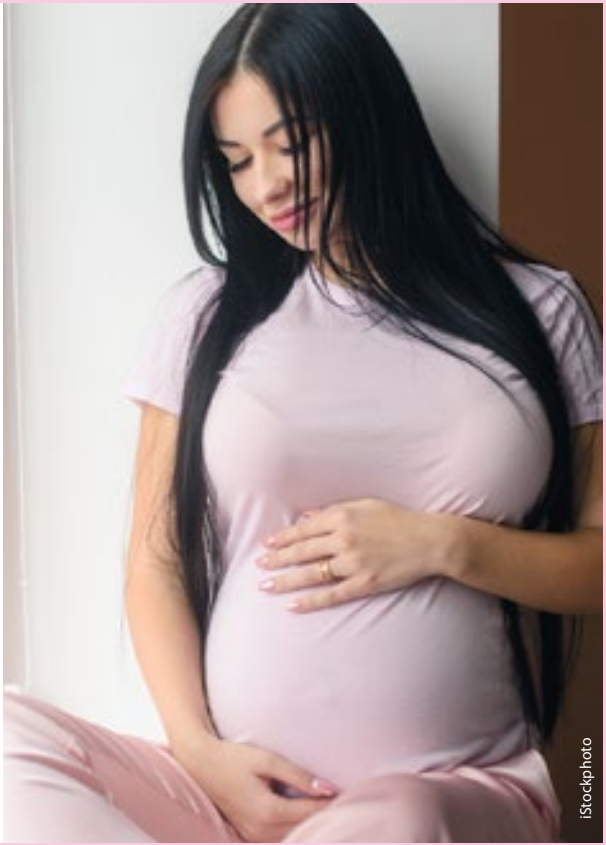
Mireille Barakat

The start of labour



You will soon be bringing your baby into the world. **Labour** generally begins spontaneously between 37 and 42 weeks of pregnancy.

Your expected delivery date is not a deadline. Even if you have not given birth after 40 weeks, there is still a good chance labour will begin on its own.

However, it may be preferable to give birth before 42 weeks rather than wait until 42 weeks have passed. If there is still no sign that labour has started after 41 weeks, your doctor or midwife will discuss the available options with you. They may suggest you undergo some tests, such as monitoring, or **ultrasound**.

The test will help determine whether you can continue to wait for labour to begin on its own or whether it is preferable to induce labour (see Inducing labour, page 227).

Recognizing the start of labour

No one can predict when and how your labour will begin. Most women will recognize labour because of certain telltale signs, such as contractions or their waters breaking. It's normal at that point to feel excited or anxious.

Passing the mucus plug

The mucus plug, which blocks the cervix during pregnancy, is made of thick, jelly-like substance sometimes tinged with blood. You may lose your mucus plug several days before you give birth or during labour. You can even lose it in several stages.

If you lose your mucus plug, 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.

You may also lose your mucus plug without realizing it.

Contractions

For most women, **labour** begins with uterine contractions. During contractions, your belly grows tight and hard, and you have pain that lasts at least 20 seconds (see Telling the difference between contractions and other abdominal pain, page 157).

Many women feel pain in the lower abdomen. For others, the pain is centred 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 sensations may be different for the same woman from one pregnancy to another.

Contractions during labour are regular and grow steadily stronger.

Breaking of the waters (rupture of the amniotic membrane)

For some women (about one in ten), the breaking of the waters (rupture of the amniotic membrane, or amniotic sac) signals the beginning of labour.

The amniotic membrane is made up of two layers, which are often referred to as "membranes." The membrane envelops your baby and holds the amniotic fluid that surrounds him. When it ruptures, the amniotic fluid leaks out.

This is commonly known 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. In some cases, 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 Telling the difference between the types of discharge, page 159). Generally with amniotic fluid, there will be enough to soak a sanitary pad.

What to do?

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

The staff will make sure your baby is doing well. They will also check whether your membrane did actually rupture, or if you simply have 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 group B streptococcus (also called GBS), labour may need to be induced (see Inducing labour, page 227).

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

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. This will depend on the distance you have to travel, your previous deliveries, your health, and the state of your cervix.

Towards the end of your pregnancy, check with your doctor or midwife at what point you should go to the hospital or birthing centre.

However you should go to your hospital or birthing centre immediately if any of the following situations occurs:

- For a first delivery, you are having regular contractions every five minutes or less for one hour
- This is not your first delivery and 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 water has broken (your membrane has ruptured)
- You are losing blood
- You no longer feel your baby move (see Lack of baby movement after 26 weeks, page 155)

Women often go the hospital or birthing centre because they think they are in active **labour**, when in fact they are still in early labour (see Early phase or "latent phase" of labour, page 218). 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.

Understanding and coping with pain

The pain of labour is unique and serves a purpose. It signals the start of the opening process that will lead to the birth of your baby. This process happens gradually. A rhythm develops and the intensity of the pain steadily increases.

The pain is stronger during contractions, while the period between contractions gives you time to recover. For some women the start of labour is hardest; for others the most difficult moment is when it is time to push.

There are various things that can help cope with childbirth pain without using medication. Knowing what they are can help women and couples better understand the pain and prepare in advance.

Having someone with you during childbirth

During childbirth, a woman needs to feel the presence and support of someone she knows and trusts. This can be the baby's father, the woman's partner, a member of her family, a friend, or a doula (see Doulas, page 120). This presence will help her feel better, and reassure and encourage her during labour.

As a father or partner you may feel helpless and powerless during the birth, especially since this is an extremely important time for 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. Try to adopt a positive and caring attitude and encourage your partner as much as you can.

You don't need to be an 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.

Creating a supportive environment

Women who give birth need an environment where they feel calm, safe and confident. This helps them to secrete the hormones needed for labour. To create a supportive environment, you can do things like dimming the lights and reducing ambient noise as much as possible (e.g. turning down the monitors, asking people to whisper).

Techniques for coping with childbirth pain

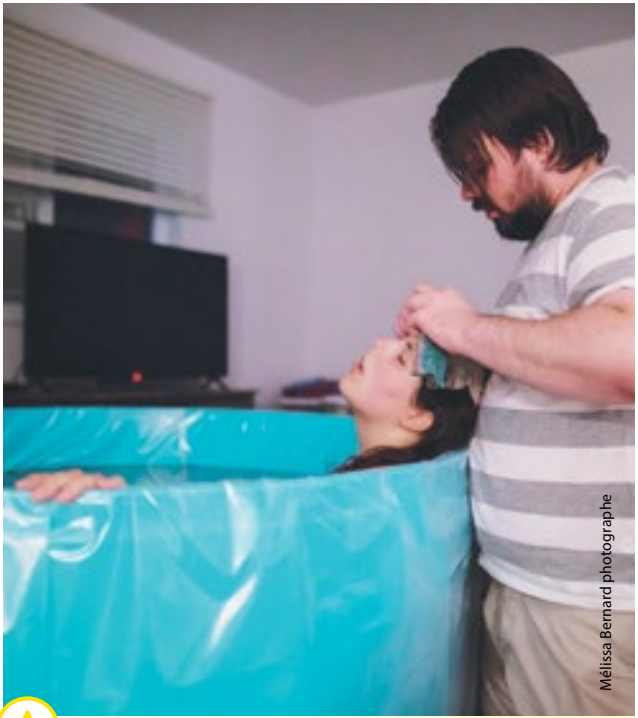
You can try various techniques to see what you find helpful for coping with the pain. Different things may work at different times during your labour.

Movement

Movement helps labour progress. During childbirth, you are encouraged to move, walk around, and squat. Find a comfortable position and don't hesitate to switch from one position to another (see Possible positions during labour, page 215). Large physio balls are usually available to sit and move around on. Don't hesitate to ask for a ball if nobody offers one to you.

Using water

Most hospitals and birthing centres offer you the option of taking a bath or shower. Many women find that being in the water helps them cope with pain.



Many women find that being in the water helps them cope with pain.

Massage

Gentle massage can help reduce anxiety and make the pain easier to bear. During contractions, some women prefer vigorous massage of painful areas or **acupressure**.

Compresses

Hot or cold compresses applied to painful areas can help reduce pain.

Relaxation methods

Some women learn relaxation methods such as breathing techniques, visualization, and self-hypnosis, or do yoga.

You can practice these methods during your pregnancy to help yourself prepare. During **labour**, listening to music and creating your own bubble of calm can also be soothing.

Other techniques

Some birthing facilities also offer injections of **sterile** water beneath the skin or the use of TENS machines, which electrically stimulate painful areas. If either of these methods interests you, don't hesitate to ask your healthcare provider for more information.

If you get to a point where the methods for coping with the pain are no longer working or you feel like you can't bear it any more, keep in mind that pain can often be relieved with drugs (see Pain medication, page 232).

Tips for coping with childbirth pain

- Have someone with you—the baby's father, your partner, a family member, friend, or 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 (don't stay lying down)—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 better.
- 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.

Keeping your upper body straight can help speed up labour.

Positions during labour

Throughout labour, you can try different positions to help dilate the cervix and help you relax between contractions. Lying flat on your back is often the least comfortable position. If you feel the need to lie down, lying on your side is often more tolerable.

Whether you're standing, squatting, sitting on a physio ball, or even kneeling on all fours, keeping your upper body straight can help speed up labour.

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

Possible positions during labour

Standing

Sitting

Squatting

Kneeling

Illustrations: Maurice Gervais

The stages of childbirth

Caroline Nicolas

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

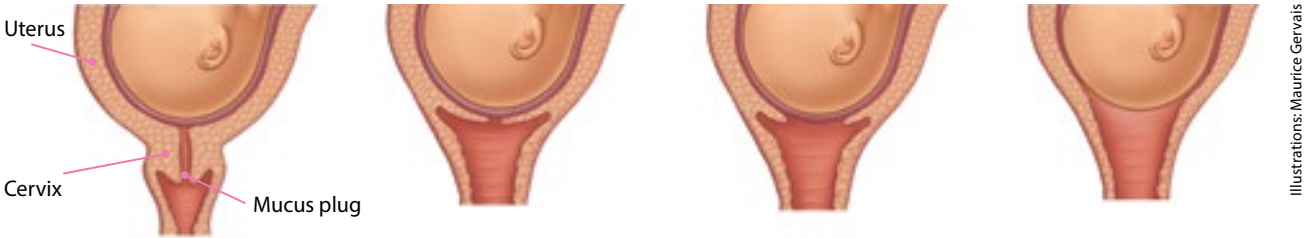
First stage: Thinning and opening of the cervix (also called dilation)
Second stage: Descent and birth of your baby
Third stage: Delivery of the placenta

It isn't possible to predict the length of each stage because it varies from one delivery to the next.

First stage: Thinning and 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 thin (efface) and open completely (dilate), until it is 10 centimetres wide.

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).

Illustrations: Maurice Gervais

Progression of labour

Early phase or "latent phase" of labour

During the latent phase, you may have contractions without being certain what they mean. Is it 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 get accustomed to what's happening inside your body.

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 no longer feel the baby moving.

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

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 strength of the contractions gradually increases and the cervix gradually opens to 10 cm (complete dilation). The contractions are often very painful at 8 or 9 cm. They are most intense just before complete dilation at 10 cm.

This phase is often compared to a storm. You may experience strong emotions or feel the need to make noise or scream. You may feel like you're losing control and that it will never end. This is normal.

Try to give in to the **labour**, breathe, visualize your baby starting to move down inside of you and stay in contact with her (see Understanding and coping with pain, page 209).

Labour can be intense and bring strong feelings and emotions. Trust yourself and don't be afraid to ask the person with you or your healthcare team for 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 open (dilated). The baby can now descend into your vagina to be born.

Pushing

When your cervix is open (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 bring your baby into the world.

You may feel the urge to push before your cervix is fully dilated. Your care team will guide you when it's time to start pushing to ensure that your pushes are more effective.

The time between contractions can allow you to recover between pushes.

You may have a bowel movement during the pushing stage. This is completely normal. It is also possible that your **perineum** won't have time to stretch enough as the baby comes out and it may tear. These tears usually heal well on their own after the birth.

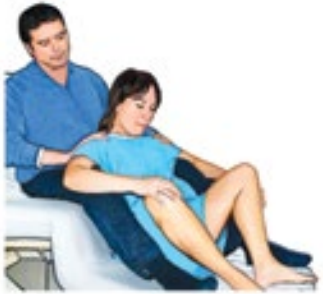
If you have an epidural, your awareness of the urge to push is lessened and may even be entirely absent at the beginning of the second stage. Awareness of the urge will come later, as your baby descends with the contractions. Normally, you can wait to push until you feel the urge to do so. Your efforts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

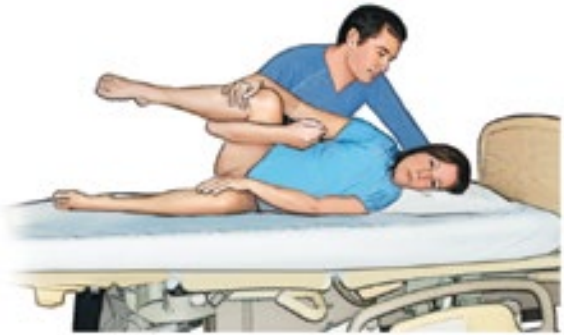
Pushing positions

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

With help from the person accompanying you or the healthcare team attending the birth, find a position that works for you. Feel free to change positions when you feel the need to do so.

Possible pushing positions





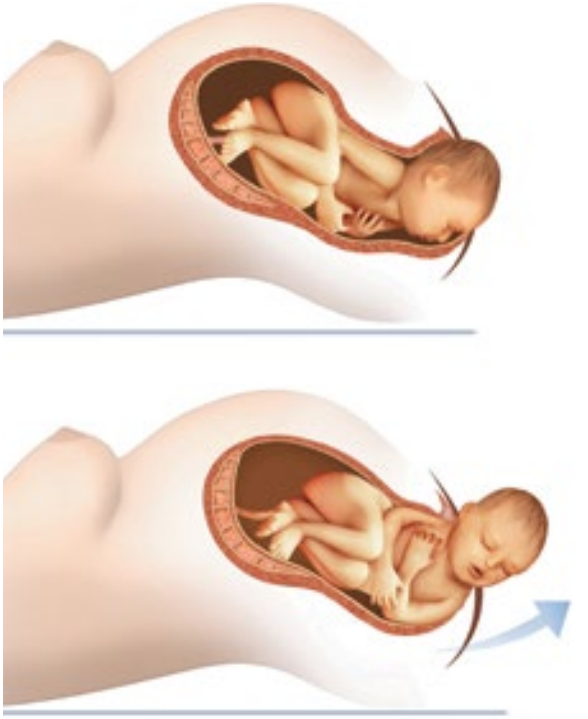
Illustrations: Maurice Gervais

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, and the father or partner will be able to see the baby's hair.

You can also watch your baby's progress in a mirror (mirrors are available in most birthing rooms). After the top of the head, the baby's face will appear. Another push and the baby's shoulders and rest of his body will come out.

Birth of the baby



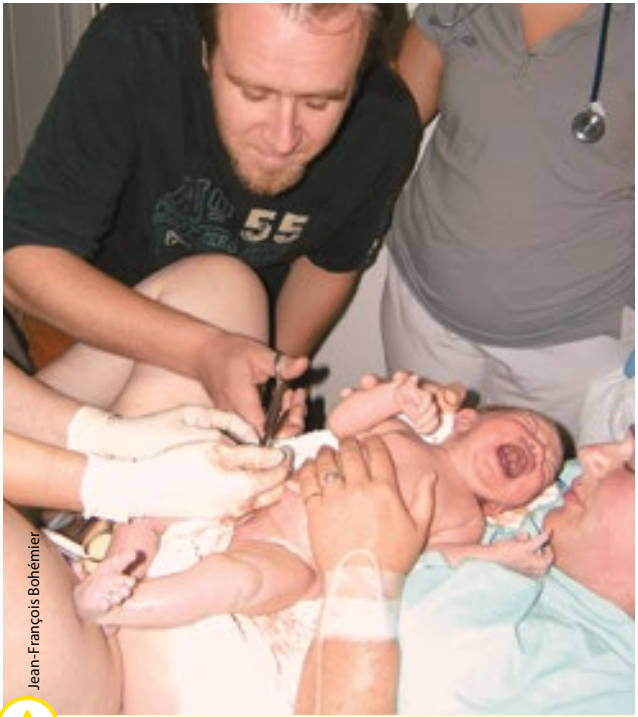
Illustrations: Maurice Gervais

Third stage: 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 prevent **hemorrhages** and to regain its original shape. If you breastfeed, your baby's first few feedings will stimulate the production of **oxytocin**, a hormone that increases contractions of the uterus.

If the contractions aren't strong enough, there is a risk of hemorrhaging. In this situation, treatment consists of massaging the abdomen at the uterus to stimulate it to contract, or giving oxytocin as a medication.



Jean-François Bohémier

Usually, the father or partner will be invited to cut the umbilical cord.

First moments with your baby

Within moments of being born, your baby will announce his arrival with his very first sounds. He will be placed on you. The care team 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.

If all is well with both of you, your baby will stay on your chest, skin to skin. Ideally he will remain there for at least two hours without interruption. With both of you under a warm blanket, you can cuddle your baby as you get acquainted for the first time. At last you can marvel at his tiny face, his fists, and feet, and meet his gaze.

All of this helps your baby to gently transition to life outside the uterus; skin-to-skin contact allows him to maintain his body heat and regularize his breathing and heartbeat.

In addition, it makes your newborn feel safe and makes breastfeeding easier. At some point, your baby's instinct will be to nurse for both food and comfort. The care team assisting with your delivery can help you get started with breastfeeding.

If your condition does not allow it, skin-to-skin contact can be with the father or another significant person. If skin-to-skin contact can't be made 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 the comfort of being held by his father or another significant person. 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.

Your baby is enveloped by the warmth of your body and instinctively seeks to nurse for food and comfort.

Possible interventions during labour

iStockphoto

Stripping the membranes

Toward the end of your pregnancy, your healthcare provider may suggest stripping your membranes (also called a membrane sweep). The procedure can trigger uterine contractions within a few days so you don't have to be artificially induced after 41 weeks (see Inducing labour, page 227).

A membrane sweep can be done during a vaginal exam to check the dilation and consistency of your cervix. It can be an uncomfortable, sometimes painful, procedure and may cause some spotting for the first 24 hours.

Inducing labour

When is labour induced?

Labour will be induced if there is a medical reason to do so, e.g., a woman's water has broken (rupture of the amniotic membrane) but she is not having contractions, or the pregnancy has gone beyond 41 weeks.

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 consequences.

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 a first delivery.

First the ripeness of the cervix is evaluated. If the cervix is still closed (or thick), the woman may be given hormones vaginally (via tampon, tablet, or gel) or orally (via a pill). This will soften the cervix and it will begin to thin (efface). The cervix will then open (dilate) 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 or pain but they help prepare the cervix for the next stage of the induction process.

Contractions may be induced using medication administered intravenously, orally, or through the vagina. Once the medication starts to take effect, it must usually be administered until the baby is born.

It is also possible to break water (rupture the amniotic membrane) artifically. This procedure is generally no more painful than a cervical examination and does not harm the baby.

Stimulating labour

Once **labour** has begun naturally, your care provider may suggest stimulating labour if your cervix is not opening (dilating) and your contractions are too far apart or not strong enough.

The frequency and strength of contractions are increased using **oxytocin**, which is intravenously administered on a continuous basis. Once the oxytocin starts to take effect, it must usually be administered until the baby is born.

Monitoring the baby's health

Throughout the active phase of labour, the care team will regularly check on the baby's well being by listening to his heart with an ultrasound machine. During this phase, an ultrasound is performed every 15 to 30 minutes.

Monitoring with a fetal monitor

If your baby needs to be watched more closely, he will be monitored with a fetal monitor. The period of monitoring can vary in lenght depending on the situation. Monitoring may be intermittent or continuous.

During monitoring, two sensors are strapped to your abdomen and connected to a machine that produces a monitoring strip.

During monitoring, 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 for more freedom of movement.

The staff can explain what the pattern on the monitoring strip means.

There's no need to worry if you stop hearing your baby's heartbeat. Most of the time it's because you or your baby have 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?

When?	Why?
During the last trimester	To make sure your baby is doing well if • You have health problems (diabetes, high blood pressure) • There are concerns about your baby (reduced movement, underweight, insufficient amniotic fluid)
When inducing or stimulating labour with drugs	To make sure your baby is doing well and to assess the frequency of contractions. Monitoring continues until the baby is born.
During labour	To make sure your baby is doing well, to monitor the frequency of contractions, and to see how your baby is handling them, if • There is any doubt about your baby's well-being, or if the situation requires more in-depth evaluation or follow-up • You request an epidural during labour, in which case you will probably be connected to a fetal monitor until the baby is born • You are planning for a vaginal birth after a caesarean (VBAC) • You have a high-risk pregnancy If you had a pregnancy without complications and you're having a normal labour, your baby's heart will be checked regularly with an ultrasound machine to make sure he's doing well.

Pain medication

In hospitals, certain drugs can be administered to ease birthing pains. The following options may be offered to you: an epidural, narcotics, nitrous oxide gas, or a pudendal nerve block. These methods are described below.

Ask in advance which of these options are available at your hospital.

Everyone reacts differently to medication. If you have any questions, don't hesitate to ask your prenatal care provider or delivery room care team.

Epidural

Epidural anaesthesia, often referred to as an epidural, is the most effective method for relieving childbirth pain. It 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 reduces or eliminates the pain of **labour** while allowing contractions to continue. However, it can diminish contractions and prevent you from moving around as freely as before. This can slow the baby's descent.

If you want 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.

Good to know...

It is best not to receive an epidural too soon, to ensure that your **labour** is well underway. On the other hand, you may not be able to have it in time to relieve your pain before the push.

Before receiving an epidural, you will be connected to an intravenous solution (IV) that will remain in place until after the medication stops working. You will also probably be hooked up to a continuous fetal monitor, especially if you are given drugs to stimulate your contractions (see Stimulating labour, page 229).

In some hospitals, you can still walk around and go to the bathroom while under an epidural. Ask your care provider.

However, if you have problems urinating, you may need a **urinary catheter**.

The effects of the epidural may make it more difficult to know how to push. This is why there may be a greater need to use vacuum extractors or forceps to deliver a baby when the mother has an epidural. Epidurals do not increase the risk of having a caesarean.

Narcotics

Narcotics are analgesics administered as injections into a muscle or vein. They decrease the sensation of pain without eliminating it completely. They are mainly used during the early phases of **labour** when the pain level is still low. The more the pain increases, the higher the dose needed to relieve it.

The possible side effects of narcotics also increase with the dose. These drugs can make you sleepy and nauseous and affect your heart rate. The baby may also experience some of these effects. That's why narcotics are not normally used at the end of labour.

Sometimes the baby requires medical monitoring for a few hours after birth until the drugs are eliminated from his system. However, these drugs have no long-term effects on the mother or baby.

Nitrous oxide

Nitrous oxide, also known as "laughing gas," is administered through a breathing mask. It partially relieves pain during labour. Nitrous oxide can cause nausea and dizziness, but is generally well tolerated.

Pudendal nerve block

A pudendal nerve block is a pain medication administered just before the push. Its purpose is to reduce **perineum** and vaginal pain during childbirth. Using a long needle, an anaesthetic is injected into the two pudendal nerves through the vagina.

You can discuss pain management options in advance with your prenatal care provider or ask your delivery room care team if you have any questions.

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.

Caesarean

The caesarean (also called caesarean section or C-section) is a type of delivery performed when the baby cannot be born through the vagina. This surgical procedure involves cutting open the mother's abdomen and uterus to remove the baby. In Québec, about one in four women give birth by C-section.

Reasons to have a caesarean

A caesarean can be planned or unplanned, and there are several reasons why it may be performed. Here are some examples of situations where a caesarean may be necessary.

Situations requiring planned caesareans:

- Certain medical problems in the mother
- When the placenta fully or partially covers the cervix (*placenta prævia*)
- Certain cases of breech presentation (see Breech presentation, page 190)
- A previous caesarean combined with conditions not favourable for vaginal delivery (see Vaginal birth after caesarean, page 188)

Situations requiring 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 progressed adequately, despite proper stimulation
- The mother has major medical problems

What happens during a caesarean

Before the caesarean, the mother will be given an intravenous solution (IV) and fitted with a **urinary catheter**.

Caesareans are generally done under an epidural (see Epidural, page 232) or spinal block. The spinal block is similar to the epidural, but the drug is injected into a different region of the spine. It allows for a faster anaesthesia. In both cases only the lower body is anaesthetised and the mother remains conscious. In rare cases, a general anaesthetic that puts the patient "to sleep" is used.

Generally, once the preparations for the caesarean are complete, the person accompanying the mother can enter the operating room and sit near her. A sheet hides the view of the belly during the operation.

The incision is usually horizontal, above the pubic hair line. Once the baby is delivered and the umbilical cord is cut, the baby is placed against the mother's skin if both baby and mother are doing well.

The placenta is then removed, and the uterus and abdomen are closed with stitches or staples.

Even after a caesarean, the mother will be able to start skin-to-skin contact with her baby and initiate breastfeeding. Depending on the circumstances and where the delivery took place, this could be in the operating room, the recovery room, or the hospital room (see Is breastfeeding still possible?, page 444). If the mother is unable to start skin-to-skin contact, the father or another significant person can do so instead.

Generally, the person accompanying the mother during a caesarean delivery can enter the operating room and sit near her.

Possible consequences of a caesarean

Caesareans may have short and long-term consequences.

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

- Abdominal and pelvic pains that require the use of drugs
- Difficulty urinating
- Possible difficulties with breastfeeding immediately after the caesarean due to the pain and discomfort caused by movement (see Is breastfeeding still possible?, page 444)
- Hospital stay sometimes longer than for a vaginal birth
- Longer recovery than for vaginal delivery

Most caesareans go well. However, since it is a surgical procedure, complications are possible for the mother, including infection, bleeding, **thrombophlebitis**, and injury to internal organs. These complications may require additional interventions and care.

In the long term, the caesarean may affect future pregnancies by increasing the risk of a placental disorder such as *placenta prævia*. There is also the possibility of **uterine rupture** during a future vaginal birth, although the risk is very low (see Vaginal birth after caesarean, page 188).

In the hours immediately after the birth, a baby born by caesarean may have a lower body temperature. Skin-to-skin contact with the mother or other parent can help improve the situation. Babies born by caesarean are also more likely to experience mild respiratory distress.

Recovering from a caesarean

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. Moving around after a caesarean helps speed recovery and prevent complications.

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 will prescribe drugs for pain relief. The incision will heal in the weeks following childbirth.

Before you leave the hospital, a health professional will tell you how to care for your wound and will give you advice for your specific situation. Don't hesitate to ask all the questions you may have. You can also read the section The body after birth, page 254, for more information.

You will also be given advice on how to care for your newborn. Usually a baby born by caesarean does not require any special care.

It will take a few weeks before you can resume all your activities, such as driving, lifting heavy objects, engaging in certain physical activities and sports (see Physical activity, page 258), or having sexual relations (see Sexuality after birth, page 263).

When to consult a health professional?
After your return home, consult a health professional if you see any signs of a possible wound infection (e.g., redness, discharge).

If you experience any of the problems listed in the red box on page 254, see your doctor or midwife right away or go to the emergency room.

You may also find that having a caesarean triggers a range of sometimes contradictory emotions. Each experience is unique, and the way you feel after a caesarean can change over time. Don't hesitate to talk your feelings over with a professional.

The first few days

François-Xavier Delorme

Your baby has finally arrived. Who does she look like? Her daddy? Her mom? Maybe a distant relative? Whatever the resemblance, your baby is unique, and now it's time to get to learn all about her.

Skin-to-skin contact

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 get acquainted with your baby and develop an emotional bond.

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

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

You can start skin-to-skin contact right after birth and continue as long as you like. Your baby will feel warm and safe snuggled up against you.

If you plan on driving home, a car seat is mandatory for your baby from the moment you leave the hospital or birthing centre (see Travelling safely: Car seats, page 673).

Your stay at the hospital or birthing centre

Hospital stays generally last 24 to 36 hours after vaginal delivery and 36 to 48 hours after a caesarean section. At birthing centres, the stay is usually about 24 hours. The length of your stay may vary depending on you and your baby's health.

Your stay at the hospital or birthing centre is a unique opportunity to get used to your baby and learn to take care of her. Make the most of it!

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

Rooming in also lets you feed your baby on demand. If you breastfeed, those first moments together are precious for getting your milk production going (see Ways to make breastfeeding easier, page 176).

If you have visitors, make sure that they're not sick when they come to see you and that they don't have any infections, such as a cold or a cold sore (oral herpes).

Many hospitals and birthing centres provide the opportunity to meet with a vaccination counsellor during your stay there. The counsellor's role is to support you with your reflection process about vaccination for your child. If you aren't given this opportunity, don't hesitate to discuss any vaccination-related questions you may have with your health professional (see Vaccination, page 616).

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

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 ensure her well-being 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 care team will suggest giving your newborn a vitamin K shot to prevent bleeding. Newborn bleeding is rare but can be severe and even fatal.

They will also suggest that an antibiotic ointment be applied to your baby's eyes to prevent certain serious infections.

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 she is healthy and identify any potential issues.

Neonatal screening

The purpose of screening is to detect rare diseases that are generally not apparent at birth, but can pose serious risks to a baby's health. If a child has one of these diseases, treatment must begin as soon as possible, before symptoms appear. Early detection can help prevent or attenuate severe, permanent complications.

Blood screening

Within a few days after birth, the staff will suggest that a blood screening be done. To do so, they will take a few drops of blood from your baby's heel.

Urine screening

Urine screening is done when your baby is 21 days old. During your stay at the hospital or birthing centre, you will receive a kit to collect a small quantity of urine from your baby, as well as a leaflet with instructions on what to do.

What happens after samples are taken?
For most children, the screening results will be normal and the parents will not be contacted. No news is good news!

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

For more information on screening, visit quebec.ca/en/health/advice-and-prevention/screening-and-carrier-testing-offer/ and click on "Blood and urine newborn screening."

For blood screening
chudequebec.ca/patient/maladies,-soins-et-services/m-informer-sur-les-soins-et-services/programme-quebecois-de-depistage-neonatal-sanguin.aspx (in French only).

For urine screening
CIUSSS de l'Estrie-CHUS, hôpital Fleurimont
Telephone: 1-855-905-5253

When the unexpected happens

All parents want a healthy baby. But sometimes the happy event of childbirth can take an unpredictable turn.

Even under the best conditions, things may not go as planned. Having a family brings great joys, as well as its share of challenges and uncertainties.

If your baby suffers from an infection, **birth defect**, or other health problem she may require hospitalization after birth or in the days that follow. 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 imagined.

The birth may also occur before the date scheduled. Babies are considered 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 page 246.

Care of premature babies

Time of birth	Care
Before 34 weeks	Transfer to a neonatal intensive care ward in a hospital that has one. Your baby may • Be placed in an incubator to keep her warm • Receive phototherapy (exposure to light in an incubator) if she has jaundice • Receive intravenous solution (IV) • Receive help breathing • Receive help feeding
34 to 37 weeks	Extra care, but less of it. Your baby may • Receive help feeding • Receive phototherapy (exposure to light or a cradle) if she has jaundice • Receive help breathing (only in rare cases)

Some suggestions for getting through these difficult moments

You may feel guilty or 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. Here are a few suggestions to help you through these difficult times.

Ask questions

Don't be afraid to ask questions about your baby's health and the care and treatment she's receiving. If you have concerns about certain aspects or her care or treatment, ask if other options are available. She's your baby and you are entitled to have a say in decisions affecting her.

It is the responsibility of members of the care team to keep you informed. However, time constraints sometimes make it hard to have these conversations. Ask them when is the best time to talk and find out when the doctor usually visits.

Don't hesitate to ask your child's care team any questions you may have.

Ask for help and support

If possible, ask your family and loved ones to help you by taking care of the house or minding your other children. 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 that you get enough rest to stay healthy and to be able to care for your baby when she arrives or returns home. Remember that your child will need you not only during the hospitalization but afterwards as well.

Don't hesitate to ask for psychological help if you feel you need it. Specialized care teams often include social workers and psychologists that can support you.

Find out about the resources available

The specialized care team at the hospital 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 the post-hospitalization period, which may also be difficult for some parents.

If your baby 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 similar challenges can be useful.

The following website lists many resources available across Québec: laccompagnateur.org (in French only).

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

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

A few suggestions for making a hospital stay easier

Many parents want to be with their baby when she is hospitalized. Sometimes, the father and mother take turns staying with their baby during the day when they are able, or may want to spend the night. Check with your hospital about the options available.

For example, you can ask if the hospital has a room where you can room-in with your baby if you want to. Keep in mind, however, that some hospitals may have space constraints that make staying with your baby difficult.

Have physical contact with your baby in an incubator

Don't hesitate to ask for help with touching your baby in the incubator or with holding her in your arms or skin-to-skin under a blanket. Your baby will feel your presence and this will help her. If you can't take her out of the incubator, ask if you can put a scarf or piece of clothing that smells of you in beside her.

Breastfeed your hospitalized baby

Even if she is hospitalized, your baby may be able to nurse and take in part or all of the milk she needs. If you want to breastfeed, but 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 (see Ways to make breastfeeding easier, page 176).

Don't hesitate to ask for help with touching your baby in the incubator or holding her in your arms or skin-to-skin under a blanket.

Express your milk until your baby can breastfeed on her own. Your milk can be refrigerated or frozen until she is ready for it. When you give her the milk, extra minerals or calories may be added to it if your baby needs them.

You can 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 breastfeed. 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 hadn't planned to breastfeed, it's not too late to think about it.

Ask about hospital visits

Some hospitals may allow visits by your other children or your loved ones. Make sure your visitors aren't sick when they come to see your baby and that they don't have any infections, such as a cold or a cold sore (oral herpes). Even an ordinary cold can be serious for your newborn.

It can be a good idea to talk with your other children about what's going on. The baby's siblings also have feelings and concerns about the baby's health.

For example, you may wish to reassure them that what's happening with the baby is not their fault. Slightly older siblings often believe that their feelings of jealousy toward the new baby have caused the complications. You can get them involved in caring for the newborn whenever possible.

Death of a newborn child

The loss of a baby is always an ordeal for the parents and family.

It is very rare for a baby to die before birth or in the first few days of life. The cause is usually extreme premature birth or birth defects.

When a baby dies during pregnancy, it is often recommended that the mother have a natural or induced vaginal delivery. After the delivery, it can be particularly difficult for her if she starts producing milk or has bloody discharge. These signs often act as reminders of the loss of the baby.

Grieving the loss of a baby

At the hospital some parents may ask to hold their baby in their arms, to dress her, or take photos. Doing so can help with the grieving process.

An autopsy may be performed to determine the cause of death. Various funeral options (e.g., cremation, burial) are usually suggested.

Back home it's normal to experience feelings of shock, outrage, confusion, and sadness. The intensity and duration of these emotions will vary from person to person, as will and the amount of time needed to recover. The different phases of grief may overlap, and don't always come in the same order. Also, the two parents often do not mourn in the same way or at the same pace.

Support resources

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 allow them to share their experience with other bereaved parents.

Parents can also see a health professional (e.g., psychologist, social worker) for counselling, either individually or as a couple.

Consult your CLSC to find out about services offered there or other services in your area.

To find the CLSC in your area
Visit sante.gouv.qc.ca/en/repertoire-ressources/clsc.

Fondation Portraits d'Étincelles
Free photo and photo touch-up service for babies who died prior to or at birth (in French only)
1-877-346-9940
portraitsdetincelles.com

Parents Orphelins
parentsorphelins.org/en

Revenir les bras vides
CHU Sainte-Justine
A series of free videos and information documents on perinatal grief.
chusj.org/en/soins-services/C/complications-de-grossesse/Deuil-perinatal-mort-perinatale

You can check with the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) for details about absences and leave you may be entitled to (see Parental leave and preventive withdrawal, page 774).

Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)
1-844-838-0808
cnesst.gouv.qc.ca/en/working-conditions/leave/specific-situations/leave-event-termination-pregnancy

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.

Québec Parental Insurance Plan
1-888-610-7727
rqap.gouv.qc.ca/en/wage-earner/death-child

The body after birth

Your body needs time to recover. Be patient—it's normal. It will take several weeks to get to a good level of energy.

Back home, if you see signs that worry you, don't hesitate to contact the CLSC nurse or Info-Santé (8-1-1). You can also consult your doctor or midwife.

The following pages provide information about the body after childbirth and about post-delivery care for both vaginal and caesarean deliveries.

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

- You show signs of **hemorrhaging**
  - You soak one regular sanitary pad an hour for two consecutive hours

  or
  - You lose large blood clots (e.g., more than one egg-sized clot)
- 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
- You have severe headaches, upper abdominal pain, or a sudden change in vision

Call 9-1-1 if you show signs of shock: agitation, weakness, paleness, cold and damp skin, sweating, confusion, palpitations.

Contractions

You may feel uterine contractions, especially while you are breastfeeding. 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.

Blood loss

After giving birth vaginally or by caesarean section, it is normal to experience blood loss, known as lochia. For the first day or two, your blood loss will be heavier than during menstruation and will then diminish. If your bleeding increases instead of diminishing, consult your healthcare provider.

Occasionally you may pass a blood clot. This happens generally in the morning after urinating or breastfeeding. So long as the bleeding lessens after passage of the clot there is no need to worry. Be aware that unusual physical effort may cause redder and more abundant lochia. See the box on page 254 to know when to see a health professional.

As the days go by, the colour and texture of the lost blood will change. It may be mixed with mucus (a whitish substance). The colour will gradually change from pink to brown, becoming paler, and it could turn yellow.

Lochia discharge usually last three to six weeks. During this time, use sanitary pads. Do not use tampons or a menstrual cup.

Hygiene

Hygiene is very important after giving birth. Here are a few helpful tips:

- Change your sanitary pad at least every 4 hours.
- Always wipe from front to back.
- Wash your hands after using the toilet.
- Wash yourself once a day or more, but do not use a vaginal douche.

If you had a vaginal birth, you can shower or take a bath in a clean tub at any time, but don't use oil or bubble bath.

If you had a caesarean delivery, you can shower at any time. You can have a bath starting around five days after the procedure, as long as the incision is healing well.

Stitches

Don't worry if you have stitches in your perineum: they will not tear when you have a bowel movement. After showering or bathing, gently dry the stitches before you get dressed.

If you had a caesarean delivery, it is important to dry the stitches on your belly thoroughly with a clean towel after taking a shower or bath. After seven days, you can remove any adhesive strips that have not come off by themselves. If you see any signs of possible infection (e.g., redness, discharge), see your healthcare provider.

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 you still haven't had a bowel movement after this period, you may be constipated. Constipation is common after both vaginal and caesarean deliveries.

These tips can help:

- Gradually increase your intake of high fibre foods:
  - Whole grain foods
  - Vegetables and fruits (fresh, dried, frozen, or canned)
  - Legumes and nuts
- Increase your daily water intake.
- Go to the bathroom as soon as you feel the need.
- Gradually resume low-intensity physical activity when you feel able to do so (see Physical activity, page 258).

If these measures aren't enough, ask a health professional whether a laxative might help.

Urine

After the delivery, you may feel a burning sensation when urinating. If you do, try spraying your vulva with warm water while you urinate.

It's also normal in the first few days after delivery to have trouble retaining urine. Urine leakage may continue for a few weeks after you give birth. If this annoyance persists, mention it to your doctor during a follow-up visit.

The perineum and pelvic floor

Seen from the exterior, the **perineum** is the part of the body located between the vulva and the anus (see Female anatomy, page 26). Inside, the muscles of the perineum form a "hammock"—the pelvic floor. The muscles of the pelvic floor support your internal organs, including the uterus, bladder, and rectum. Among other things, the perineum helps prevent leakage of urine and feces.

During pregnancy and childbirth, the perineum adapts to facilitate the birth. After the baby is born, the pelvic floor muscles are stretched. It is also normal that the vulva looks different, e.g., the labia are more open.

After a vaginal birth, the perineum may remain sensitive for a while. In some cases, it may also be sensitive after a caesarean.

It can take several weeks or months before the pelvic floor muscles regain their muscle tone. Exercises such as Kegel exercises can help. It's advisable to talk to your healthcare provider to find out when to start doing these exercises and how to do them properly.

If you have urine leakage, pain during sexual relations, or any other concerns, don't hesitate to talk to your healthcare provider. If necessary, he or she can give you advice about specialized perineal rehabilitation resources (e.g., physiotherapists).

Fatigue

It's normal to be tired after a vaginal or caesarean delivery. It takes a few weeks to get to a good level of energy. Be patient—your body needs time to recover.

Recovery speed and energy levels vary from day to day and from one woman to another depending on things like the baby's demands, the mother's quality of sleep, and the help she has available. Despite your newborn's needs, try to take care of yourself. If possible, try to sleep when your baby does.

Don't hesitate to ask for help when you need it.

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

If you're concerned about your fatigue, don't hesitate to contact Info-Santé (8-1-1) or your health professional.

Physical activity

Pregnancy and childbirth bring about major physical changes that can last for months after your baby is born.

Resuming physical activity little by little can help improve your energy level and physical fitness. It can also contribute to your psychological well-being.

When your pain is gone and you feel up to it, you can gradually resume low intensity activities such as walking. For example, you could start with one daily walk and gradually work up to a few short walks per day. You can increase their frequency and length bit by bit, depending on your energy and tolerance level.

Around four to six weeks after giving birth, you can gradually start increasing the intensity of your activities (e.g., take brisk walks). Choose activities you enjoy while paying attention to how your body has recovered since giving birth.

Listen to your body and its limits. They may not be the same as they were before your pregnancy.

It's usually recommended that you wait until your **perineum** has regained its muscle tone (see The perineum and pelvic floor, page 257) before you move on to high intensity or high impact exercise like running. This can take from a few weeks to several months after childbirth.

As for swimming, you can usually start again once your lochia discharge (see Blood loss, page 255) becomes less abundant. It is advisable to talk to your healthcare provider before you resume swimming.

If you had any complications during your delivery, it may also be wise to check with your healthcare provider before you start exercising again.

Weight

Some of the weight gained during pregnancy is lost with the delivery of the baby and placenta and the release of amniotic fluid. In the six weeks that follow, the uterus returns to its normal size. Blood volume and swelling also decrease, leading to further loss of weight.

After that, your body will gradually use up the fat reserves it accumulated during pregnancy. The pace of weight loss can differ from one woman and one pregnancy to the next. Be patient! It takes time to shed the weight you gained over nine months.

With a balanced diet (see Eating well, page 77) and an active lifestyle (see Physical activity, page 258), losing 1 to 2 kg (2 to 4 lb.) a month is reasonable.

Going on a weight-loss diet is not recommended, especially if you breastfeed. A low-calorie diet can diminish your milk production and energy level.

Pregnancy transforms a woman's body. Even if the weight gained can be lost within a few months, you may not get your pre-pregnancy silhouette back.

Give yourself time to accept these changes and don't hesitate to talk about them with people you trust.

Baby blues

After the birth of your baby it's normal to have mood swings and to cry more than usual. Many new moms experience the baby blues for a short period of time.

The baby blues follow the birth of the baby and can last from a few days to approximatively 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.
- Allow yourself to take a break or nap.
- Talk about how you feel.
- Take care of yourself.
- Talk to other parents.
- Enjoy skin-to-skin contact with your baby.
- Let the tears flow without trying to resist or worry too much about the cause—it's perfectly normal!

If your baby blues last for more than two weeks or if you feel more and more sad or irritable, you may be experiencing depression.

You can contact Info-Santé or Info-Social at any time by calling 8-1-1.

Hormonal changes and fatigue are largely responsible for baby blues.

Depression

After the birth of a child, new mothers and fathers sometimes go through a depressive episode. Women and men often experience depression differently.

Depression in women

About two in ten women experience depression after childbirth.

Women suffering from depression 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
- A sleep disorder (sleeping too much, difficulty sleeping, or inability to sleep, even when baby is sleeping)
- Agitation or psychomotor impairment (e.g., slowed speech)
- Fatigue or loss of energy
- Excessive anxiety and irritability
- 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 developing a sense of attachment, feelings of ambivalence or disinterest toward the child
- Difficulty concentrating or indecisiveness
- Thoughts of death or suicidal ideas

Some of these signs can be confused with normal changes that occur after the birth of a child (e.g., fatigue from lack of sleep due to caring for the baby).

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.

Depression in men

As many as one in ten men may suffer from depression after their baby is born.

Men experience the same feelings as women but may express their distress differently.

For example, they may be more aggressive or irritable, have mood swings, or feel physical discomfort such as stomach aches, headaches, or difficulty breathing. Some men may also show hyperactive behaviour (escaping into work or sports for long hours) or excess consumption of alcohol or drugs.

Seeking support

Treatments exist for depression. If you have noticed these changes in yourself or your partner, consult a health professional. You can also contact your local CLSC or a psychologist, or call Info-Social at 8-1-1.

Sexuality after birth

Some people feel less sexual desire after the birth of the baby. Fatigue, the adaptation to parenthood, the 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. After the birth of a child, the time available for intimacy can also be limited.

Many partners aren't sure when to resume sexual activity after the delivery. If there are no medical reasons to put it off, partners can engage in sexual activity without fear when they feel like it.

The timing for resuming sexual activity with penetration will vary depending on you and your partners' individual needs and preferences.

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

Don't pressure yourself. Adapt your sex life to your new reality.

Birth control

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

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 or caesarean delivery. Use an effective birth control method to prevent an unplanned pregnancy.

Breastfeeding and lactational amenorrhea method (LAM)

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

To be effective, LAM requires the following conditions:

- Your baby is less than six months old.
- You breastfeed exclusively (no commercial infant formulas, food, or water is given to the baby)
  - Breastfeeding is on demand and not according to a set schedule (see Breastfeeding on demand or often enough to meet baby's needs, page 177). For LAM, feedings should be no more than four hours apart during the day, and six hours apart at night.
- You haven't had any bleeding or started having your period again.

Before using LAM or another natural method of birth control (e.g., Billings or symptothermal), it's a good idea to contact the Serena organization for further information and support.

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

You can also visit the following website:

World Alliance for Breastfeeding Action (WABA)
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 with your health professional. This assessment can be done at the end of pregnancy or before you leave the hospital or birthing centre.

The table on page 266 describes the birth control methods available.

Birth control methods

Method	When you can start if you have no contraindications
Hormonal IUD (Kyleena®, Mirena®)	Any time after giving birth, depending on your state of health
Copper IUD	Any time after giving birth, depending on your state of health
Contraceptive injection (Depo-Provera®)	Any time after giving birth
Progestin-only pill (Micronor®)	Any time after giving birth
Combined hormonal contraceptives that contain estrogen and progestin: • Pills • Contraceptive patch • Contraceptive vaginal ring	• 6 weeks after giving birth • Depending on your situation, your healthcare provider may recommend you start three to four weeks after giving birth
• Diaphragm • Cervical cap	6 weeks after giving birth
Condom	From the start of sexual relations

IUDs, contraceptive injections, the progestin-only pill (Micronor®), and combined hormonal contraceptives are the most effective types of birth control. Don't stop your current birth control method before starting another. To avoid unprotected sex, keep a supply of condoms handy.

The withdrawal method, or coitus interruptus, and the calendar method are not effective.

Learn about birth control methods by visiting the website prepared by the Society of Obstetricians and Gynaecologists of Canada sexandu.ca.

Possible effects of hormonal contraceptives on milk production

Hormonal contraceptives do not affect the quality of your milk or the health of your baby.

However, if you use a combined hormonal contraceptive and you are breastfeeding, it's possible you will experience a slight drop in milk production. If this happens, contact a lactation consultant, your midwife, your doctor, or a CLSC nurse.

If you use a hormonal IUD, contraceptive injection, or progestin-only pill, it is unlikely that any of these methods will affect your breastfeeding. If you do notice a problem, contact a lactation consultant, your midwife, your doctor, or a CLSC nurse.

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)

This method works up to five days after unprotected or poorly protected sex, at any time after a vaginal delivery or a caesarean, whether or not you're breastfeeding. 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 breastfeeding, be sure to mention it to the pharmacist or doctor. They can prescribe an EOC that you can take while you're breastfeeding.

Copper IUD

Provided it is not contraindicated for you, your doctor can insert a copper IUD up to 7 days after unprotected or poorly protected sex.


Odile Ste-Marie