped' to conform to the shape of the mothers pelvis. Each contraction helps to mould baby's head, rather than forcing baby's head down the birth canal. If the mother is given a quiet, uninterrupted & low-lit space this process happens unhindered. Then all of a sudden baby's head moves past the rectum & is crowning. All is well. It is common for birth care providers to want to intervene, but as long as baby is showing no signs of distress then any interventions are usually unnecessary.

Those times when baby is not progressing down the birth canal, where the pushing phase has gone on for hours & the birthing mother is languishing there is a technique that may be useful called 'reversing the energy'. The birthing mother lays either face down or on her back, with her knees tucked up to her chest, & for the next 6 or so contractions instead of pushing she imagines taking baby's head up towards her neck. This is thought to help baby gain momentum for descending the birth canal.

A common scenario is a slowly progressing labor causing a caregiver to decide to augment with Syntocinon, only to have baby react with fetal distress & resulting in an emergency cesarean. This suggests that perhaps a slow labor is just what this baby needed, & perhaps baby may even be able to influence the pattern that labor takes on. As long as mother & baby are doing fine the necessity of labor running to a schedule is very questionable. It is certainly worth discussing with the caregiver what their thoughts are on it & making the birthing mother's desires clear.

12. INDUCTION, MONITORING, AUGMENTATION & MEDICAL PAIN RELIEF OPTIONS

You may be hoping your loved one will have a straight forward birth with no need for any form of interventions, but there's a chance they will be faced with the possibility of requiring an intervention. If this happens it is a really good idea for you, as a support person, to have an idea of what the intervention entails & what the possible benefits & risks are, so you will be able to help the birthing mother make an informed decision.

i). INDUCTION METHODS

There are times that the caregiver may want to get labor started when it has not begun on its own accord. This is called induction. The main times a caregiver may want to do this is if the mother is 7 to 14 days over their due date, if the mother has a pregnancy complication, or if there are signs baby is in distress.

MEMBRANE SWEEP

A membrane sweep (sometimes called a stretch & sweep) is generally the option for assisted induction. The midwife (or doctor) is likely to offer one at 40 weeks if it is the woman's first baby or 41 weeks if not. A sweep is literally the midwife or doctor sweeping their finger around the cervix. The idea is that it will help to separate the membranes surrounding the baby, from the cervix. In turn, this will hopefully release prostaglandins (naturally occurring chemicals which can start off labor.) If it is going to happen after a sweep, labor is likely to start within the next 48 hours. If this doesn't happen, it's likely that the sweep was unsuccessful. The mother may be offered another sweep after the first being unsuccessful, or the caregiver may suggest other forms of induction.

Some women say that a membrane sweep is uncomfortable & painful. It may be followed by very light bleeding & irregular contractions. (If shortly after, she is bleeding very heavily, it is important that the caregiver is contacted straight away.) Despite being uncomfortable, a sweep is often a good first option as it is relatively unobtrusive & fairly natural. There is also no risk of infection from a membrane sweep.

PROSTAGLANDINS

Prostaglandins are fatty acids which occur naturally in the bodies of humans and animals. They work in the same way as hormones & during pregnancy they can start off contractions in the uterus.

Prostaglandins are released from sweeping the membranes, & are naturally found in semen. Artificial prostaglandins can be administered by an oral tablet, a pessary or a gel (which is inserted into the vagina), or intravenously. Administration of prostaglandins can augment labor in up to 50% of women, & is more likely to be successful if baby is more than a week overdue & if it is a subsequent baby.

The initial dose of prostaglandins may not be successful, so the caregiver may give her another dose after about 6 hours. As a pessary takes longer (about 24 hours) to take effect, she will only be offered it once. Baby's heart rate is monitored with a CTG machine for 20 minutes beforehand & 40 minutes afterwards. If the prostaglandins are effective the mother will likely experience cramping lower back pain or abdominal pain. If her waters do not spontaneously break they are often broken after the cervix starts to dilate to encourage stronger contractions. If labor has not begun after 12 hours or so a Syntocinon drip is often recommended.

If the reason for induction is not due to concerns for her or her baby's health she may have the option of waiting a few days & trying prostaglandins again. She may wish to talk to her caregiver about this as it can avoid alternative modes of delivery, such as a cesarean.

The main advantages of prostaglandins include:

- It is a relatively simple procedure, with few side effects.
- After the initial administrations & monitoring the woman is free to move around, allowing her to have an active labor in whatever positions she chooses.
- Compared to Syntocinon there is less need for pain relief & less chance of requiring forceps or cesarean delivery.
- If she is planning on having the baby at a Birth Centre or at home you all still have the option of going to the chosen birthplace once it is administered.

The main disadvantages of prostaglandins include:

- There is a 1 to 7% chance that hyper-stimulation of the uterus can occur, where the uterine muscles contract too much, reducing oxygen to baby. If this happens the caregiver may try to suppress the contractions with medication. Occasionally an emergency cesarean is required.
- Prostaglandin gel cannot be removed easily.
- Because of the risk of hyper-stimulation prostaglandins cannot be used if the cervix is too favorable (too thin, or effaced) or possibly if the waters have broken.

ARTIFICIAL RUPTURE OF MEMBRANES (ARM)

This is a doctor or midwife breaking the waters to start off labor. Most hospitals no longer use this as an induction method (unless prostaglandins can't be used) but rather to speed up a very long labor. ARM's can be a successful form of induction, particularly if the cervix is favorable, & can be performed at any birthplace by a midwife or doctor. If the mother is given an ARM make sure she is allowed a reasonable amount of time for labor to become established (at least 6 to 24 hours). However if labor does not start within 12 to 24 hours she is at an increased risk of infection.

Because of this increased risk of infection there is often a policy of commencing syntocinon as soon as 2-4 hours after the ARM if contractions do not begin spontaneously. If the pregnant woman has an ARM it is so very important for her to be active afterwards, such as going for a good walk, to help get things going & to avoid the 'cascade of interventions'.

SYNTOCINON / PITOCIN

Syntocinon contains a synthetic form of the hormone oxytocin. It is given via a drip to start off contractions, & is also used if contractions are too weak to move the woman into established labor. While Syntocinon will get contractions going, it is not powerful enough to force the uterus to push the baby out, so natural labor will have to have started for her to be able to give birth.

Syntocinon can also be offered during labor if contractions have slowed, & post-labor to help the woman to quickly push out the placenta. This reduces the risk of excessive bleeding after she's given birth. It is also used as a treatment for post partum hemorrhage.

If she is given Syntocinon to initiate labor it will be started at the lowest dose & gradually increased every 15 to 30 minutes until labor is established, at which point it is maintained at that dose until baby is born. Usually the drip needs to be run for several hours before labor establishes. If the maximum dose is reached & maintained for several hours, the waters have been broken & still labor is not established the induction is deemed unsuccessful & usually baby is then delivered by cesarean. But if the waters have not broken & there are no complications you both may wish to talk to the caregiver about trying Syntocinon again in a few days.

The main advantages of Syntocinon include:

- Generally it will shorten labor.
- It can be used where the cervix is too favorable for prostaglandins, or if the waters have broken.

- The dose can be lowered if hyper-stimulation occurs.
- The effects wear off quite quickly once stopped.

The main disadvantages of Syntocinon include:

- Side effects such as nausea, headaches, quickening or slowing of the woman's heat rate.
- Baby's heart rate is continuously monitored with a CTG machine, restricting the mother's movements & making showers or baths impossible. However you could talk to the caregiver about the possibility of disconnecting the CTG machine after the Syntocinon dose has been established, as long as baby's heart rate is normal & there is no sign of meconium stained amniotic fluid. The caregiver could then monitor baby's heart rate intermittently, (say every 30 minutes using a Doppler machine, or continuously with a CTG machine for 30 minutes every two hours or so).
- If the pregnancy is less than 41 weeks or the cervix is unfavorable it is less likely than prostaglandins to be successful at augmenting labor.
- Labor may feel more intense for the mother, with contractions being more painful & closer together than in spontaneous labor, making it more common for women to ask for pain relief.
- Water retention can occur in prolonged use, as it causes the kidneys to make less urine. This can be a potentially life threatening situation.

Syntocinon is not used if:

- Baby is in distress
- She is already experiencing strong contractions
- Baby is in a difficult position for natural labor
- She has been given prostaglandins in the last 6 hours.

If she becomes overdue & the caregiver begins talking about inducing the mother please be aware that if she does use a medical form of induction this is a form of intervention, increasing the chance of a cascade of interventions. If she & baby are

both well & there are no signs of complications you both may want to talk to the caregiver about delaying an induction until 8 to 12 days after the due date. This will give her some time to try some natural forms of induction; it allows her body more time to spontaneously begin labor, & if all else fails it will increase the chance that the induction will be a success.

NATURAL FORMS OF INDUCTION

There are many things that can help to induce labor naturally. Natural forms of inductions aim to ripen the cervix, prepare the body for labor & perhaps stimulate contractions. Natural inductions will more likely work where the woman is already past baby's due date, or if she is already in prelabor or if the waters have broken. They may take hours or days to work, & if a method does not work one day, it may produce better results in a few days time. If the pregnant woman has any medical conditions be sure she talks to the caregiver &/or a practitioner before using a natural remedy for induction.

NATURAL FOODS / DRINK

Raspberry leaf: Helps to tone the muscles of the uterus. It is therefore best used in the weeks or months leading up to baby's due date to help contractions be most effective, & to help baby come on time. In order for it to have an affect, raspberry leaf (tea or tablets) needs to be taken over a course of a few weeks, so taking it once she is due (or overdue) is likely to have little effect.

Pineapple: There is an enzyme in pineapple called 'bromelain,' which is said to soften the cervix. (Similar enzymes are found in mangoes & kiwifruit). Bromelain is found mostly in the core of pineapple, & the fruit needs to be eaten fresh (the canning process destroys most of the bromelain). To get a medicinal dose she would need to eat a LOT of pineapple, however bromelain is available as a supplement.

SEXUAL STIMULATION

Nipple stimulation: This is considered to be effective because it simulates the action of a feeding baby on her nipples. It also helps her body to release oxytocin which can start off, or intensify contractions. If you are her partner, offering to stimulate her nipples can help to create closeness before the birth of your baby. It can be a pleasant feeling for her. However if she has any medical health conditions complicating her pregnancy it is suggested to avoid nipple stimulation as it is unclear whether or not it is safe for baby.

The aim of nipple stimulation is to mimic the timing of contractions. Take turns stimulating each nipple for one minute, waiting 3 minutes before swapping nipples. Do this for about ½ an hour, & then repeat in a few hours time or the following day. This form of natural induction may take 24 to 72 hours to work.

Orgasm: Orgasms release the body's natural supply of oxytocin, which causes the woman's womb to contract. In earlier stages of pregnancy this won't induce labor, but towards the end, as her body is naturally getting ready to give birth, it will help to speed things along.

Sex: Sex can also help to release the hormone oxytocin. In addition to this, semen naturally contains prostaglandins, which helps to ripen the cervix. Having sex regularly in the last weeks of pregnancy can help to ripen her cervix, helping to ensure she does not go excessively over her due date.

ALTERNATIVE THERAPIES

Acupuncture: Acupuncture aims to balance the body- creating the best possible environment for labor to start. There are also specific points that can be used to stimulate contractions. There is evidence that acupuncture can speed up labor once it has already begun. Acupuncture can also be very good for natural pain relief so may be effective in alleviating the woman's pregnancy and labor symptoms.

Massage: Massage of certain acupressure points may also help to induce labor. It is commonly suggested that massaging a woman's foot may stimulate such points. Most reflexologists suggest doing this to increase contractions during the early stages of labor, rather than to start them off.

Aromatherapy:

Essential oils that have emmenagogue (helping to bring on menstruation) properties, such as clary sage, jasmine, & lavender can be used to help stimulate labor. They can be massaged into the woman's abdomen after being mixed with a carrier oil (such as almond oil).

Homeopathic remedies: Many women have found that homeopathic remedies have helped to induce their labor. Medical studies have reported it is likely they help to lengthen and intensify contractions naturally as opposed to starting them off. Homeopathic remedies that may be considered include Pulsatilla, Caulophyllum & Blue Cohosh.

Herbs: Herbal remedies that are oxytocic, such as adhatoda, schisandra, black cohosh & blue cohosh can have a much stronger effect than homeopathic remedies but may cause complications during birth & unpleasant side effects. They should therefore be treated with caution, & only used after consultation with a trained Herbalist or Naturopath.

BOWEL STIMULATION

The nerves that innervate the uterus are very close to the bowels' nerves, so what stimulates one will likely stimulate the other. Bowel stimulation as a way of inducing labor has been used since the time of Ancient Egyptians, primarily with the use of castor oil. However drinking castor oil can have some nasty side effects (other than the taste!) including nausea, abdominal cramps & diarrhea. Also each individual will respond differently to castor oil, so the recommended dose of 1-2 tablespoons in a glass of juice (& repeating 1 hour later) will have varying results. Although bowel

stimulation may help initiate labor it is considered a last resort (particularly using castor oil) as there are concerns regarding dehydration due to the loose stools & it possibly causing fetal distress. Another thing to consider is that if the castor oil does work her bowels may still be very loose during the pushing stage of labor.

If the woman is overdue & is interested in using bowel stimulation to induce labor have her talk to the caregiver, & if she uses castor oil make sure she takes it in the morning so she is not on the toilet all night!

ii). MONITORING BABY & PROGRESS OF LABOR

INTERNAL EXAMINATIONS

An internal examination may be offered during pregnancy, & is usually offered in labor. It involves her lying on her back on a bed, while a caregiver, using a sterile glove & a lubricating antiseptic cream, inserts 2 fingers into her vagina to feel for:

- Effacement- how thin the cervix feels.
- Dilation- how open the cervix is.
- The consistency of the cervix- whether it is favorable (soft & yielding) or unfavorable (tight rimmed & firm) which indicates how close to labor she may be.
- What part of baby is presenting (that is, the head & what part of the head, or the bottom, if baby is in a breech position). A 'well applied' head helps the cervix open.
- How far baby's head has come into the cervix.

An internal examination is an information gaining tool. It can help assess how close to labor she may be, how progressed in labor she is, whether the membranes have ruptured, if there is cord prolapse, & it is used to apply a fetal scalp electrode. There are times when an internal *may* be a good idea, such as if:

- She is laboring at home but planning on moving to a hospital.
- She wants pain relief, to assess how far along she is.

- She is Group B Strep positive & thinks her membranes have ruptured so she can begin the antibiotics if she has chosen to do so. Although in this situation usually a speculum examination will be performed (a bit like a pap smear) to avoid touching the cervix & increasing the risk of infection.
- You all need to know what is happening.

However an internal examination requires the woman changing from a comfortable position to lying on her back (which tends to make the contractions much more painful), & can feel fairly invasive, which can impact on her helpful hormones & increase adrenalin, thus slowing labor. They can also be fairly painful.

It is often hospital policy to do routine internals every 4 hours, or may be offered to her "just to know where she is at", or if the shifts are changing etc. If she is offered a vaginal examination the first thing to ask the caregiver is "why?"- What do they hope to ascertain? *If* the answer is reasonable & she agrees to it make sure that:

- Privacy is ensured- that all unnecessary people leave the room.
- She has emptied her bladder.
- She is warm, comfortable & adequately covered.
- She breathes deeply throughout the examination & relaxes her pelvic floor muscles.
- The examiner explains to you all what they learn from the examination.

Remember, it is the woman's right to refuse an internal examination. To gain information for information's sake alone may be counter-productive. If she has been laboring hard for hours, then finds out she is only 4cm dilated may be crushingly disappointing & all her resolve to avoid pain relief may go out the window.

What is important to understand is that nobody knows how quickly she may dilate.

Just because it has taken 'x' number of hours to get to 'x' cm's dilation *does not* mean that it will take equally as long for the remainder dilation.

In my first childbirth I had labored most of the night & at dawn the midwife wanted to an internal (it was by far the most painful part of first stage of labor for me). I was 4cm dilated. I remember feeling daunted that I still had so far to go- it felt overwhelming. My support person suggested we change position, so at dawn I got up from the position I'd been in all night (resting over a birthing ball) & used standing positions, holding onto a latticed wall during contractions. I went from 4 to 10cm in about an hour, & my baby was born at 9.30am. So while having the internal was painful & depressing to find I was so little dilated, I suppose on the upside perhaps it encouraged me to do something different & change positions.

Some other points on internal examinations to consider are:

- A trained midwife can get a pretty clear idea of how far progressed she is by observing her for a short while- an internal is not necessary for determining this.
- Whilst routine examinations may be an overuse of this form of monitoring & she may choose to decline them it is very important to remember that at times the information gained from an internal examination can be crucial. So encourage her to be flexible if the answer to the question "why do you want to do an internal?" seems important.

WHY MONITOR BABY?

The pattern of baby's heart rate is a good indicator of baby's wellbeing. During labor contractions cause reduced blood flow to baby, temporarily reducing baby's heart rate. By monitoring the changes in baby's heart rate caregivers aim to have warning of baby not coping with the rigors of labor & birth. Many medications used in labor, whether to increase contractions or reduce pain, can affect how baby copes with contractions, necessitating constant monitoring of baby's heart rate.

There are numerous ways of monitoring baby's heart rate, as outlined below. They can be divided into intermittent & constant forms. With intermittent monitoring baby is monitored for a set length of time leaving the laboring woman free to move around outside that time, while continuous fetal monitoring requires her to be constantly attached to a machine, limiting her mobility.

FETOSCOPE

A fetoscope (or Pinard's stethoscope) is much like a stethoscope but has a larger bell on the end to allow the user to hear baby's heart rate. It can be used at any time during labor, is non-invasive & simple to use, but can only be used intermittently.

DOPPLER MACHINE

The Doppler, or Doptone is a hand held ultrasound machine. It also is non-invasive & can be used in any position, including during contractions, is water proof, so is useful in the bath or shower, but it cannot provide continual monitoring.

ELECTRONIC FETAL MONITORING

The electronic fetal monitor (EFM) is a machine that gives a continuous readout on a screen & a piece of paper, recording baby's heart rate & the relative strength, duration & frequency of contractions. It can be used intermittently or continuously & requires the laboring woman to sit with her knees & back partially elevated & a cushion under her right hip so her uterus shifts to the left. Electrodes are placed on her belly over a conducting jelly & held in place with an elastic band. EFM's require the woman to remain immobile. In larger hospitals the readings from an EFM will often be sent to the nurse's station, so they are able to monitor multiple women at once.

EFM may be offered on first admission to hospital to determine a 'baseline'- a sense of baby's normal heart rate. If everything appears normal it can then be taken off after 20 minutes. It is used continuously if there are any concerns for the health of

baby, such as meconium stained amniotic fluid, & if any medication is used, such a Syntocinon, Pethidine or an epidural.

There are numerous issues associated with EFM including:

- False readings. The machine can inaccurately record baby's heart rate if mother or baby moves. It can read fetal distress where there is none, causing an increase in cesarean rates without an increase in the health of mother or baby.
- The readings are open to interpretation, & often different caregivers will disagree about the meaning of a trace. There is also no clear consensus of what is normal for baby's heart rate pattern to vary during labor, leaving interpretations even more subjective.
- To get more accurate readings the mother is asked to remain immobile. Limiting mobility of the mother can prolong labor time & increase pain perception. Comforting measures such as back massage can be much more difficult to do with an EFM in place.
- There can be a shift in focus from the laboring woman to the readouts from the machine.
- Another criticism is that if a woman requires continuous monitoring then it ought to be done by a person in the room, who can respond immediately if indeed there is an emergency, & not 15 to 30 minutes later when the reading is reviewed.
- Being connected to a machine may decrease the woman's sense of safety, thus affecting her birthing hormones & the progress of her labor.

INTERNAL FETAL MONITORING

Internal Fetal Monitoring (IFM) is another form of continuous fetal monitoring. It uses an electrode that is attached under the skin of baby's scalp. In some countries there is also a pressure catheter inserted that records contractions. IFM requires the amniotic sac to be broken & the laboring mother needs to be at least 2cm dilated. IFM is the most accurate form of fetal monitoring & does not use ultrasound. It is

usually reserved for high risk births, or if the readouts from EFM are suspicious. The benefit of using it in this situation is it may prevent unnecessary interventions. It also means she can be more upright & mobile, within the limitation of the electrode wires' length. The negative aspects are the same as for EFM (other than accuracy) & there is also a risk of infection for mother & baby & injury to baby from the electrode.

TELEMETRY MONITORING

Telemetry monitoring is the newest form of fetal monitoring. It is an electronic fetal monitor that uses radio waves to send the readings to the nurse's station, instead of wires hooking the laboring woman up to a machine. This means the issues around mobility are eliminated. It does not improve the false readings of EFM & is only available in some hospitals.

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While knowing the fetal heart rate is undeniably important for ascertaining how baby is coping with the labor, the use of continuous fetal monitors in the low risk mother is of highly questionable use. Numerous clinical studies have shown that their routine use does not improve mother or baby outcomes, but does increase cesarean rates. It's important to talk to the caregiver during the pregnancy & for the woman to be clear in her birth plan of her wishes. Remember, if she use's medications such Syntocinon, Pethidine & epidurals continuous monitoring is fairly unavoidable.

iii). AUGMENTATION

If labor has become established, but contractions are not strong or regular enough for dilation to be progressing adequately the caregiver may wish to speed things up with augmentation (interventions aimed at increasing the rate &/or intensity of contractions). If she is feeling exhausted & overwhelmed by the protracted labor then knowing the caregiver has methods for accelerating labor may be a vast relief. However if baby's heart rate is normal & the mother is feeling well then a slow labor is nothing to be concerned about. Many women need time to sink themselves into

first stage, while others need time to allow baby to descend in second stage. Forms of medical augmentation are similar to medical induction methods & include breaking the waters & intravenous syntocinon.

BREAKING THE WATERS (ARM)

If active labor has slowed down & she isn't progressing as quickly as the birthing mother or her caregivers would like, the doctor or midwife may suggest breaking the waters (ARM), if they have not already broken. It involves them inserting a stick type device which has a hook on the end into the woman's vagina. This then is used to scratch the membrane surrounding baby in order to make it rupture. It is a highly effective technique but can be painful & uncomfortable for the mother. After breaking the waters caregivers would need to monitor the baby's heartbeat to make sure that it hasn't caused him/her any distress.

Breaking the waters is an effective means to speed up labor as baby's head is putting more pressure on the cervix, thus increasing dilation. It can shorten labor by up to 2 hours & reduce the likelihood of Syntocinon being used, but it can also increase the chances that baby becomes distressed, therefore making a higher chance of a cesarean being required. It can also dramatically increase the amount of pain the mother experiences as the cushioning from the amniotic fluid is no longer there. This can increase the desire for pain relief.

SYNTOCINON

Intravenous Syntocinon is used to increase the intensity of contractions where labor has stalled & is not progressing. It can take a few hours for it to show effects on labor, & a few more after that to show changes in the cervix. The use of Syntocinon may be what is needed for a successful vaginal birth, however it is also increases the risk of fetal distress, which can lead to the use of forceps, ventouse or cesarean delivery. The contractions caused by syntocinon can feel more painful, & this coupled with the reduction of movement can lead the mother to feel the need for pain relief (the cascade of interventions).

iv). INTERVENTIONS FOR BIRTH

VENTOUSE/FORCEPS

During the last stages of delivery, the caregiver may feel the need to assist the birth with either a ventouse device or forceps. These may be used if she is fully dilated, baby's head is in the birth canal, baby's head position is known &…

- She is so tired that she can't push on her own anymore or there is a medical reason why she can't push for very long (e.g. heart disease)
- The baby has become distressed when she is pushing
- She has been pushing for a long time & the baby is not progressing through her pelvis.
- The baby is breech & she is having a natural delivery (forceps only.)

Ventouse: Where an assisted birth is necessary the use of ventouse can reduce the likelihood of the mother having an episiotomy & is apparently not as unpleasant as it sounds for mother or baby. It requires the birthing woman lying on her back, usually with her feet in stirrups, & a ventouse cup being placed onto the baby's head. Then the machine will gently suck all of the air from the cup, creating a vacuum. During the next contraction, she will be asked to push as the doctor pulls. They will try this for a few contractions, but if it is unsuccessful after 20 minutes forceps may be used or she will be given a cesarean.

Forceps: Forceps are a pair of metal instruments that are inserted into the vagina & placed on either side of baby's head. A forceps delivery requires a local or general anesthetic (unless an epidural is being used) for pain relief, & often involves a doctor performing an episiotomy to create space for them to be inserted, or as baby's head is crowning. Like with the ventouse, the mother will push as the doctor pulls. Usually stirrups are used to give her something to push against. If this is unsuccessful after a couple of tries, a cesarean will need to be performed. Unlike the ventouse, forceps can mean a more painful delivery because of the episiotomy. On the positive side, they do tend to be more successful than the ventouse.

Forceps have been around since the 1600's, while ventouse is a much more recent invention. Forceps are becoming less commonly used, as ventouse is associated with less injury to the mother or baby. Here are some suggestions on how to help her avoid either:

- Just having a supportive support person/ people present is associated with less use of forceps or ventouse.
- Help her use upright positions (not reclining or laying down).
- Help her with natural pain management techniques so she does not require an epidural.
- Make sure she waits until she is fully dilated & has a strong urge to push before she begins pushing.
- Make sure she has drunk sufficient water.

EPISIOTOMY

An episiotomy is the incision (or cutting) of the perineum (the tissue between the vagina & anus). It is performed to reduce the chances of tearing as baby's head crowns through the vaginal opening, with the thought that a tear may be larger & more difficult to repair than a planned cut. Historically it has been used quite routinely (& in some countries still is used in up to 90% of hospital births). However it was introduced as a birthing intervention without any evidence to support its benefits, & even though the proposed benefits are highly questionable it is still performed routinely by some caregivers.

The possible indications for an episiotomy include:

- Where baby is distressed & needs to be birthed quickly. Here it may decrease the second stage by around 15 minutes
- Where mother is exhausted & forceps are required
- Where a woman has female genital mutilation that affects her vaginal opening
- Where there is serious risk of deep tearing of the mothers vaginal wall
- In a breech birth where baby's head becomes 'stuck'.

Episiotomies were originally introduced to decrease incontinence, post-partum pain & sexual dysfunction, however studies have found that they may actually cause all of these problems & in some cases can even increase these risks. More than one study suggests that routine episiotomy ought to be abandoned.
(http://jabfm.org/content/18/1/8.full)

Here are some things you can do to help the birthing woman avoid an episiotomy or significant tearing:

- Remind her to do pelvic floor exercises. This gets her familiar with her pelvic floor muscles, which will help her be able to relax these muscles during the pushing phase of labor, so she does not push too strongly.
- Make sure she paces herself in the earlier stages of labor. Remind her to rest, eat & drink plenty of water so she is not too exhausted when in comes time to push. If she is too exhausted to push her caregiver may deem it necessary to perform an episiotomy to have an assisted birth.
- Make sure she doesn't push too quickly. This gives her perineum time to stretch as baby's head crowns. Help her use a position such as on all fours that will give her greatest control over how hard she push's.
- You can hold a warm compress over her vaginal opening as this may help to reduce tearing & the level of pain she feels.

CESAREAN

A cesarean involves making an incision in the mother's abdomen & the uterus through which the baby can safely be pulled out. Most of the time a woman is given a regional anesthetic in the form of an epidural or spinal block. On rare occasions it may take place under general anesthetic. Either way, there is no pain involved; she may just feel a tugging sensation. After the baby is taken out the placenta is delivered. Then the uterine wall, abdominal muscles & her skin is stitched up & she is taken to a recovery room where she will be able to hold her baby. The whole process is completed in about 45 to 60 minutes. If you are her partner you generally

ought to be able to be with her in the operating room, & after the midwife's initial examination of baby you can hold your newborn while your partner is being stitched up.

Cesarean sections (c-section) can be planned (elective) or unplanned. An unplanned (or emergency) cesarean is performed when during labor concerns arise for the health of the mother &/or the unborn baby. Reasons include:

- Cord prolapse. This is when the umbilical cord slips through the cervix, which can cut off oxygen supply to babe.
- Placental abruption (where the placenta comes away from the uterine wall), which also cuts off oxygen supply to baby.
- Fetal distress (elevated or lowered heart rate in baby).
- Unsuccessful induction or augmentation.
- An outbreak of genital herpes, as a vaginal delivery puts baby at risk of infection with the virus.

A cesarean section is a major abdominal surgery, & therefore does put the mother at risk to further complications such as infections, risks from the anesthetic, blood loss from a ruptured or cut blood vessel, adhesions & damage to internal organs, embolism (a blood clot that enters the blood stream), air bubbles entering the blood stream, injury to the bowel or bladder & a weakened uterine wall.

After having a cesarean, a woman will need more recovery time than if she delivers naturally and will stay in hospital for longer. She is also likely to experience pain for some weeks after and will need to take it easy, particularly with lifting. Antibiotics are also prescribed to reduce the possibility of infection.

A cesarean section can undoubtedly be a life saving operation. However the rates of cesarean operations being performed is steadily increasing, & varies dramatically from region to region & depending on the caregiver & type of birth place, which indicates that c-sections are not being performed purely due to true emergency need.

While there are certainly situations where a cesarean section is a clear necessity here are some ways you can help her to avoid an unnecessary one:

- Encourage her to avoid inducing labor & using pain medications unless absolutely necessary, as once interventions begin the 'cascade of interventions' is a lot more likely. If pain medication becomes necessary, the mother being over 5cm dilated & in active labor can decrease some of the risks.
- Being there! Having a doula or an educated support person at a birth can decrease the cesarean rate by as much as 50%.
- Everything we talked about in the 'specific tools for the support person' chapter can help her birthing hormones do their job & keep adrenalin levels down- which will help labor progress at a healthy rate & minimize the risk of fetal distress.
- Be educated about labor & birth, as this way you can help her make decisions for the birth that are appropriate to her, & will help her to be relaxed & confident with the birthing process.

SYNTOCINON / SYNTOMETRINE

Aside from being used for induction & augmentation Syntocinon is often routinely given as an injection in the mother's leg either as baby's shoulders are born, or immediately after birth. It causes the uterus to strongly contract & push the placenta out. Sometimes Syntocinon is combined with a drug called Ergometrine (Syntometrine) which makes the uterus to clamp down to reduce bleeding. Using these drugs is called 'active management of third stage'. It means that third stage is over very quickly, the average blood loss is lower & it reduces the risk of post-partum hemorrhage. It also means that the mother does not have to actively push out the placenta.

The disadvantages of these drugs include:

- Side-effects such as nausea, dizziness or headaches. This may be mild or so strong that the mother is unable to hold her baby for a short while. Estimates of women affected vary from 1 in 8 to 1 in 3.
- A possible increase in the risk of retained placenta.

It is the choice of the birthing mother whether she wants to have an actively managed third stage or not.

v). MEDICAL PAIN RELIEF OPTIONS

TENS MACHINE

TENS stands for Transcutaneous Electrical Nerve Stimulation. The TENS machine utilizes a small battery operated pulse generator that has 2 pairs of electrode pads that are attached to specific areas on the mothers lower back which sends electrical signals to her brain. An obstetric TENS machine has 2 levels of stimulation. The lower level is used in between contractions & aims to increase endorphin production. When she feels a contraction coming she press's a boost button which causes greater stimulation which may provide pain relief via the pain gate control mechanism. The Pain Gate Control is where stimulating larger fibers by vibration, massage, heat etc over-rides some of the pain messages being sent to her brain telling her about the sharper, more intense pain of contractions- so she is less likely to feel these as intensely.

TENS machines are a natural form of pain control. It does not block all the pain sensations of labor, yet it can provide a good distraction to the pain of labor, particularly in the earlier stages. They are usually not provided by hospitals, so if she is interested you could help her look into hiring one. If she wants to use one for her labor be sure to get familiar with it before her due date.

GAS

Gas is actually a combination of nitrous oxide gas & oxygen, & is known by professionals as Entonox. It is administered through a mask which contains a mouthpiece. It takes 10 to 15 seconds to circulate from the lungs to the brain, where it depresses the brain's normal functioning, thus affecting how one perceive pain. It is also a sedative & can have an amnesic affect.

Gas is usually the first option for medical pain relief as it is easy to use & quickly reversible if she doesn't like it. As soon as she feels a contraction coming, she breathes in through the mouthpiece, allowing the gas to enter her lungs & then out again. It provides a reasonable amount of pain relief during her contractions. Some women breath the gas in once a contraction has started which often proves too late for it to take an effect. Breathing in the gas can take some getting used to, so sometimes perseverance can pay off. And if she decides she doesn't like it the effects wear off within minutes.

Gas does allow the woman to be in charge of her own pain relief, it can be used right up to the moment of giving birth & is thought to be the safest form of medical pain relief. Although it does pass through to baby it is believed to have no lasting side-effects for bub. However it can have some unpleasant side effects for the mother such as nausea, vomiting, drowsiness, hallucinations or dizziness & it can limit how much she can walk about.

PETHIDINE/ MEPTAZINOL

Pethidine & Meptazinol are both opioid (narcotic) pain relieving drugs which mimic the effects of endorphins. They are usually administered through an injection to the thigh or bottom, or sometimes by an IV drip. A muscle injection takes effect within 20 minutes & lasts for 2-3 hours, while a UV injection takes effect within 2 minutes, but the effects subside much quicker. Opioids are most commonly given during the early stages of labor, & are most effective between 3 & 8cm dilation.

The benefits of Opioids include:

- ✦ It can be used where Gas has become ineffective, but she wishes to avoid or delay an epidural.
- ✦ It is effective at helping her relax, & thus can speed up labor. If she is in the earlier stages & is needing sleep Pethidine can help here too.
- ✦ It can be fairly effective at relieving the pain of contractions, but can be less effective on the intense pain of transition.

The negative issues with Opioids include:

- ✦ Once it is administered, it cannot be stopped.
- ✦ Some side-effects to the mother include nausea, vomiting, sweating, drowsiness, disorientation, dizziness, an altered mood (feeling elated or depressed) & suppression of breathing.
- ✦ Narcotics pass through the placenta to baby & decreases as the drug is excreted by the mother's liver & kidneys. This takes up to 6 hours for an injected Opioid. If baby is born while the mother still has the medication in her bloodstream it takes up to 3 days for baby's body to excrete it due to their less mature liver & kidneys. It can cause the following effects in baby for up to the following 3 days:
    - Suppressed breathing
    - Reduced suckle reflex, making it harder for the mother to breastfeed
    - Behavioral changes, such as less eye contact, decreased reaction to stimuli & irritability.

Meptazinol has a similar effect to pethidine but is less likely to make the mother feel drowsy. Its main side effects are nausea & vomiting. It is not as sedating,

EPIDURAL/ SPINAL ANASTHESIA

Epidurals & Spinals involve an injection of medication by an anesthetist directly into the area of the mother's spine that innervates her uterus, which results in blocking pain & other sensations from the waist down. Usually the medication is a

combination of an anesthetic mixed with a narcotic, although a 'walking' or 'light' epidural uses only a narcotic & allows more mobility, but is less effective at relieving pain.

If labor is too long & painful, or complications arise, the caregiver may suggest an epidural or spinal anesthetic, or the mother may choose to ask for one. They are generally given after 4cm dilation (so as not to slow the progress of labor), & not recommended after 9cm dilation as it can make it difficult to push baby out. So a vaginal examination is required before an epidural or spinal can be given. An IV drip is inserted into the mothers arm in case fluids are needed, then, whilst bending forwards over a chair or curling up in a fetal position her lower back is swabbed clean & a local anesthetic is inserted into the area so the epidural or spinal injection is hardly felt.

For an **epidural** the anesthetist inserts a small tube into the area of the mothers spine called the epidural space, which is separated from the spinal fluid by tissues called the dura mater. Once the small tube, or catheter, is inserted the medication is delivered by a needle. The catheter is left in place so top-up medication can be given if needed, or if a pump is used medication can be delivered continuously. Epidurals usually take around 20minutes to work, & lasts for 1 to 2 hours before wearing off or needing a top-up. Some times an epidural does not work at first & requires an adjustment.

A **spinal** involves a much finer needle being inserted through the dura mater, delivering the pain medication to the spinal fluid, then the needle being removed altogether. It takes effect within 10 minutes & lasts for 1-2 hours, but cannot be topped up.

Sometimes a combined epidural & spinal are given (a CSE), which gives the rapid effect of a spinal & allows the ongoing use of the epidural catheter if more pain relief

is required. Epidurals & CSE's are more commonly used during labor, while spinals are more likely used in cesareans or assisted deliveries.

Epidurals & spinals are the most effective medical way to relieve labor pain. They do not affect the mother's mental alertness, yet provides a break from the pain of labor, however she may still be aware of her contractions. This break can reduce anxiety & stress related responses such as hyperventilation & excessive adrenalin, thus improving oxygen & blood supply to the placenta. In certain scenarios an epidural may contribute to the woman's overall positive experience of her labor. Having a break from the intensity of labor may be what is needed to allow the woman to get back in her centre & feeling like she can cope with the labor experience. Once an epidural wears off there is a choice of whether to be topped-up with more medication or not.

However epidurals are not a guaranteed success. Sometimes women experience a 'patchy block', where only one side of the body is pain free, & in 3 to 5% of women epidurals or spinals are ineffective at relieving pain. And whilst epidurals & spinals are relatively safe procedures when administered by an experienced anesthetist there is the potential for more side-effects or complications than other labor pain relieving medications, & they have the greatest potential to affect the way the baby is born (whether an assisted delivery or cesarean is required). Side-effects for the mother associated with epidurals or spinals include:

- A **drop in blood pressure** is expected, with a significant drop that affects blood flow to baby in up to 18% of women. Spinals tend to cause a more severe drop. Intravenous fluids are given to counteract this side-effect, however in rare cases baby may need to be delivered by a cesarean. If the mother already has low blood pressure this may be a more likely serious side effect.
- **Reduced mobility.** A low dose epidural may allow her to shuffle around on the bed, but an active labor & upright positions are not possible.

- **Increased monitoring** of babies heart rate & the mothers blood pressure. When she's first given an epidural & after each top-up baby has continuous monitoring for at least 30 minutes & her blood pressure is taken every 5 minutes in this time also.
- A **fever** may develop if she has an epidural for over 4 hours, which is commonly treated with antibiotics in case it's caused by infection, & baby may have numerous tests after the birth to screen for infections.
- **Labor slows down**- making it 3 times more likely that Syntocinon is used to speed it up. The caregiver ought to allow her more time to compensate for the effect of the epidural; however it is worth talking to the caregiver about what their policy is. Delaying an epidural to after 5cm dilation can reduce the risk of needing augmentation.
- The pushing phase of labor lasts longer
- There is an increased chance of **forceps** or **ventouse** being used to help birth baby. This is because baby finds it harder to move into the ideal position for birth as epidurals limit the mother's mobility- laying on her back increases the likelihood of baby turning posterior. Also baby's head is not pushing on her cervix, thus slowing down dilation & oxytocin production.
- An epidural blocks the nerves to the mother's bladder, causing **urine retention**, or the insertion of a **catheter**.
- **Nausea & vomiting** may occur, which may lead to anti-nausea medication being used.
- **Itchy skin** is experienced for up to 24 hours after an epidural or spinal in 40 to 80% of women where a narcotic is used.
- A **severe headache** may occur after a spinal, lasting a few days & up to a couple of weeks

Other risks, such as infections, long term nerve injuries, a total spinal (where a epidural accidentally becomes a spinal, which is life threatening) & permanent paralysis are much more rare.

Epidurals & spinals can also affect baby.

- If the mother's blood pressure drops too dramatically baby may become distressed from lack of oxygen, which may lead to a cesarean.
- The narcotics in an epidural or spinal can pass through the placenta, potentially causing a non-reactive CTG trace (baby's heart rate not reacting to contractions or movement) & sedation once birthed.
- An epidural induced fever may cause baby to be unwell at birth.

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What a chunky chapter! It's certainly a lot of information to digest. While being familiar with what may be offered to the birthing mother by the caregiver in the course of labor is extremely important please don't let it overwhelm your 'worry brain'. Remember, the journey of childbirth is a great unknown- you just don't know how it will all unfold until you are all there living it. Be informed, be prepared, & make sure you are able to support the birthing mother in as many ways as you can so she can sink in to her primal brain & get on with the job of birthing her baby.

13. CONCLUSION

I hope you now feel like you have a good understanding of what your role is & have a whole host of ideas on how you can best fulfill your job as a valuable support person for the birthing mother.

Be sure to talk with your birthing mother & any other support people she has enlisted so you all have a clear idea of her expected needs & wants. Also make sure you have read & understand her Birth Plan. When it comes to the time of labor & birth keep these needs & wants in mind, but also remember you will then be in the great unknown of how it will all unfold, so be prepared to go with the flow of her expected needs or wants changing.

You have taken on such an important & worthwhile role, & it will no doubt be a very memorable experience for you. I wish you all the very best in your support person journey. May it be an enriching experience for all of you!