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The start of labour

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Recognizing the start of labour

You will soon be bringing your baby into the world. Labour generally begins spontaneously between 38 and 41 weeks after the start of your last menstrual period. However, delivery anywhere between 37 and 42 weeks is considered full-term. Your expected delivery date is not a deadline. Even if you have not given birth at more than 40 weeks, there is still a good chance labour will begin on its own.

In some cases it may be preferable to give birth between 41 and 42 weeks than to wait until 42 weeks have passed. If you have completed 41 weeks and there is no sign that labour has started, you can discuss your options with your doctor or midwife. They may have you undergo some tests (monitoring, ultrasound) to determine whether you can continue to wait for labour to begin on its own or whether it is preferable to induce labour (see Possible interventions during labour, page 188).

No one can predict when and how your labour will begin. Most women will recognize labour because of certain tell-tale signs. It’s normal at that point to feel excited or scared.

Passing the mucus plug

The mucus plug, which blocks the cervix during pregnancy, is made of thick secretions sometimes tinged with blood. You may lose your mucus plug without even realizing it several days before you give birth or during labour. It’s also possible to lose it in stages.

If you do notice it, don’t be too quick to jump to conclusions. This doesn’t necessarily mean labour has started. You will need to wait for other signs.
Contractions

For most women, labour begins with uterine contractions (see How to tell the difference between contractions and other abdominal pain, page 131). You may have already felt your abdomen become hard during pregnancy. These are contractions that, while sometimes uncomfortable, aren’t really painful (Braxton Hicks contractions).

Contractions experienced during delivery are different from Braxton Hicks contractions. Your abdomen gets tight and hard and the contractions become more and more uncomfortable. Generally women feel pain in the lower abdomen, but for others the pain is located in the lower back and spreads to the front. Some women find the pain of contractions similar to menstrual cramps, only stronger. Every woman will experience contractions in her own way. The feelings may even be very different for the same woman from one pregnancy to the next.

Natural rupture of the amniotic membranes

For some women (about one in ten), the rupture of the amniotic membrane, or amniotic sac, signals the beginning of labour. The amniotic membrane is made up of two layers, hence they are often referred to as “membranes.” These membranes surround your baby and contain the amniotic fluid around him. When they rupture, the amniotic fluid leaks out. It is often referred to as having your “water break” because the liquid that leaks out is clear like water, although sometimes tinged with a bit of blood. You may only leak a few drops or it may leak enough to wet your bed or your clothes. There may be so much liquid that it drips onto the floor.

At the end of pregnancy it can be difficult to distinguish between normal vaginal discharge and amniotic fluid (see Possible types of discharge, page 128). Generally with amniotic fluid, there will be enough to soak a sanitary pad.
What should I do?

When your water breaks, you should head for the hospital or birthing centre, even if you have no contractions.

The staff will make sure your baby is doing well and will check whether your membranes did actually rupture, or if it is merely vaginal discharge, which tends to be heavier at the end of pregnancy.

Labour will likely start in the hours after your water breaks. If the contractions still haven’t begun or if you are a carrier of streptococcus (also called group B or BGS), labour may need to be induced.

When should I go to the hospital or birthing centre?

Towards the end of your pregnancy, your doctor or midwife will explain to you the right time to head to the hospital or birthing centre depending on your previous deliveries, the distance you have to travel, your health, and the state of your cervix (effacement and dilation).

Towards the end of your pregnancy, check with your doctor or midwife at what point you should head to the hospital or birthing centre.
However you should go immediately if you experience any of the following:

- For a first delivery, you are having regular contractions every five minutes or less for one hour.
- If this is not your first delivery, you are having regular contractions every five minutes or less. If you live more than 30 minutes away, you should head to the hospital or birthing centre when your contractions occur every ten minutes.
- Your membranes have ruptured (your water breaks).
- You are losing blood.
- You no longer feel your baby move (see Your baby doesn’t seem to be moving, page 129).

Often women go to the hospital or birthing centre because they are certain they are in active labour, when in fact they are still in early labour. If this happens, you will be advised to return home and come back later. This allows you to get used to the contractions at home, in a familiar environment.

When labour begins or when in doubt, call your midwife or a nurse at the obstetrics department of your hospital. They will check with you to see if labour has started and answer your questions, give you advice, and tell you when to come to the birthing centre or hospital.
Continuous support during childbirth

A woman in labour needs to feel that she’s not alone. During delivery, she needs to have continuous support from someone she knows and trusts. This may be the baby’s father, a member of her family, a friend, or a birth companion, also called a doula (see Doulas, page 92). This company and closeness will help her feel better, and reassure and encourage her. This is a stage in life that is important to share.

As a father you may feel helpless and powerless while your partner is giving birth, especially since this is an extremely important time for both of you. What do you do when the one you love is in pain and tells you she can’t take it anymore? How do you deal with all these emotions? There’s no game plan that’s guaranteed to work, but you should know that your presence makes a big difference.

You don’t need to be a massage expert to be useful during delivery! Don’t be afraid to try different things. Your partner will tell you what feels good. Keep supporting her and continue what you’re doing if your words and actions seem to be helping.
Understanding and managing pain

The pain of labour is unique and serves a specific purpose. It signals the start of the opening process that will lead to the birth of your baby. These changes take place inside your body. They happen gradually. A rhythm develops and the intensity of the pain increases over time. For some women the start of labour is hardest; for others it may be when it is time to push. The pain is stronger during contractions while the period between contractions gives you time to recover.

There are methods to help women and couples better understand the pain and prepare themselves during pregnancy. This preparation can also help the father become more involved and active during the delivery.

For example, some learn techniques that involve breathing, relaxation, visualization, yoga, self-hypnosis, acupressure, or other approaches. Massage can also help reduce anxiety and make the pain easier to bear.

Most hospitals and birthing centres offer moms in delivery the option of taking a bath or shower. They also have large physio balls on which you can sit and move at the same time. If they are not offered, don’t hesitate to ask for one.

If there comes a time when your pain management methods are no longer working or you have the impression you can no longer bear the pain, it can be relieved with drugs. In most cases you will be offered an epidural. There are also other drugs if the epidural is not available or if it is not appropriate for you (see Epidurals and analgesic drugs, page 191).
Tips for managing childbirth pain

- Have someone with you—the baby’s father, your partner, a family member, friend, or birth companion (doula).
- Create a warm, calm, and intimate atmosphere.
- Stay warm.
- Trust yourself and your instincts.
- Stay in the moment.
- Visualize what is happening inside of you.
- Move and change positions as needed (do not remain in bed)—walk around between contractions.
- Relax.

- Breathe slowly.
- Take a shower or bath.
- Eat and drink as needed.
- Make noise.
- Don’t hesitate to ask for whatever would make you feel good.
- Have someone encourage and comfort you through their words and actions.
- Have someone touch you, massage you, or simply hold your hand.
- Have someone sponge you with a wet compress.
Positions during labour

Throughout labour, you can try different positions to help the cervix dilate and help you relax between contractions. Lying flat is often the least comfortable position.

The following page shows examples of the various positions you can try during labour.

For many women, being in water helps manage the pain.
Possible positions during labour

Standing

Sitting

Squatting

Kneeling

Illustrations: Maurice Gervais
The stages of labour

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Throughout labour your body undergoes changes to allow your baby to make his way to the world outside. Labour is divided into these three main stages:

**First stage:** Opening of the cervix (also called dilation)
**Second stage:** Descent and birth of your baby
**Third stage:** Delivery of the placenta

It isn’t possible to predict the length of each stage because they differ from one delivery to the next.

### Opening of the cervix

During pregnancy the cervix is closed and thick. At the beginning of labour the cervix has thinned (also called “effaced”). During labour the cervix opens (dilates). At the end of the first stage of labour the cervix is fully dilated (10 cm).

**First stage: Opening of the cervix**

The first stage of labour is the period when your contractions start to be regular. These contractions allow the cervix to open completely, until it is 10 centimetres (cm) wide.

Illustrations: Maurice Gervais
Progression of labour

Early phase or “latent phase” of labour

Before getting to the actual stage of labour itself, you may have contractions without knowing how things will go next. Is this the start of labour or a false alarm?

At the beginning, the contractions are not very strong. You’ll be able to talk during a contraction. They are often irregular and don’t last very long. Try to stay calm and don’t forget to sleep and eat. Feel free to take a bath or shower if you like. Take this opportunity to come to grips with what’s happening to you.

This phase may be long or short; you’ll need to be patient. It’s not yet time to go to the hospital or birthing centre unless your water breaks or you don’t feel the baby moving as usual.

If your contractions become weaker or stop altogether, this is false labour. Something is happening inside you, but it’s preparatory labour that is helping to “ripen” the cervix.

If the contractions become regular (for example, every 5 minutes) and get closer together, more painful, and longer lasting (30 to 60 seconds), this may mean that you have gone beyond the latent phase.
Active labour

At some point, you’ll feel that labour is progressing. The contractions are painful and are closer together, longer and more intense. This is the active phase of labour: the cervix has thinned (effaced) and is open (or dilated) to about 3 to 5 centimetres.

The rhythm of the contractions gradually increases and the cervix opens over time to 10 cm (complete dilation). The contractions are often very painful at 8 or 9 cm. They reach their highest intensity just before complete dilation at 10 cm. This phase is often compared to a storm. You may experience many strong emotions or you may want to scream. You may feel like you’re losing control and that it will never end. This is normal. Try to open yourself up to the labour, breathe, visualize your baby starting to move down inside of you and stay in contact with him.

Trust yourself and don’t be afraid to ask the person with you or the health professionals caring for you to give you what you need.
Second stage: Descent and birth of your baby

The second stage of labour begins when your baby has dropped well down into your pelvis and the cervix is fully dilated. The baby can now get through the cervix and descend into your vagina to be born.

Pushing

When your cervix is dilated to 10 cm, the sensations become different; you will probably feel the need to push. The contractions become a force within you, and all your energy is concentrated on pushing to help your baby be delivered. The time between contractions can allow you to recover between pushes. While you may feel the need to push before your cervix is fully dilated, your health professional can tell you when the time is right to start pushing.

If you have an epidural, the pushing sensation is lessened and may even be entirely absent at the beginning of the second stage. The pushing feeling will come later, as your baby descends with the contractions. Normally, you can wait to push until you feel the urge to do so. Your efforts will then be more effective—you’ll do a better job of pushing and won’t have to push as long.

Pushing positions

The following page shows examples of the various positions you can try during the second stage of labour. Get help from the father or the person and professionals accompanying you to find a position that is comfortable and effective for you. Feel free to change positions when you want.
Possible pushing positions

Illustrations: Maurice Gervais
Birth of your baby

The time when you push is an intense experience for you and those accompanying you. As your baby prepares to enter the outside world, the top of his head will appear. If he likes, the father can get into a good position to see the baby’s hair. You can also watch your baby’s progress using a mirror set up in the birthing room. After the top of the head, the baby’s face will appear. Another big push and the baby’s shoulders and rest of his body will come out.
Just after birth, your baby will announce his presence with his very first sounds. He will then be placed on your belly. The health professionals will dry your baby off and make sure he’s doing well. If needed, they will clear the secretions out of his nose and mouth.

With both of you under a warm blanket, you can cuddle your baby. At last you can marvel at his tiny face, his fists, and feet, and meet his gaze. Your baby’s instinct will be to nurse for both food and comfort. The professionals assisting with your delivery can help you start breast-feeding.

The health professionals usually ask the father if he wants to cut the umbilical cord.
Third stage: Delivery of the placenta

Delivery of the placenta

Your baby is born, but the delivery isn’t over yet. Contractions will continue for a little while longer to deliver the placenta.

After the placenta is delivered, your uterus will continue to contract to regain its original shape and to prevent haemorrhaging. The first few times your baby breast-feeds will stimulate the production of a hormone called oxytocin, which increases contractions of the uterus. If the contractions aren’t strong enough, there is a risk of haemorrhaging. Your abdomen will then be massaged at the uterus to stimulate it to contract, or else oxytocin will be given as a medication for this purpose.

First moments with your baby

The next few hours are a precious time to welcome your baby and get to know him. The health professionals, who up to this point have been helping very closely, will now be more discrete.

Right after birth, if you are both doing well, your baby is placed directly on your chest, skin to skin. Ideally your baby will stay with you for at least two hours, his head covered with a hat and his little body wrapped in warm blankets.

This helps him gently transition to life outside the uterus, the contact allowing him to maintain his body heat and regularize his breathing and heartbeat. In addition, the skin-to-skin contact makes your newborn feel safe and makes breast-feeding easier.
If your condition does not allow it, this skin-to-skin contact can be done with the father or another significant person. If you cannot enjoy skin-to-skin contact right away, don’t worry, you will have the opportunity later on and your baby will be just fine.

Your baby will enjoy the warmth of your body or discover comfort in his father’s arms. He will recognize the voices of his parents. Your baby will stick out his tongue, blink his eyes, breathe more quickly, move his lips, turn his head—it’s time to get to know one another! This is a wonderful and emotional time of discovery for all, one that marks a special period of bonding as a family.

If you are both doing well, your baby will benefit from snuggling against your chest in direct, skin-to-skin contact.
Possible interventions during labour

Inducing labour

When should labour be induced?

Labour will be induced if there is a medical reason to do so, e.g., if your water has broken but you're not having contractions yet, or if you are past 41 weeks of pregnancy. In other rare situations the health of the mother or baby may justify inducing labour. Talk to your health professional about the reasons for induction and its potential effects.

Methods used to induce labour

There are several different ways to induce labour, and the method chosen will depend on many factors, like how ripe the cervix is and whether or not it is your first delivery. There may be several steps involved.

First the ripeness of the cervix is evaluated. If your cervix is still closed or only slightly effaced (meaning it is still thick), you may be given hormones vaginally (via tampon or gel) or orally (via a pill). This will soften the cervix and it will begin to efface (thin). The cervix will then dilate, or open, a few centimetres.

Sometimes a catheter with a small balloon attached is inserted into the cervix. The balloon can then be inflated inside the cervix to open it. These methods may sometimes cause discomfort but they help prepare your cervix for the next stage of the induction process.

Contractions may be induced or intensified—if you are already having them—using the drug oxytocin, administered intravenously.

Also your amniotic membranes can be artificially ruptured (breaking your water). This intervention is generally no more painful than a cervical examination and does not harm your baby.
Stimulating labour

Once labour has begun, either naturally or by induction, your health professional may suggest stimulating labour if your cervix is not dilating and your contractions are too far apart or not strong enough.

The frequency and strength of contractions are increased with the administration of continuous intravenous oxytocin. Once the oxytocin starts to take effect, you may need to continue taking it until your baby is born.

Monitoring the baby’s health

During the active phase of labour, your baby’s well-being is checked by listening to his heart with a fetal stethoscope or portable ultrasound machine. During this phase your baby will be monitored every 15 to 30 minutes.

If your baby needs to be watched more closely, continuous electronic fetal monitoring will be done. This means you will be connected to an electronic fetal monitor for a prolonged period. Two sensors are strapped to your abdomen and connected to a machine that produces a monitoring strip. One sensor tracks your baby’s heartbeat and the other records your contractions and the baby’s movements.

If the monitor bothers you or you would like to move around more, ask if you can take monitoring breaks to allow you more freedom of movement.

The staff can explain what the tracing means. There’s no need to worry if you stop hearing your baby’s heartbeat. Most of the time it’s because the baby or mother has moved and the sensor is no longer in the right place. Tell the staff so they can readjust it.
## When and why is monitoring used?

<table>
<thead>
<tr>
<th>When?</th>
<th>Why?</th>
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<tbody>
<tr>
<td>During the last trimester</td>
<td>To make sure your baby is doing well if:</td>
</tr>
<tr>
<td></td>
<td>• You have health problems (diabetes, hypertension);</td>
</tr>
<tr>
<td></td>
<td>• There are concerns about your baby (reduced movement, underweight, insufficient amniotic fluid).</td>
</tr>
<tr>
<td>When inducing or stimulating labour</td>
<td>To make sure your baby is doing well and to determine the frequency of contractions. Monitoring continues until the baby is born.</td>
</tr>
<tr>
<td>with drugs</td>
<td></td>
</tr>
<tr>
<td>During labour</td>
<td>To make sure your baby is doing well, to determine the frequency of contractions, and to see how your baby is handling them, if:</td>
</tr>
<tr>
<td></td>
<td>• You had a pregnancy without complications and you’re having a normal labour. Many hospitals suggest you be monitored for 20 minutes when you arrive and then every 15 to 30 minutes thereafter, based on the intensity of the contractions and how dilation is progressing (intermittent electronic monitoring);</td>
</tr>
<tr>
<td></td>
<td>• There is any doubt about your baby’s well-being, or if the situation requires more in-depth evaluation;</td>
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<tr>
<td></td>
<td>• You request an epidural during labour, in which case you will probably be connected to a monitoring device until the baby is born;</td>
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<tr>
<td></td>
<td>• You are planning for a vaginal birth after caesarean (VBAC);</td>
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<tr>
<td></td>
<td>• You have had a high-risk pregnancy.</td>
</tr>
</tbody>
</table>
Epidurals and analgesic drugs

In hospitals, certain drugs can be administered to ease birthing pains. The options available are the epidural, narcotics, and nitrous oxide gas.

Epidural anaesthesia, often referred to as an epidural, involves injecting a local anaesthetic through a flexible tube (catheter) inserted between two vertebrae in the lower back. The drug numbs the nerves in the abdominal area and partially numbs the leg nerves.

The epidural diminishes the pain of labour, but does not stop the contractions. This drug is administered and managed by an anaesthesiologist. If you want to have the option of having an epidural, find out ahead of time if it is available where you plan to give birth.

If you decide to have an epidural, an evaluation will first be done to ensure, among other things, that this type of anaesthesia is not contraindicated for you. Once the epidural is in place, its effects can be adjusted to suit your needs by varying the amount of drug administered through the epidural catheter. This catheter will be removed after delivery.

Once under the effects of the epidural, you will no longer be able to move around, but you will be able to move your legs. You must stay in bed, lying down or sitting up.
You will be connected to an intravenous solution until after the birth of your child. You will probably be connected to a continuous fetal monitor, especially if you are to be given drugs that stimulate contractions. If you have problems urinating during labour, you may need a **urinary catheter**.

Epidural anaesthesia is the most effective way to relieve labour pain. However it can slow the progression of labour because it may diminish uterine contractions and prevent you from moving about as you did before. For these reasons it is not usually administered until labour is well underway.

The effects of the epidural may make it more difficult to know how to push when the time comes for your baby to be born. This is why vacuum extractors or forceps are more often used to deliver a baby when the mother has an epidural. Epidurals do not increase the risk of having a caesarean.

Other drugs are also used, but less often than an epidural.

**Urinary catheter**: A flexible tube that allows urine to drain freely from the bladder. The catheter is inserted into the bladder through the urethra.
Narcotics are administered as injections. They decrease the sensation of pain without eliminating it completely. They can make you sleepy and nauseous and have the same effect on the baby. Sometimes the baby requires medical monitoring for a few hours after birth until the drugs are eliminated from his system. These drugs have no long-term effects on the mother or baby.

Nitrous oxide is not widely used. It is a gas administered through a mask that partially relieves pain during labour or delivery.

Episiotomy

An episiotomy is a cut (incision) in the perineum that is made just as the baby is about to be delivered. It may occasionally be used in situations where the baby needs help to exit more quickly. The cut is then sutured under local anaesthesia.

Episiotomies are no longer done routinely because they have been shown to increase the risk of deep tears to the perineum.

► Perineum: The part of the body between the vagina and the anus.
Caesarean section

The caesarean (C-section) is a major surgical procedure performed when the baby cannot be delivered through the vagina. It is employed if there are health risks to you or your baby.

The procedure involves cutting open the mother’s abdomen and uterus to remove the baby. The incision is usually horizontal, above the pubic hair.

The caesarean is generally done under an epidural or spinal block. The spinal block is similar to the epidural, but the drug is injected into a different region of the spine with only a needle (no catheter) and in a single dose. It allows for a faster anaesthesia. In both cases only the lower body is anaesthetised and the mother remains conscious. In rare cases general anaesthesia is used.

Caesareans may be planned in advance or decided upon during labour if the unexpected occurs. In most cases, the spouse or other person of the mother’s choice may be present during the procedure, which takes place in the hospital.

Reasons to have a caesarean

In Québec, almost one in four women give birth by C-section. There are several reasons that could lead one to a caesarean. These reasons may be related to the mother, the baby, or to labour itself. Below are examples of different situations that may arise.

Planned caesareans:

- When the placenta covers the cervix (placenta prævia)
- In certain cases of breech birth (e.g., the baby presents feet first)
- A previous caesarean combined with obstetric conditions not favourable for vaginal delivery
Unplanned caesareans:

- The baby is in a position that does not allow for a safe delivery.
- There are concerns about the baby’s health.
- Labour has not moved far enough along.
- The mother has major medical problems.

Possible consequences of a caesarean

Most C-sections go well, but like any surgery caesareans may have consequences.

Short-term effects of a caesarean delivery include the following:

- Abdominal and pelvic pains that may require the use of drugs
- Longer hospital stays, about 3 to 4 days
- Difficulty urinating (use of a catheter)
- The need to have a person present in the hospital room to lend a hand during the first 24 hours
- Longer recovery than for vaginal delivery

Since it is a surgical procedure, the caesarean may bring about certain complications: admission to intensive care, infection, bleeding, thrombophlebitis, injury to internal organs, and readmission to the hospital after the birth of the baby.

Over the long term, the caesarean may affect future pregnancies by increasing the risk of a placental disorder (placenta prævia). There is also a small risk of uterine rupture.

Not many significant consequences for the baby are associated with this surgery. Some babies can be injured by the manipulations performed during the caesarean. Likewise, mild respiratory distress is more common among babies born by caesarean. A baby born by C-section may have a lower body temperature. The practice of skin-to-skin contact with the mother or father can help alleviate this situation.

Thrombophlebitis: Inflammation of a vein associated with clot formation.
Recovering from a caesarean

At the hospital

You will be able to start breast-feeding and enjoy skin-to-skin contact with your baby right away, or a little later, depending on how you’re doing. It may be more difficult to start breast-feeding after a caesarean due to the pain and discomfort involved in moving. The support of your family and health professionals during this time will help you overcome these difficulties.

At the hospital, you will be encouraged to gradually start walking, drinking, and eating as the effects of the anaesthesia wear off and you feel better. Recovery from a caesarean will be easier if you move about.

You will also have vaginal bleeding (lochia) (see Physical recovery of the mother, page 210). While you have lochia you should use sanitary pads rather than tampons.

The pain of the incision and numbness of the skin in the surrounding area may be uncomfortable. The presence and duration of the pain and numbness vary from one woman to another. Your doctor can prescribe drugs for pain relief. The incision will heal in the weeks following childbirth.

Usually a baby born by C-section does not require any special care.

Before you leave the hospital, a health professional will tell you how to care for your wound and will give you advice on dealing with your specific situation. You will also be given tips on how to care for your newborn. Feel free to ask any questions you may have.
Returning home

You should rest for two weeks following a caesarean but not remain in bed. During this time your activities should be limited to taking care of your baby, your personal care, and moving about as much as possible to ensure a prompt recovery. Having someone around to lend you a hand during this period is helpful.

Once the bleeding and vaginal discharge have subsided you may consider bathing and swimming. It is recommended you give yourself a few weeks before resuming all your activities, such as driving, heavy lifting, certain physical activities and sports, or sexual relations.

Recovery and energy levels vary from one woman to the next and from one day to another. They depend on several factors, such as your baby’s needs, the amount of sleep you get, and available help. The important thing is to be tuned to yourself and not overdo it.

It’s also possible that while recovering from a caesarean you will experience varied, sometimes contradictory emotions. Some women may be relieved to have a healthy baby, but feel disappointed or dissatisfied with their delivery, while others may just be happy they made it through an exhausting and inefficient labour.

Each experience is unique, and the first impressions a woman has after undergoing a caesarean or a difficult delivery can evolve over the years.

When to contact a doctor?

Once back home after a caesarean, contact your doctor right away if:

- You see signs of a possible wound infection (redness, discharge).
- You experience one of the problems discussed in the section Physical recovery of the mother, page 210.
The first few days

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Your child is born at last. Who does she look like? Her daddy? Her mom? Maybe a distant relative? Whatever the case, your baby is unique, and now it’s time to get to learn all about her.

**Skin to skin**

Skin-to-skin contact with your newborn in the first hours, days, and weeks of life soothes and comforts her. Skin-to-skin contact is an excellent way to discover your baby and strengthen the emotional bond.

Enjoy skin-to-skin contact as often as you like. Just place your baby, with just a diaper on, directly on your chest and cover her in a blanket.

Skin-to-skin contact with the mother’s chest can make breastfeeding easier.

Skin-to-skin contact can start right after birth and go on for a long while. Your baby will feel warm and safe snuggled up against you.
The first few days

Your stay at the hospital or birthing centre

Hospital stays generally last 2 days after vaginal delivery and 3 to 4 days after a caesarean section. At birthing centres, the stay is usually about 24 hours.

Most hospitals are encouraging parents to room-in with their newborn. This gives them more time to get to know their baby and begin taking care of him, with a nurse nearby if they need help or advice.

Staying together will also let you nurse your baby on demand. These first moments together are precious.

During your stay you must also complete the paperwork required when there is a birth.

If you plan on driving home, a car seat is mandatory for your baby’s safety from the moment you leave the hospital or birthing centre. You will find all the information you need to know on page 617.

Your hospital stay is an ideal time to get to know your baby and learn how to look after her. Take full advantage of it.

Dominique Belley
Caring for your newborn

During your stay at the hospital or birthing centre, the nurses, doctors, or midwives will provide care to your baby to make sure she is thriving and to prevent or screen for health problems.

If you have concerns or questions about the care provided to your newborn, feel free to talk to these health professionals.

Preventive care

In the hours following delivery, the staff will recommend giving your newborn a vitamin K shot to prevent bleeding. Newborn bleeding is rare but can be severe and even fatal.

An antibiotic ointment will be applied to your baby’s eyes to prevent serious infections that can cause blindness.

Physical examination

During your stay at the hospital or birthing centre, a health professional will also give your newborn a thorough physical examination to make sure he is healthy and identify any potential issues.
Blood screening

Within a few days after birth, the staff will suggest that a blood screening be done and will take a few drops of blood from your baby’s heel. The purpose of screening is to detect diseases that, while rare, can pose serious risks to your baby’s health. If a problem is detected, treatment must begin before symptoms appear. This can help prevent severe, permanent complications.

For most children, the screening results will be normal. The parents will not be contacted. No news is good news!

If the screening results are abnormal, you will be contacted and directed to a specialized centre for additional tests. If these analyses confirm a diagnosis, you will be offered appropriate monitoring and treatment.

When the unexpected happens

All parents want a healthy baby. But sometimes the happy event doesn’t unfold as expected.

Even under the best conditions, things may not go as planned. Deciding to have a family brings great happiness and also some degree of uncertainty.

If your baby suffers from an infection, birth defect, or other health problem she may require hospitalization after birth or in the days following. This comes as a shock to parents who must learn to live with this new reality and adjust to a role different from the one they envisaged.

The birth may also occur before the date scheduled. The baby is considered to be premature when birth takes place before 37 weeks of pregnancy. A premature baby may require some of the special care presented in the table on the following page.
## Care of premature babies

<table>
<thead>
<tr>
<th>Birth</th>
<th>Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 34 weeks</td>
<td>Transfer to a neonatal intensive care ward in a hospital that has one.</td>
</tr>
<tr>
<td></td>
<td>Your baby may</td>
</tr>
<tr>
<td></td>
<td>• Receive phototherapy (exposure to light in an incubator) if she has jaundice</td>
</tr>
<tr>
<td></td>
<td>• Be placed in an incubator to keep her warm</td>
</tr>
<tr>
<td></td>
<td>• Receive intravenous solutions</td>
</tr>
<tr>
<td></td>
<td>• Receive help breathing</td>
</tr>
<tr>
<td></td>
<td>• Receive help feeding</td>
</tr>
<tr>
<td>34 to 37 weeks</td>
<td>Extra care, but less of it.</td>
</tr>
<tr>
<td></td>
<td>Your baby may</td>
</tr>
<tr>
<td></td>
<td>• Receive help feeding</td>
</tr>
<tr>
<td></td>
<td>• Receive phototherapy (exposure to light in an incubator) if she has jaundice</td>
</tr>
<tr>
<td></td>
<td>• Receive help breathing (only in rare cases)</td>
</tr>
</tbody>
</table>
A few suggestions for difficult moments

You may feel guilty and helpless if your baby is hospitalized for a complication such as premature birth, infection, birth defect (whether discovered before or after birth) or another health problem. Whatever the situation, here are a few suggestions to help you through these difficult times.

You don’t know what’s happening

Don’t be afraid to ask questions about your baby’s health and the treatment she’s receiving. If you have worries about the care and treatment, ask if an alternative is available. She’s your baby and you have the right to be involved in decisions affecting her.

It is the responsibility of members of the care team to keep you informed. However, time constraints sometimes make having these conversations difficult. Ask them when the best time to talk is. If you never get to see the doctor, find out when he or she usually visits.

You need support

If possible, ask your family and loved ones to help you by taking care of the house, minding your other children, or taking turns being with your baby. It’s possible you may not always be able to be at the hospital, especially if you have other children.

In the case of a prolonged hospital stay, it’s essential you rest yourself so you can stay healthy and be able to care for your baby when she first arrives or returns home. Remember that your child will need you not only during the hospitalization but afterwards as well.

Feel free to ask for psychological help if you feel you need it. Specialized hospital teams include social workers and psychologists.
Your hospital’s specialized team can advise about help you can receive at home. You can also request a follow-up with your CLSC when your child is discharged from the hospital. It’s important not to neglect post-hospitalization care, which may also be difficult for some parents.

If your baby is suffering from a chronic illness or has a particular health problem, check if there are resources for parents of children with the same problem. The help of other parents who face the same challenges can be useful.

The following website lists many resources available across Québec:

laccompagnateur.org
www.laccompagnateur.org

There is also an association to support parents of premature infants:

Préma-Québec
1-888-651-4909 / 450-651-4909
www.premaquebec.ca/en/

Suggestions for making a hospital stay easier

Many parents want to stay by their hospitalized baby’s side. Sometimes when they are able, the father and mother can take turns beside the crib during the day, or may want to spend the night. Check with your hospital to see what options are available. For example, see if they can offer a room where you can stay with your baby if you want to. Some hospitals may however have space constraints that make staying with your baby difficult.
Your baby is in an incubator

Don’t hesitate to ask for help touching your baby in the incubator or holding her in your arms or kangaroo style, i.e., skin to skin under a blanket. Feeling your presence will help your baby. If you’re unable to take her out of the incubator, ask if you can put a scarf or piece of clothing that smells of you beside her.

Breast-feeding when your baby is in the hospital

Your baby may be able to nurse and take in part or all of the milk she needs. Even if your baby is not yet able to suck, it is important to stimulate your breasts in the hours after birth to get your milk production going. Express your milk until your baby can breast-feed on her own. Your milk can be refrigerated or frozen until she is ready. At that time supplements can be added to your milk if necessary.

Ask for help expressing your milk. Breast pumps are often available in intensive care wards. Don’t be discouraged if you get only a few drops the first few times. Your breasts need regular stimulation to produce what your baby needs.

Don’t forget that your baby has a tiny stomach and only needs a few drops of milk when first starting to breast-feed. Having a photo of your baby, being close to her, or making skin-to-skin contact for a few minutes beforehand can help you express more milk.

If you weren’t expecting to breast-feed, it’s not too late to think about it. Premature babies and hospitalized newborns have special needs, including the antibodies only your milk can provide.
Who is allowed to visit?

Some hospitals may allow visits by your other children and members of the immediate family. Be sure your visitors are not sick when they come to see your baby. Even an ordinary cold can be serious for a newborn.

It can be a good idea to talk with your other children about what’s going on. The baby’s siblings also have concerns about the baby’s health. Reassure them that what’s happening to your baby is not their fault. Slightly older siblings may believe their jealousy of the new baby has caused the complication. You can also get them involved in caring for the newborn whenever possible.

Death of a newborn child

While not uncommon years ago, today it is fortunately rare for a child to die before birth or in the first few days of life. The cause is usually extreme premature birth or birth defects. Whether it can be explained or not, losing a baby is always traumatic for the parents and family.

When a baby dies during pregnancy, the mother is often requested to deliver it naturally or through induction. After delivery it can be particularly trying for her to go through the physiological postpartum response, such as lactation and bloody discharge.

At the hospital some parents may ask to hold their stillborn baby in their arms, to dress her, or take photos. Subsequently an autopsy may be performed to determine the cause of death. Various funeral options (e.g., cremation, burial) may be proposed.

Back home it’s normal to go through periods of shock, outrage, disorientation, and sadness. The intensity of the emotions experienced and the time needed to recover will vary from person to person. The two parents often do not mourn in the same way or at the same pace.
Parents who have experienced the death of a newborn say that the presence and support of their loved ones helped them through the ordeal.

There are also support groups for parents who have lost a child. These groups can provide valuable assistance to parents as they go through the mourning period, and they can share their experience with other bereaved parents. You can also see a health professional (e.g., psychologist, social worker) for counselling individually or as a couple.

Consult your CLSC to find out about services offered there or other services in your area. You can also seek help from these organizations:

**Centre d'études et de recherche en intervention familiale (CERIF-deuil)**
This centre provides telephone and email support.
1-800-567-1283, ext. 2387
deuil@uqo.ca

**Parents Orphelins**
www.parentsorphelins.org/en

You can check with Commission des normes, de l’équité, de la santé et de la sécurité du travail for details about absences and leave you may be entitled to (see Parental leave and preventive withdrawal, page 713).

If your baby died after 19 weeks of pregnancy or after her birth, you may also be entitled to receive maternity benefits under the Québec Parental Insurance Plan.

**Commission des normes, de l’équité, de la santé et de la sécurité du travail**
1-844-838-0808

**Québec Parental Insurance Plan**
1-888-610-7727
www.rqap.gouv.qc.ca/travailleurs_salarie_autonome/evenement-particulier/index_en.asp
Physical recovery of the mother

You’re happy, but tired—this is normal! It will take a few weeks to get your usual energy level back. Be patient. Try to take care of yourself and don’t hesitate to ask for help when you need it.

Your body needs some time to recover. Back home, if you show signs which worry you, don’t hesitate to contact the CLSC nurse or consult your physician or midwife.

After you return home, consult your doctor right away or go to the emergency room if

• You show signs of haemorrhaging
  – You soak one regular sanitary pad an hour for two consecutive hours
  – You lose large blood clots (e.g., more than one egg-sized clot)
  – Your bleeding increases rather than decreases

• You have a fever—temperature of 38.0°C (100.4°F) or higher

• You have severe abdominal pain not relieved by analgesics

• You have difficulty breathing

• You have a new pain in your leg with swelling

Go directly to the emergency room if you show signs of shock: agitation, weakness, paleness, cold and damp skin, or hot flashes and palpitations.
Blood loss

For the first day or two after childbirth your blood loss (lochia) will be heavier than during menstruation. Eventually the bleeding will diminish and the blood will change texture and colour. It may be mixed with mucous (a whitish substance). The colour will gradually change from pink to brown, becoming paler, and it could turn yellow.

Occasionally you may pass a clot. This happens generally in the morning after urinating or breast-feeding. So long as the bleeding lessens after passage of the clot there is no need to worry. Be aware that unusual physical effort or a caesarean delivery may cause redder and more abundant lochia.

Lochia usually lasts three to six weeks. During this time, use sanitary pads, not tampons.

Contractions

You may feel uterine contractions, especially while you are breast-feeding. If this isn’t your first pregnancy, you may experience more contractions than during previous pregnancies. If you need relief from the pain, contact your health professional.

Hygiene

You can take baths safely and as often as you like after giving birth, as soon as you get home. These quiet moments will give you a little time-out for yourself. Hygiene is very important. Here are a few helpful tips:

- Take a shower or bath once a day or more in a clean bathtub without oil or bubble bath.
- Change your sanitary pad at least every 4 hours.
- Always wipe from front to back.
- Wash your hands after using the toilet.

However, don’t give yourself a vaginal douche. You can go swimming as soon as your bleeding is lighter.
Perineum

After a vaginal birth your perineum will remain sensitive for a while. It’s also normal that the labia are more open and the vulva looks and feels different.

Don’t worry if you have stitches: they will not come loose when you go to the bathroom. After bathing, let the stitches dry before you get dressed.

You can do exercises to tone your perineum. Several times a day contract the pelvic floor muscles as if you were holding in urine and then relax them. You can begin these exercises a few days after delivery even if you have stitches since these exercises stimulate blood flow and promote wound healing. You can gradually work up to 100 contractions per day.

Urinating and bowel movements

It is normal not to have a bowel movement in the first two to three days after vaginal delivery and three to five days after a caesarean. However, if this persists you may be constipated. This often happens after both a vaginal delivery and a caesarean. If this is the case, follow these tips:

• Eat high fibre foods like bran cereal, whole grain bread, raw vegetables, fruits, legumes, and nuts.

• Drink plenty of fluids.

• Go to the bathroom when you feel the need.

• Drink prune juice or eat prunes.

If these measures fail you can try a laxative. Opt for a fibre-based product (e.g., Metamucil®) and drink enough liquid so that your constipation doesn’t worsen. You can also take a stool softener like docusate (e.g., Colace®).
After delivering you may feel a burning sensation when urinating—try spraying your vulva with warm water. It’s normal in the first few days after delivery to have trouble retaining urine and gas. If this annoyance persists, mention it to your doctor during a follow-up visit.

**Exercise**

About two weeks after vaginal delivery you can resume your activities gradually. As soon as you feel up to it, it’s a good idea to get out of the house. You’ll feel better for it. It’s best to start with short walks because at the beginning you will tire more quickly and perhaps suddenly.

There are exercise programs designed for new moms and their babies, many of them organized by municipalities. Books and DVDs on postnatal exercise can also be helpful.

**Weight**

Most women get back to their normal weight without any special effort. Within a few months your body will exhaust the fat reserves it accumulated during pregnancy. Eat a healthy diet and be patient! Don’t expect the weight you gained over nine months to disappear overnight.

Resist the temptation to lose weight quickly, especially if you’re breast-feeding. Losing 1 to 2 kg (2 to 4 lb.) a month is reasonable. A woman who is breast-feeding should not follow a strict weight-loss diet. A low-calorie diet can diminish your milk production and energy level.
Get some rest

It’s a good idea to take the first few days after your baby’s birth to rest. If possible, adjust your rest period to your baby’s feeding schedule, i.e., try to sleep when your baby sleeps. Don’t get up except to wash, eat, and care for your baby. Your partner or another friend or family member can help you change diapers, bathe the baby, run errands, and prepare meals.

During the first week, you should not schedule other activities apart from caring for your baby and yourself. Until about the third week you will need the help of others to take care of housework, cooking, and looking after your other children.

Taking naps during the day is a good idea as long as your baby is still waking at night.

All new mothers need rest and a helping hand to recover from the demands of childbirth.
Baby blues

After the birth of your baby it’s normal to have mood swings and crying periods. Many new moms experience the baby blues for short periods of time. The baby blues follow the birth of the baby and can last from a few days to two weeks. Hormonal changes and fatigue are largely responsible for this temporary depression.

Here are few tips to help you feel better during this time:

• Get your family and friends to help out a little more.
• Take a break or nap when you get the chance.
• Talk about how you feel.
• Take care of yourself.
• Talk to other parents.
• Enjoy skin-to-skin contact with your baby.
• Most importantly, let the tears flow, and don’t worry—it’s perfectly normal!

If this temporary depression goes on for more than two weeks or if you feel more and more sad or irritable, you may be experiencing postpartum depression.

Depression

Depression is not a rare disease. About one in ten women experience depression during pregnancy and about two in ten experience depression after delivery. Men can also suffer from psychological distress or depression during the pregnancy or after the baby is born.
When a person is suffering from depression they usually experience sadness or a general loss of interest and overall pleasure in daily activities. They can also show some of the following signs:

- A decrease or increase in appetite or weight
- Trouble sleeping (sleeping too much or difficulty sleeping)
- Agitation or psychomotor impairment (e.g., slowed speech)
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt (e.g., the impression of not being a good parent or not being able to establish an emotional bond with the baby)
- Difficulty concentrating or indecisiveness
- Thoughts of death or suicidal ideas

Some of these signs can be confused with normal changes that occur after childbirth (e.g., fatigue).

Men may have the same symptoms as women but express their distress differently. For example, they may be more aggressive or irritable, have mood swings, and feel physical discomfort such as stomach aches, headaches, or difficulty breathing. Some men may also exhibit hyperactive behaviour (devoting many hours to escaping into work or sports) or excess consumption of alcohol or drugs.

Unlike the baby blues, which is temporary, the changes in behaviour and mood associated with depression are present almost every day for at least two weeks.
If you notice these changes in yourself or in your partner, consult your family doctor or your midwife. You can also contact your CLSC or a psychologist. Psychological treatment and drug treatments are available for depression.

**Sexuality after birth**

Some people say they feel less sexual desire after the birth of the baby. Fatigue, adapting to parenthood, time and energy invested in caring for the baby, physical or emotional complications, and hormonal changes can all lead to a decreased interest in sexual activity.

Many parents aren’t sure when to resume sexual activity after the delivery. If there are no medical reasons to put it off, the people can engage in sexual activity without fear when they feel the desire. The timing of intercourse involving penetration will vary depending on individual needs and preferences.

While breast-feeding, the body releases hormones that can prevent the vagina from producing sufficient lubrication. If that happens, you can use a water-based lubricant to facilitate genital fondling and penetration.

Don’t pressure yourself. Let your sex life adapt to your new reality.
Birth control

During your pregnancy, you should start thinking about what kind of birth control you will use after birth.

You can still get pregnant even if you haven’t had your period yet. Ovulation can occur as soon as the third week after vaginal delivery or C-section. Use an effective birth control method to prevent an unplanned pregnancy.

Breast-feeding and the lactational amenorrhea method (LAM)

If you breast-feed exclusively, ovulation may be delayed. To use breast-feeding (lactation) as a birth control method, you have to understand the principle behind the lactational amenorrhea method (LAM).

LAM is only effective during the first six months after the baby is born. For it to work, LAM requires:

- Breast-feeding exclusively (the baby should not be given any commercial infant formulas, food or water)
- Not having a period for those first six months
Before using LAM or another natural method of birth control (e.g., Billings or symptothermal), you should contact the Serena organization for further information and support.

You can also visit the following websites:

**Serena**
Organization promoting natural family planning methods
www.serena.ca
514-273-7531 / 1-866-273-7362

**World Alliance for Breastfeeding Action (WABA)**
www.waba.org.my/resources/lam

**Birth control methods**

Your choice of a birth control method depends on your preference and your personal situation, which should be assessed by your health professional. This assessment can be done at the end of pregnancy or before you leave the hospital or birthing centre.

The table below describes the birth control methods available.
# Birth control methods

<table>
<thead>
<tr>
<th>Method</th>
<th>When you can start if there are no contraindications</th>
<th>Possibility of a slight drop in milk production</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hormonal IUD (Jaydess®, Kyleena®, Mirena®)</td>
<td>Any time after a vaginal delivery or C-section</td>
<td>✓</td>
</tr>
<tr>
<td>Copper IUD</td>
<td>Any time after a vaginal delivery or C-section</td>
<td></td>
</tr>
<tr>
<td>Contraceptive injection (Depo-Provera®)</td>
<td>Any time after a vaginal delivery or C-section</td>
<td>✓</td>
</tr>
<tr>
<td>Progestin-only pill (Micronor®)</td>
<td>Any time after a vaginal delivery or C-section</td>
<td>✓</td>
</tr>
<tr>
<td>Combined hormonal contraceptives that contain an estrogen and a progestin:</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>• Pills</td>
<td>6 weeks after vaginal delivery or C-section</td>
<td>• Depending on your situation, your health professional may recommend you start as soon as you resume sexual activity</td>
</tr>
<tr>
<td>• Contraceptive patch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Vaginal contraceptive ring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diaphragm</td>
<td></td>
<td>6 weeks after vaginal delivery or C-section</td>
</tr>
<tr>
<td>• Cervical cap</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom</td>
<td>From the start of sexual relations</td>
<td></td>
</tr>
</tbody>
</table>
The IUDs, contraceptive injection, progestin-only pill (Micronor®), and combined hormonal contraceptives are the most effective types of birth control. The withdrawal method, or coitus interruptus, and the calendar method are not effective.

When using the progestin-only oral contraceptive (Micronor®), be sure to take it at the same time every day. If you deviate by more than three hours from this time, it becomes less effective. Use condoms during sex until you are back on your regular schedule for at least two days.

Don’t stop your current birth control method before starting another. To avoid unprotected sex, keep a supply of condoms handy.

If you use hormonal contraceptives and you are breast-feeding, it’s possible you will experience a slight drop in milk production. These methods do not affect the quality of your milk or the health of your baby. If you notice a problem, contact a lactation consultant your midwife, your doctor, or a CLSC nurse.

Learn about birth control methods by visiting the website prepared by the Society of Obstetricians and Gynaecologists of Canada: www.sexandU.ca/.
Emergency contraception

If you have had unprotected or poorly protected sex, there are emergency contraception methods you can use.

Emergency oral contraception (EOC; the morning after pill) – It works up to five days after unprotected or poorly protected sex, at any time after a vaginal delivery or C-section, whether or not you’re breast-feeding. The sooner it is taken after poorly protected or unprotected sex, the more effective it is. You can get it from a pharmacist without a doctor’s prescription.

If you’re breast-feeding, be sure to mention it to your health professional. They can prescribe an EOC that you can take while you’re breast-feeding.

Copper IUD – Provided it is not contraindicated for you, your doctor can insert a copper IUD up to seven days after unprotected or poorly protected sex at any time after a vaginal delivery or a C-section.