



Some Information About Birthrites...

Birthrites: Healing After Caesarean Inc. supplies women who have experienced a caesarean birth with support, and information about future birth choices.

We have monthly get-togethers, which allow women to share their stories and knowledge, and borrow a book while relaxing with a cup of coffee. The women who attend have all experienced a caesarean; some go on to have a VBAC, some have repeat caesareans, but they all gain much from being able to freely talk about their experiences and share their wisdom.

We send women, who contact us, a free copy of our quarterly magazine, which is full of stories, articles, letters, etc, related to caesarean/VBAC birth.

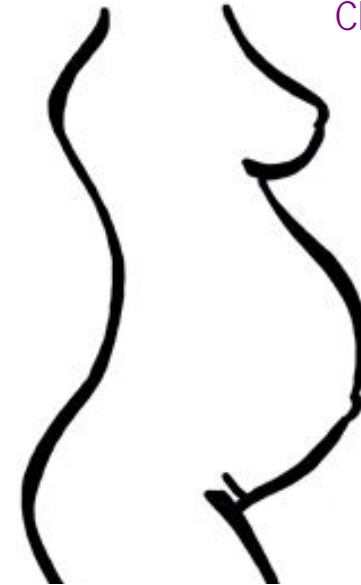
Our website, at www.birthrites.org has several interactive forums within it, a 'VBAC Discussion forum' and an 'Ask an Obstetrician' forum, which women can freely access to discuss issues surrounding VBAC/caesarean birth, or make queries. It also has hotlinks to many relevant sites worldwide.

Our philosophy is -

"With knowledge we can make choices that lead to empowerment, and healing, through birth." ♥.

Caesarean Birth...

Making Informed
Choices



An Initiative of
Birthrites:
Healing After Caesarean Inc.
www.birthrites.org



Information Booklet.

Contributors...

This information booklet was produced by a consumer group, and is aimed at consumers.

Any medical information provided has been proofread by medical practitioners, to ensure accuracy. Birthrites does not claim to have the qualifications to provide this.

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

Each individual woman, and each individual pregnancy, will differ. While natural birth is usually the safer option, this will not always be the case.

Birthrites acknowledges this, and supports all women towards making an informed birth choice in regard to natural, caesarean and Vaginal Birth After Caesarean (VBAC).

The contributors to this booklet ranged from consumers with no medical knowledge of caesarean birth (other than their own birth experiences) through the spectrum of all choices of available professional childbirth carers – Midwives, Obstetric GP's and Obstetricians.

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



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Maternity Coalition

Webpage

www.maternitycoalition.org.au

* Your Local Area Contact Details and Relevant Local Resources:



Suggested Reading List:

- 1) **A guide to effective Care in Pregnancy and Childbirth.** Enkin et al, 1995
- 2) **Birth After Caesarean: The Medical Facts.** Dr Bruce L Flamm, 1990 (USA)
- 3) **Natural Childbirth after Caesarean - A Practical Guide.** K. Crawford & J. Walters, 1996 (USA)
- 4) **Open Season.** Nancy Wainer Cohen, 1991 (USA)
- 5) **Optimal Foetal Positioning.** Jean Sutton & Pauline Scott 1996.
- 6) **Transformation through Birth.** Claudia Panuthos, 1984 (USA)
- 7) **Trust Your Body! Trust Your Baby! - Childbirth wisdom and caesarean prevention.** Andrea Frank Henkart, 1995 (USA)
- 8) **Your Body, Your Baby.** T. Libesman & V. Sripathy, 1996 (Aust)
- 9) **The VBAC Companion.** Diana Korte, 1997 (USA)
- 10) **Caesarean Birth in Britain: A Book for Health Professionals and Parents.** By C. Francome, W. Savage, H. Churchill and H. Lewison, 1993.
- 11) **Songs from the Womb: Healing the Wounded Mother.** By Benig Mauger (1998).
- 12) **Women's Bodies, Women's Wisdom.** By Dr. Christiane Northrup. 1998 (UK).
- 13) **VBAC Sourcebook and Teaching Kit.** By Nicette Jukelevics and Ruth Ancheta
- 14) **Birth As a Healing Experience: The Emotional Journey of Pregnancy Through Postpartum** By Lois Freedman, 1999
- 15) **The Thinking Woman's Guide to Better Birth** Henci Goer (USA)
- 16) **Obstetric Myths versus Research Realities.** Henci Goer, 1995 (USA)
- 17) **The VBAC Experience: Birth stories by parents and professionals.** Lynn Baptisti Richards, 1987 (USA)
- 19) **The Expectant Parent's Guide to Preventing a Caesarean Section.** Carl Jones (USA)
- 20) **An Easier Childbirth: A Mother's Guide for Birthing Normally.** Gayle Peterson, California, 1993
- 21) **Pregnancy as Healing Vol II (Caesarean Birth: Risk and Culture).** Gayle Peterson & Lewis Mehl, 1984 (USA)
- 22) **Childbirth Choices.** Bennett, Etherington and Hewson, 1993 (Aust)
- 23) **Silent Knife.** Nancy Wainer Cohen & Lois J Estner, 1983 (USA)
- 24) **Artemis Speaks: VBAC stories and natural childbirth information.** Nan Koehler
- 25) **The Caesarean Experience.** Sarah Clement, 1991 (Eng.)
- 26) **Caesarean Birth: A reassuring guide for Australian parents.** Zena Armstrong, 1990 (Aust)
- 27) **Unnecessary Caesareans: Ways to avoid them.** Diony Young and Charles Mahan, 1989
- 28) **Birthing from Within an extra-ordinary guide to childbirth preparation.** 1998. Pam England and Bob Horowitz (USA).
- 29) **What every pregnant woman needs to know about Caesarean Section, 2004.** Maternity Center Association. Free download available www.maternitywise.org.
- 30) **Preparing for Birth: Mothers,** 2004. Andrea Robertson (Aust).
- 31) **Preparing for Birth: Fathers,** 2004. Andrea Robertson (Aust).
- 32) **The Caesarean,** 2004 Michel Odent
- 33) **The Pink Kit** www.birthingbetter.com
- 34) **Birth Your Way,** 2002 Sheila Kitzinger
- 35) **Breech Birth,** 2003 Benna Waites
- 36) **Breech Birth Woman-Wise,** 1998, Maggie Banks
- 37) **Care in Normal Birth: A Practical Guide,** 1997, WHO
- 38) **The Farmer and the Obstetrician,** 2002 Michel Odent
- 39) **Your Birth Rights: A Practical Guide to Better Care in Pregnancy and Birth** 2002, Pat Thomas

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

- CAPERS. Ph: 07 3369 9200
Email - jan@capersbookstore.com.au
<http://www.capersbookstore.com.au>
- Acegraphics. Ph: 02 9564 2322
Email:
sales@birthinternational.com.au
www.birthinternational.com.au



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Introduction

This booklet is all about making informed choices in regard to your child's birth, but it will focus on the choice you have as to whether that birth will eventuate in a caesarean birth, a vaginal birth or a vaginal birth after caesarean (VBAC).



The birth process itself sometimes deviates from our well-laid plans. We may find, upon the arrival of our baby and especially in those first few days of mothering, that the mode of birth matters less than the safe arrival of our little one. It may only be later, weeks or months after the birth of our child or even in a subsequent pregnancy, that we reflect on our past birth experience and discover that we may still harbour feelings of disempowerment - depending on how it unfolded. Especially if we feel we were not fully 'involved' in the decisions made surrounding our child's individual birth process.

Labour and birth unfold differently for each and every woman, and we can never predict what will actually happen on the 'day', but there are ways we can improve our chances of experiencing an empowering birth – whether that birth should be caesarean or vaginal.

Women will feel empowered during childbirth when they choose a childbirth professional that bases their client's maternity care on woman-centred, research-based practises. Such a professional will involve the Mother in all aspects of her care, informing her of her specific circumstances and the birth choices available to her in relation to these.

This involvement in decision-making during a caesarean birth, or subsequent births after a caesarean experience, enables the Mother to become truly involved in the process of birthing her children.

This basic strategy, of providing women with information about the

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*(*Not OB' Questions and Answers section)*

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"Common Questions and Answers"
References:

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2. Flamm BL et al. Elective repeat caesarean delivery versus trial of labour: A prospective multicenter study. Obstet Gynecol 1994;83:927-32
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pros, cons, risks and consequences of the various birth choices available to them, is a positive way to ensure that the rate of elective caesareans, and other related interventions, in Australia becomes appropriate. Provision of information is every person's basic right, and a legal requirement, before they can be asked to submit to a procedure or treatment. Thus providing patient information not only assists towards informed choices, it increases the "patient's" empowerment resulting in higher satisfaction and less likelihood of litigation.

We must recognise that Childbirth Professionals can only guide women towards relevant sources of information. It's ultimately the Mother's responsibility to educate herself about the process of birth, the technology available and the risks and benefits of each available choice presented to her. The Childbirth Professional's role is that of an important confidant who can provide the Mother with guidance towards legitimate sources of such information.

The many people who have contributed to the following pages of information hope that the small amount of wisdom contained within this booklet will enable the women who read it to experience empowered births.

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

Birthrites' philosophy



Birthrites wishes to expressly thank the dedicated professionals who contributed their knowledge to validate medical information provided in the collation and production of this information booklet.



Making Informed Choices About Caesarean Birth.

“For the first birth, I felt like no one really educated me enough. I didn't know a lot and I didn't know where to find resources to learn more...”

One thing that women need to be aware of, if they are to be involved in making informed choices, is what this actually means. It is becoming truly 'involved' in the decisions to be made, in regard to your pregnancy, labour and the birth of your child. It involves listening to your childbirth professional's advice, researching the options available to you in your own specific circumstances, and then following your own inner guidance in making an informed decision. Basically, it means accepting responsibility for the decisions that *you* have made in regard to your maternity care, and the birth of your child

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

During the process of negotiation your midwife, or doctor, may need reassurance that you are aware of the possible consequences of your decision/s. Occasionally it may be a matter of asking for “a little more time to give labour a chance to unfold” or some space in which to discuss your alternatives with your support people and get it all sorted out in your head. It is much better to negotiate your care, give and take, than to demand the care you want. Your childbirth professional is as human as you are, with all the same fears, concerns and issues, and you will achieve more by working together than you will if you alienate each other by demanding care that the other can't provide or accept.

Caesarean Statistics.

Up until the 1970's, the caesarean rate worldwide remained low, around 5%. The reasons for the dramatic rise in the next decade to 20-25% in Western countries are complex, but are thought to include the increasing safety of the operation leading to complacency, defensive practises resulting from fear of litigation on the



counselled differently from patients with 1 prior caesarean scar about the increased risk of uterine rupture and decreased chance of vaginal delivery in a subsequent trial of labour, on the basis of evidence from this study and the existing literature, motivated patients may still wish to undergo a trial of labour”.

What if my baby is breech?

Up to a quarter of babies are breech (bottom first) early in the third trimester (last 12 weeks). Most will turn by themselves, so be patient. External cephalic version (ECV) is a technique used to gently turn the baby and has been shown to decrease the need for caesarean or vaginal breech birth by half²¹. ECV can be used if you have had a previous caesarean but you will need to talk in detail to your carer about the possible risks. Limited data suggests that serious complications are rare^{22, 23}. Most of the major teaching hospitals would offer an ECV service if your carer is not experienced with the technique. There is some reported experience of vaginal breech birth after caesarean^{24, 25}, but you should also discuss the recent 'Term Breech Trial' with your carer²⁶. The study and an editorial comment can be read on-line by using the address below.

What if my baby is thought to be big (macrosomic)?

A study found somewhat lower successful VBAC rates of 58% for those babies weighing 4000-4499g and 43% in those over 4500g²⁷ but no significant difference in baby or mother morbidity (injury or sickness) when compared to VBAC with babies under 4000g, or when compared with women with macrosomic babies but with no uterine scar. There is also the problem that ultrasound is not particularly accurate at determining the weight of larger babies²⁸. The guidelines of the SOGC suggest "Published information does not suggest that a diagnosis of suspected macrosomia is a contra-indication to labour after previous low segment Caesarean section"¹⁶.

So, is VBAC safe?

Neither elective Caesar nor VBAC nor normal birth is without risks to mother and baby though, for most, serious complications are rare. No one can predict with certainty the outcome in any individual. You should seek out information from a variety of sources – midwife, obstetrician, books, and other women - weigh up the risks, look at your own special situation, then make your plan for your birth.



labour started spontaneously. If there is a strong reason to justify induction of labour, you must consider this increased risk when deciding what is right for you. If labour really must be induced, you could try just breaking the waters first.

Can I have an epidural if I need one during my VBAC?

Uterus rupture rate may be increased significantly¹³, but perhaps only if oxytocin is also used¹². Another study that had an epidural rate of 75% with VBAC, however, showed no increased chance of scar rupture in those women who chose epidural¹¹. Sometimes an epidural is the only way to continue with a labour that is really difficult for you. Good antenatal preparation for labour and good support people may be really important here. It is important to note that these are not randomised controlled trials, and it may be that the women who need epidurals are the ones who also have increased risk of rupture for, as yet, undefined reasons. We cannot say that the epidural is the cause of the increased rupture rate. Pain does not reliably indicate uterine rupture, so an epidural is not contraindicated. It would be wise, however, to have continuous monitoring if an epidural is placed.

Why does my doctor suggest continuous CTG monitoring?

A continuous CTG monitor (reading of baby's heart beat) is said to give the best indication of uterus rupture⁸ and nearly all reported studies on the safety of VBAC have used continuous monitoring. It is usually part of the VBAC protocol in Australian hospitals. In the rare event of uterine scar rupture, the danger to mother or baby is somewhat dependent on how quickly emergency action is taken¹⁵. There is no "proof" that it is necessary, however, and being connected to the monitor can sometimes interfere with freedom of movement in labour. The Canadian Society of Obstetricians and Gynaecologists (SOGC) recommendations for VBAC suggest, "In cases of induction and/or augmentation, continuous electronic foetal heart rate monitoring is advised. Intermittent foetal heart rate monitoring is to be reserved for cases in which neither induction nor augmentation with oxytocin is performed"¹⁶. It is very important not to let a CTG monitor be replacement for one-on-one midwifery care in your labour.

Why do I need a drip in VBAC?

The rationale for the insertion of the bung is to prevent any delay in instituting emergency management in the rare event of uterine rupture. An anaesthetist needing to give an emergency anaesthetic would take less than a minute to insert an IV line. One could argue that this is not a significant delay when considering the time needed to get a caesarean organised, and considering the rarity of rupture. You may be able to negotiate this with your doctor.

I have had two previous Caesars - can I try for VBAC?

Many studies of women with more than one previous caesarean have been reported now^{9, 17-20}. The risk of uterine rupture has varied from 0.7% (one in 142), the same as with one previous caesarean, up to 3.7% (one in 27). The chance of vaginal birth tended to be lower than after only one previous caesarean, but still as high as 65-75%. One study aptly summarised their experience: "Although patients with 2 prior caesareans should be



part of obstetricians¹ and the effects of the increasing use of epidurals, labour induction and electronic foetal monitoring².

It's true that the caesarean procedure has become less dangerous, as anaesthetic and surgical skills improve, but birthing a child via major abdominal surgery, when it is not medically necessary, is still not as safe, even by today's standards, as birthing your child naturally.

The caesarean rate for all confinements in Australia in 2000 was 23.3%. Notably, this rate rose to 53.3% for twin pregnancies, and to 59.1% for singleton very low birth weight babies. 84.6% of babies presenting in the breech position were born by caesarean section^{3, 4}.

It has been noted that these statistics may fluctuate, depending on many external factors, some of which we have control over. A clear example of this is how the rates may vary depending on whether you have private insurance, where you plan to birth your baby (hospital, Birthcentre, home), your age, your education level and the professional caregiver you choose (i.e., Ob, GP or Midwife).

The World Health Organization (WHO) recommends a caesarean rate of 15%, which we are currently exceeding. But this isn't only occurring in Australia, the caesarean rates worldwide continue to increase year by year. Australia's caesarean statistics are following this pattern.

It is hoped that informing women of the pros, cons, risks and consequences of caesarean birth will enable women to make an informed decision in regard to birthing their child in this manner. It will also be a positive step towards achieving a more acceptable caesarean rate, without risking either Mother or Child in doing so.

What exactly happens during a Caesarean Section?

Caesarean birth is an operation that enables your baby to be born through an incision made on your pregnant belly. You may plan an elective caesarean, for medical or social reasons, or you may experience an emergency caesarean when labour does not go as planned. An emergency caesarean usually occurs after labour has begun.

*The common medical reasons for elective caesareans (although natural birth is often possible in many of these situations) are:*⁵

- Previous caesarean/s is the commonest reason
- Suspected CPD - Cephalo-Pelvic Disproportion (i.e. the baby's head is too big to fit through the mother's pelvis)
 - Often due to the head being posterior in labour (baby facing up towards the pubic bone)
 - History of big babies/difficult past deliveries with/without shoulder dystocia involved
 - Gestational Diabetes may lead to extra large babies if poorly controlled
- Placenta Problems
 - Placenta Praevia - where the placenta covers some or all of the cervix
 - Placental abruption – (where the placenta separates from the uterus)
- Foetal distress – which *may* occur in labour or late pregnancy when the blood supply to the placenta is reduced for any reason
 - May be caused by Pre eclampsia (mother's high blood pressure and fluid retention)
 - Intrauterine Growth Restriction
 - Abnormal placental function
 - Cord compression
 - Intra uterine infection
- Baby's Position
 - Breech baby – especially footling breech
 - Transverse lie – baby is sideways
- Twins
- Active Genital Herpes Simplex

The common non-medical reasons for elective caesareans are:

- Social reasons
 - Choice of baby's Birthday
 - Work leave – for mother or partner
 - Convenience for Mother and/or her caregiver
- Retaining control over the birth experience, especially if the Mother experienced a traumatic (physically or emotionally) birth experience previously
- Other emotional reasons
 - History of sexual abuse of the mother



Common Questions about VBAC birth

By Dr. David Simon.

It has been said that VBAC depends far more on mental, emotional and spiritual factors than physical factors¹, but having up to date medical information can help in deciding what is right for you and your baby.

What are my chances of birthing vaginally if I've had a Caesar?

Most studies suggest successful VBAC rates of 60- 80%, or three to four out of five, in those who try. Most women currently in Australia do not try for VBAC, or are not permitted to, so the overall VBAC rate in Victoria was only 22% in 1999.²

What if I had "failure to progress" or "CPD" last time?

There is still at least a two-thirds chance (67%) of vaginal birth if you try VBAC³. This continues to be true even when CPD is defined by strict conditions including that the baby was not posterior, the cervix was dilated at least 5 cm and labour was not responsive to oxytocin⁴. Even if you needed a caesarean at fully dilated for an unsuccessful forceps or vacuum birth you still have up to a 75% chance⁵. Each labour is different.

What if I've previously had a vaginal birth as well as a caesarean?

You are in the group of VBAC women with the highest (85-93%) chance of vaginal birth, and the lowest chance (0.2% or 1 in 500) of uterus rupture^{6, 7}.

Are there situations where the risk of rupture is higher?

Yes - a 'classical', or up and down uterus scar has a 2 to 10 fold risk of rupture and a 5 to 10 fold risk of maternal or baby death⁸. This type of scar is also more likely to rupture prior to labour than a lower segment scar. J or T incisions are thought to have a similar risk of rupture as classical scars.

Can I be induced if I have had a previous caesarean?

An early VBAC study suggested that scar dehiscence rate was not significantly increased when oxytocin was used for induction or augmentation⁹, and a further review found a similar finding as long as an epidural wasn't also used¹⁰. More recent studies have not been as reassuring. One US series showed an almost five-fold increase in uterine rupture with oxytocin induction compared to no oxytocin use¹¹ whilst European experience also suggests caution^{12, 13}. A recent report cautions that induction with prostaglandin (the gel) may put the risk of rupture as high as one in 40¹⁴. In this study there was a modest increase in the risk of uterine rupture when labour was induced without prostaglandin to 0.77% (one in 130), compared to 0.52% (one in 192) when

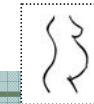
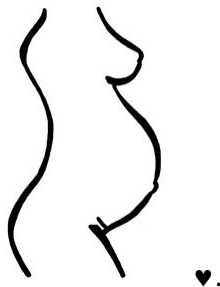
Physical feelings vary depending on the individual experience. Some common physical feelings are:

- Abdominal soreness (like bruising)
- Perineal soreness (more so if you've had stitches, though the amount of bruising involved is a big factor)
- Sore tailbone
- Sore (bruised feeling) anus
- Sore arms/shoulders (from hanging on to things – hubby, bed, etc)
- Tired legs (from standing, kneeling or squatting)
- Sore throat – if you have been vocal in labour!
- Exhausted, but not at all tired!

For perineal soreness small ice packs, salt baths, even ultrasound therapy (performed by physiotherapists) are all excellent for reducing swelling, bruising and tenderness. Frequent showers or bathing of the area keeps it clean to avoid infection and it is soothing. A simple analgesic such as paracetamol will usually alleviate any soreness. Discuss this with your doctor or midwife and make sure you feel comfortable. Just because you have birthed naturally doesn't mean your body doesn't deserve, or need, a lot of TLC – Tender Loving Care!

*Hot packs work wonders, as does a long, hot shower.

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



- Profound fear of childbirth
- To avoid stretching/damage to the vagina

The common medical reasons for emergency caesareans are:

- Failed induction
- Prolonged labour that's not progressing
- Foetal distress
- Maternal distress
- Placental problems – bleeding, separations, etc
- Undiagnosed foetal position – i.e., breech, brow presentation, etc

The types of incisions used

Transverse Incision (LUSCS)

The most common type of incision used is made on the lower part of your stomach, just above your bikini-line, and is referred to as a transverse incision or LUSCS as it cuts through the lower fibrous part of your uterus to deliver your baby. This part of your uterus heals very well, and involves less blood loss, so it is the preferred site on which to perform the incision.

Classical Incision

Your obstetrician may rarely need to do a classical incision during a caesarean. This type of incision runs vertically (up and down) your uterus. It's normally done either because your baby is premature, the uterus has not stretched enough to allow a LUSCS to be performed, because the baby is lying crossways in the uterus, or because the placenta is in the way.

A classical caesarean is only used in these specific circumstances because this approach is associated with a greater blood loss, and may not heal as strongly as a LUSCS, leading to an increased risk of uterine rupture during future pregnancies and births.

"T" or "J" Incision

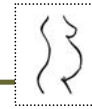
There are other rarely used incisions, entitled "T" or "J" incisions – because of the shape of the incision. These are the result of a LUSCS incision unexpectedly being inadequate to deliver the baby. The obstetrician extends the uterus incision in a "T" or "J" shape to increase its size and allow delivery. Usually the baby is in an unusual position, such as a transverse lie (sideways across your belly) or some unforeseen circumstance has arisen and the surgeon needs to get the baby out quickly.

The increased risk of uterine rupture involved in birthing vaginally after a previous classical, T or J caesarean need to be thoroughly discussed with the professional caregivers involved, and acknowledged by the mother

*Note: The type of incision used on your skin 'usually' indicates the type used on your uterus, but not always. A classical incision on your uterus may have been done after a 'sideways' incision was done on your belly, and vice versa. The only way you can be sure what type of internal incision you have is to check with your doctor

What are the Common Caesarean Risks? For the Mother and/or Baby.

- Anaesthetic risks (explained in more detail further on in the booklet)
 - Related to the drugs used (type of drug and quantity)
 - Possible side-effects experienced by the Mother and/or child
- Increased blood loss – which may lead to a need for a blood transfusion, or an emergency hysterectomy
- Damage to the bladder or intestines
- Wound, uterine and/or bladder infection
- Blood clots forming in the deep veins of the legs, or pelvis. Rarely, these clots can travel to the lungs, causing life-threatening pulmonary embolus
- In elective caesarean
 - Unplanned prematurity of the baby if the dates are wrong, which may increase the risk of the baby having breathing problems.
 - Respiratory distress syndrome – where the baby retains fluid in his/her lungs (vaginal birth assists the baby to clear this fluid, which normally fills the lungs when your baby is still inside your uterus, whereas some of it can remain after a caesarean). This can be serious, or even fatal
- Each caesarean increases the risks for future pregnancies – the risk of the placenta implanting low in the uterus (placenta praevia) or into the uterine scar (placenta accreta) and the risk of uterine scar separation
- Future difficulties becoming pregnant, and increased chance of ectopic pregnancy – due to scarring
- Small risk of the baby being cut by the scalpel
- Increased risk of maternal death (4 per 10,000 births for all caesareans, 2 per 10,000 for elective caesareans and 1 per 10,000 for all vaginal births)⁶



What to expect during a VBAC labour

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

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

Some women experience a “stall” in their VBAC labour, at the point they had reached during an earlier labour; usually at the stage where the decision to perform a caesarean was decided (eg, at 5 cm's). It is not known if this has a physical cause, but it is more likely to be a response to the emotions surrounding the memories of the previous experience, triggered by reaching the same stage in this labour. Fear is a powerful emotion. If this does happen, it doesn't mean you will not birth vaginally. Nearly all women are able to work past this point, especially with the right support, and have a wonderfully empowering birth experience.

Working through memories, and informing yourself of your body's ability to birth naturally, during the interval between your caesarean and your VBAC will decrease the likelihood of your body “stalling” in this way.

So, read, discuss, research and inform yourself if aiming for a natural birth.

After your VBAC

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

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

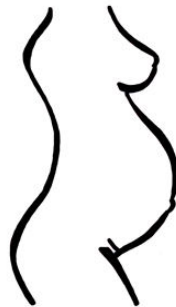
- | | |
|----------------|------------------|
| • Relief | • Love |
| • Exhaustion | • Joy |
| • Exhilaration | • Accomplishment |

throughout your labour (no matter how long – though they may share your care with another independent midwife during an especially long labour). When your baby is born they continue to care for you, and your baby, up until 6 weeks after the birth. Most women develop a friendship with their midwife that lasts a lifetime.

“My support person held my hand, something very simple but which gave me great comfort, and strength to endure.”

The other childbirth support person that you might like to employ is a doula. Doula supposedly means “with woman/female servant” and she will support you emotionally and, to a certain extent, physically during labour, birth and in the days following. A doula may not have any formal educational training in regard to childbirth, though some states of Australia now run doula -training courses, but she is generally very knowledgeable about the natural birth process. A doula can provide you with the emotional support you may need during pregnancy (i.e., coming to doctor’s appointments with you, etc) and labour, and her role can vary from support person for you, to support person for you partner or child/ren. Your doula may find herself directed by you to take the photos, massage your back, affirm your ability to birth. Or she may suggest ways of easing labour pain, remind you of your birth plan, etc. A doula should not replace the childbirth professional that you organise to be present at your VBAC birth, but she can enhance the whole experience with her presence and emotional support.

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



What sort of anaesthetic is used during a caesarean?

The dose of anaesthetic used during a caesarean is very finely tuned. This is to reduce the amount of drug that may be passed, through the placenta, to the baby. So, although the Mother should feel no pain during the surgery, it is common to feel tugging, or pulling, sensations as your baby is being removed from your uterus.

The most common type of anaesthetic, used to control pain during a caesarean, is a spinal. This involves injecting an anaesthetic drug into the actual spinal fluid, which surrounds the spinal nerves and cord. This method of anaesthesia is faster acting than an epidural, and is given in a single injection, whereas an epidural dose can be adjusted.

The other type of anaesthetic commonly used during a caesarean birth is an epidural. In this case the local anaesthetic drug is injected into the epidural space, which contains the spinal nerves and their blood vessels.

Both a spinal and an epidural enable the Mother to remain awake during the surgery, and therefore be aware of the birth of her child, participating in this important life experience.

The epidural catheter, which is a fine plastic hollow tube through which the anaesthetic is administered, is often left in place for the first day after the c/section. This enables immediate pain relief to be given, directly into the epidural space, when requested by the Mother.

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

Using one of these types of anaesthesia, rather than a general anaesthetic has other benefits than being awake to welcome your child. It also avoids the risk of vomiting under general anaesthesia and breathing this into your lungs.

The drugs used for epidurals/spinals also have the side-effect of relaxing the blood vessels in your lower body, below the spot on your spine that they were injected into, which may cause your blood pressure to drop, but it also contributes to less blood loss during the surgery.

Once the spinal/epidural have taken effect, then a urine catheter is inserted, and

your bladder emptied. This reduces it in size and thus helps protect it during the surgery. This may remain in place until the morning after your caesarean, when you will be able to walk to the toilet.

Spinals and epidurals do in themselves carry some risk. Between 1 and 10% of women experience fairly severe headaches after the spinal/epidural. Some women have suffered injury to the spinal cord and other severe effects – but these are very rare (between 1 in 3000 and 1 in 2 million)⁷. Your anaesthetist can further discuss these risks with you.

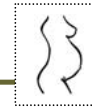
General anaesthesia, where you are actually 'put to sleep' during the caesarean, is usually only used when an extreme emergency occurs (i.e., cord prolapse, uterine rupture). It's avoided, where possible, due to the drug's ability to pass through to the baby and make him/her drowsy.

If it should be necessary, this is what may happen: a drip is inserted in your arm, heart monitor dots are placed on your chest and you are tilted onto your left side to remove the weight of your uterus from your major blood vessels, which supply vital oxygen to your baby. Then a mask, flowing oxygen, is placed over your mouth and nose to boost your oxygen levels before proceeding with the surgery. A rapid-acting anaesthetic is injected via the drip, in your arm. You may get a metallic taste in your mouth depending on the drug used.

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

After your baby has been born, a narcotic is often given to aid your after-surgery pain relief, and at the end of the operation a drug is given to reverse the muscle relaxation. The anaesthetic gases wear off quickly, and the tube is removed when you start to awaken, and begin to swallow or cough. You may be given antibiotics, to avoid infections, and a drug that thins your blood, to help prevent the possibility of blood clots forming in your legs.

Even after a general anaesthetic your baby will often be able to stay with you and your partner in recovery whilst you wake up fully. This may not always be possible, however, and if your little one does have to go to the nursery, you should be able to meet her/him very soon. Staff will make every effort to make sure of this, and you *can* remind them if they seem to have overlooked the



I did it! I had my VBAC at home in a pool to soft music and candle light. It was a dream come true."

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

This will encourage her body to labour effectively and birth naturally.

Your choice of childbirth professional during a VBAC

The choice of caregiver available to women who wish to birth by VBAC is basically the same as for any woman:

- Obstetrician
- Obstetric General Practitioner
- Midwife – Independent, Birthcentre or hospital (some hospitals even have midwifery teams)

You can choose one of these, or choose to combine your care – eg, a midwife and an Ob GP team, or an Ob GP and an Obstetrician team, etc. Again, this choice of caregiver will be related to your local birthing community's views of VBAC labour, and the appropriateness of each type of childbirth professional in regard to supporting VBAC clients. With a little research, though, you may find you have quite a few options available to you in regard to this choice.

Remember that you do not have to go with the first practitioner you visit, or are referred to. If your discussions with the practitioner leave you feeling uncomfortable, or unsure about their true dedication to your VBAC success, then interview others until you find one you feel confident to have managing your maternity care.

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

The continuity of care that can be attained by hiring an independent midwife should be noted. The midwife may support you in either a homebirth VBAC, or a hospital VBAC, depending on what you want and how she feels about each birth environment. Each individual midwife will have her own protocol, but most visit you at home during your pregnancy, for regular antenatal appointments and build up a trust. They then come to you when you are in labour, and stay with you right

- Eating and drinking during labour (some allow this, others worry about 'if' a caesarean should become necessary and the risks of inhaling vomit during the surgery, etc)
- Use of labour inducing drugs – to induce or augment (speed up) labour. There is an increased risk of rupture involved with the use of these, and this needs to be taken into consideration when deciding upon the pros and cons of induction.
- Whether or not an epidural should be used for pain relief in labour

All women wanting a VBAC should be encouraged to find out as much as possible about the reasons for these interventions, and the possible consequences of their use, so as to be able to negotiate with their Childbirth Professional an appropriate birth plan for their individual VBAC labour.

Birth environment for a VBAC labour

Basically, the choice about where to actually labour and birth during a VBAC is based on what local options are available to you, and these all relate to the current political climate surrounding VBAC in your local birthing community. You may have the option of a Birthcentre birth for your VBAC labour, or you may choose to birth in hospital. You may even be able to choose the option of homebirth for your VBAC, with the support of an experienced independent midwife, GP or Obstetrician. The options available to a woman planning a VBAC should vary, from those available to all birthing woman, **only** in that you would need to resource a childbirth professional that is experienced in VBAC births, especially when choosing the homebirth option.

Women who do choose the homebirth option often do so to avoid the technology that was involved in their previous caesarean birth experience, or to avoid the interventions that the VBAC policies adopted by many hospitals stipulate (eg, CTG, fasting, I/V access, etc). They also wish to regain faith in their body's ability to birth naturally, and are usually making an informed decision, after much research into the risks involved, in choosing this birth environment. If women do choose a homebirth VBAC, with the support of an experienced childbirth professional, then it is important for them to be aware of the risk that, in the rare circumstance of uterine rupture, the time delay involved in transferring to hospital may have serious consequences for both mother and child.

"My midwife had been with me for a marathon 29 hours.



importance of this monumental meeting!

Women often tell of their concern, if they received a general anaesthetic, that their baby seems like a stranger. They have felt that they have missed out on witnessing the birth of their child. They search their children's faces for 'family features' as they try to connect with their little ones. It's sad that the natural bonding process has had such a big upheaval right at the beginning. Suggestions on how to recreate that bonding process are contained under the heading "Healing" further on in this booklet.

Suture materials used in your skin wound.

Your obstetrician will probably have a preference for the method of stitching the skin wound. It could be a dozen or so individual stitches or metal clips across the wound (they look like staples), or a single, continuous stitch running just under the skin. This latter type of stitch may be of absorbable material so that it dissolves over a few weeks, or be non-absorbable and need removal - usually on about the fifth post-operative day. If you have your own preference for the type of skin suture, discuss it with your doctor beforehand, so that it can be negotiated.



What to Expect After a Caesarean Physically

Straight after the surgery, you will need to spend some time in recovery. This is to enable your vital signs to be monitored until they stabilise. Once you are ready, you will be moved up to your room.

Except in extreme circumstances, you should be able to have your baby stay with you during the surgery and in recovery, if your professional caregivers and the hospital policies support you in these choices. It's worthwhile requesting your baby stay with you, if you would like this to happen, and even better to organise this with your professional caregivers beforehand. If staff are concerned about either your baby, or you, then this may not be possible. It's also less likely if you have experienced a general anaesthetic.

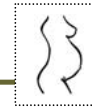
It will take some hours for the effects of the anaesthetic to wear off. If you received a spinal, or an epidural, you may be numb from below your breasts down to your toes. Being moved from the trolley to the bed can be a bit unnerving, as you may feel like a 'whale' and very unwieldy, until the numbness wears away (usually 4-6 hours later).

Just snuggle up with your little one, try some skin-to-skin contact, and have a go at that first real breastfeed, if this is one of your choices, while you wait for the feeling to return.

You may feel sleepy and really tired. Take this time to allow yourself to recover from the excitement, or emotional trauma, of the surgery. You may have lots of visitors appearing later in the day, so you need to rest while you can. It may be worthwhile limiting your visitors, during the first few days, to only close family and friends. You can also ask hospital staff to block phone-calls, or visitors, if you feel that requesting this yourself may offend.

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

Sometimes women get the shakes during the surgery, and even their teeth can chatter. This shaking may continue into the recovery phase but will disappear as the anaesthetic wears off. It occurs because the spinal/epidural anaesthetic dilates your skin blood vessels and you lose a lot of body heat - the recovery



prevent a single baby death attributable to VBAC. ¹²

A VBAC, where not medically contraindicated (advised against) has advantages for the baby, too. The contractions of labour massage and stimulate the baby and get him/her ready for birth. Waiting until labour starts assures that the baby is ready to enter the world, rather than being immature, with lungs that may not be able to cope with life outside his/her Mother's protective womb.

What to expect in a VBAC labour.

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

To gain a full understanding of what to expect during a VBAC, Birthrites encourages you to read some of the many books available. There is a suggested reading list at the back of this booklet. You can also contact Birthrites, or a similar local support group (again there is a list at the rear of this booklet), which offers women support and information about their future birth choices after experiencing a previous caesarean/s.

“My labour started and I was told to go to the hospital when my contractions were 3-4 minutes apart. Arrived at the hospital and was immediately hooked up, plugged in, I.V'd, vaginal checked, you name it...”

Each individual childbirth professional (doctor, midwife) will have their own personal requirements for a VBAC labour (some professionals are supportive of VBAC, but not all). Some of the requirements that may be discussed with you are:

- Time limits on the duration of both the pregnancy itself, and each stage of labour
- Intravenous access – which is having either a drip (I/V fluids), or a bung (catheter, but not attached to a drip) in the vein in your arm, in case of emergency.
- Use of continuous, or intermittent monitoring – either using a CTG or a foetal stethoscope

Making an informed choice about Vaginal Birth After Caesarean (VBAC)

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

A vaginal birth after a caesarean (VBAC), especially after a LUSC, in the absence of medical complications associated with this pregnancy, is the safer choice for most women.

A meta-analysis of literature concluded that 7 out of 10 women, who undergo a trial of labour after a previous caesarean section, can expect to birth vaginally¹¹.

Uterine Rupture risks.

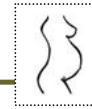
The scar from your previous caesarean is strong. While many people fear that the scar will rupture, and cause the death of the Mother and/ or her Child, medical studies have shown that this risk is greatly overstated.

The only way that VBAC differs from other labours is the small increased risk of uterine rupture - about 0.4% (one in 250). The risk of uterine rupture prior to elective repeat caesarean is 0.2%¹².

To put this risk into some perspective, consider that the probability of requiring a caesarean section for other emergency obstetric situations (not related to the previous c/section), such as acute foetal distress, cord prolapse or ante partum haemorrhage is up to 30 times higher.¹³

Early VBAC studies did not always distinguish between a scar rupture and dehiscence. The latter is a partial separation of the uterine wall with little or no symptoms and minimal (if any) maternal or foetal morbidity. The risk of uterine dehiscence or rupture combined occurs with the same frequency, up to 2%, whether a woman chooses VBAC or planned repeat caesarean¹¹.

A recent Australian study estimates the risk of uterine rupture in VBAC at 0.3% (one in 300). In that study, the risk of the baby dying because of uterine rupture in a woman trying for VBAC was 0.05% (one in 2000)¹⁴. It has been suggested that between 693 and 3332 women would need to undergo elective repeat caesarean to



nurse, or your midwife, should be able to organise an extra blanket for you, which will help warm you up. Your blood pressure may drop due to the epidural and, especially if you had a general anaesthetic, you may feel nauseous. Again these are a reaction to the drugs used and these symptoms will fade very soon.

One other annoying side effect of caesarean birth, which may occur, is shoulder pain. This is a sharp pain felt beneath your shoulder blade/s. It is due to air that has entered your abdominal cavity during the surgery, something that is impossible to avoid. The air pocket will gradually be absorbed by your body over the next day, or so, and the pain will disappear.

Some rarer reactions, when an epidural/spinal has been used, are headaches or a swelling at the site of injection. If you experience these symptoms, then speak to your caregiver about why they are happening and how to alleviate the symptoms.

Please realise that it will take you longer to recover from a caesarean birth than it would from a vaginal birth, generally, so you need to really take care of yourself. Don't hesitate to ask for support from the staff, family and friends, especially in those first few days of caring for your brand new baby.

Pain relief after a caesarean.

Some women really need good pain relief after experiencing a caesarean; others are up and about within a few days, and report experiencing hardly any traumatic pain at all. This could be based on each individual's pain tolerance, or what happened during the caesarean, or preceding it, or it could be related to the Mother's attitude towards the whole experience.

Women can feel traumatised (emotionally and/or physically) by their caesarean experience and then may have more difficulty coping afterwards, as they will have emotional issues to deal with as well as the physical pain associated with a surgical birth.

There are several medications, taken individually or in combination, which will offer pain relief after your caesarean. Your midwife, or anaesthetist, will recommend which drugs will help you best to cope with any pain experienced. If you continue to experience pain, then you should alert your midwife to your condition so that she can help alleviate your distress.

Please remember that it can be better to 'stay on top' of the pain, as some of the drugs work best once they reach a certain level. If you force yourself to cope with

pain until you desperately NEED pain relief then you may not get the full benefit of the medication. So, don't be a martyr!

Then again, it's worthwhile checking how your body is coping using lower doses of medication, as the days pass. All drugs may have some effect on your baby if you are breastfeeding – either passing through your milk to your baby, or possibly affecting the flow or production of your milk supply. Your midwife/doctor should guide you towards a reduction in pain relief over the time until your discharge from hospital.

Relying on too much pain relief, gained through medications, can actually give women a false sense of wellness. This can have the undesirable effect of encouraging the Mother to do too much, too soon. Women must be aware of some pain, so that they will remain in tune with the healing that their body is performing. If the Mother over-exerts herself too soon after the caesarean, then this may prolong the whole healing process.

Please remember that you have the right to be informed about the possible side effects of any drugs that you take to help you manage pain after your caesarean. If you have any concerns about how any of these drugs may affect you, or your baby (especially if breastfeeding), your worries should be discussed with a relevant person (i.e., the midwife, doctor, anaesthetist or the pharmacist associated with the hospital). Below is a list of drugs commonly used.

The types of pain relief offered are:

- **Narcotic medication.** Specifically Pethidine and Morphine. They can be given by injection, each 3 – 4 hours, intramuscularly (an injection in your leg) but may also be given as a 'fixed dose infusion' through an I/V line into a vein in your arm, via a Patient-Controlled Analgesia Pump, which enables you to self-medicate as needed (you are instructed how to use this pump) or in small doses through the epidural catheter, which may still be in place from your surgery. Another way of receiving this medication involves a single spinal injection.
- **Suppository.** The suppository contains an anti-inflammatory drug that will help you cope with pain while it reduces any abdominal inflammation you may be experiencing. This drug is inserted into your rectum, and is quickly absorbed. It is usually given twice a day.



- How about breastfeeding your baby straight away, rather than hours later? Let them know that you would like to feed your baby while you are being sutured, if you feel up to it, and you would like your baby to stay with you throughout the surgery and even during the recovery. Or you could arrange for the lactation consultant of the hospital (or your own private one) to be present at the caesarean birth and bring the baby to you in recovery, to breastfeed within that first hour of birth.
- Let them know that your partner would be delighted to hold his/her child within your view throughout these procedures, if you feel unable to participate in the bonding (at least you would be able to witness it this time).
- You may also be able to organise with your doctor to allow a quiet relaxation CD to be played throughout the birth. Chosen by the parents of course. They may find the music so enjoyable, that they may make it a regular part of caesarean births. Don't let it intrude on the birth, though, just gently enhance the experience.
- And lastly, what about that placenta? Most women who birth vaginally get to see it, at least, and maybe you would like to too. Make sure theatre staff know you want to view the placenta. Make sure they realise the importance of this and let them know not to just discard a part of you that you have carried for nine months as insignificant. You may like to take the placenta home, to plant under a tree, or even to eat (see the placentophagy article on the Birthrites website) so please tell them to be sure to make suitable arrangements with you to see that this happens.

Make a birth plan!

Have several copies with you and give it to everyone involved in your caesarean!!! They won't know what is important to you unless you let them know. Birthrites hopes that your caesarean birth is everything you hope it to be: that you and your baby reap the rewards of fore planning a better birth experience, both physically and emotionally.



- able to begin labour naturally before the caesarean is done. That is, you do not want a date and time preset, you wish for your baby to decide the day on which it is ready to be born to avoid any problems with prematurity and for both of you to reap the benefits of your hormones.
- If you are convinced that a scheduled caesarean must be performed, then you should request preoperative blood work and tests to be done on an outpatient basis, and hospital admission on the day of the birth (not the night before).
 - You can request that your baby remain with you at all times, no disappearing off to the nursery with your partner. This separation may seriously affect your bonding with your child. If your baby must go to the nursery, then DO send your partner and encourage the "skin-to-skin" contact mentioned before. Your baby will really be craving this beautiful contact, and should recognise your partner's voice.
 - Would you, and your partner, like to view the actual birth? Then make sure your Ob. realises this... Tell him you (both?) would like the option of viewing the birth, either by lowering the screen or by positioning a mirror. Maybe your previous caesarean is still a bit unreal, as you never have actually seen a baby leave your body - they tend to just appear from behind the green screen and be held up for a quick look before they disappear to be wrapped up and tested.
 - Make sure theatre staff realise that you would appreciate a verbal description of the birth as it occurs. You may have previously felt left out of your past caesarean(s) as your body and labour might have been discussed as though you weren't there.
 - How about asking the surgeon to leave the umbilical cord long and allow the father or mother the chance to cut it. That way the parents do not miss out on the sensation or their own right to tell their story of 'cutting a cord.'
 - I bet you would love to meet your new baby in his/her unclothed, naked newborn state - a wet, slippery baby? Then request that the baby please be placed on your chest with a warm blanket over you both. It would do a lot to make this surgical delivery a bit more natural for mother, father and baby. And it may even resolve a few inner conflicts that are faced after the birth.



- **Paracetamol, or a Paracetamol/Codeine combination.** These are usually offered in combination with the other drugs listed, in the early days, helping to reduce the amount of drugs needed. They can then be used alone as time passes, especially as the time of discharge approaches.
*Note that Codeine, Morphine and Pethidine (all narcotic drugs) can cause constipation, and this is not something you want to experience after a caesarean, so use these medications moderately if possible, drink lots of fluids and keep mobile.

Drinking and eating after a caesarean.

It is wise to start with fluids and clear foods soon after your surgery. Your midwife/doctor will advise you about any restrictions in your individual case, and the reasons for them. Each doctor, or hospital, will have guidelines related to this, so you need to check if it's okay before eating or drinking anything.

Generally, if you had an epidural/spinal, then your fluid intake will not be restricted. You may drink any fluids, such as water, juice and cordial, etc, and eat clear foods such as soups and jellies, etc. But you mustn't start eating solid foods until you have passed wind – this is a sign that your intestines (which will have been 'relaxed' during your surgery) are beginning to function normally again. At this stage in your recovery, a light diet is best, until your intestines become better able to handle your food intake.

Once you have passed a motion, then you can eat whatever you like. Remember though, especially if you are breastfeeding, that certain foods encourage wind (i.e., especially anything you are allergic to) and they may upset your tummy, or your little one's.

It's really important to keep up your fluid intake especially when breastfeeding – in which case always have a glass of water close at hand while feeding your baby.

It's recommended that you try really hard to drink at least 8 glasses of water a day. This will stop you becoming dehydrated, will help replace any blood loss you experienced; it will also keep your bladder functioning well and help prevent constipation.

Urinating after a caesarean.

When your urinary catheter is removed, on day two or sooner, you may be asked to measure the amount of urine you pass on that first day without it. You may be supplied with a special measuring container in which you urinate, so don't forget to hold on to your urine until the midwife has noted the amount.

If you are having difficulties urinating, then you might like to try some ways of triggering the urge (eg, turning on a tap, hopping in a warm shower, pouring an amount of warm water over that area, etc) because if the difficulties persist, then the catheter may need to be reinserted.

It should be noted that some of the drugs given to you, during the surgery or for pain relief afterwards, may affect your bladder function. It would be worthwhile investigating this as soon as possible to ensure nothing interferes with regaining normal bladder function.

Some women experience physical trauma related to the urinary catheter, so if you experience any burning pain upon urinating, especially if this persists, you need to let your doctor/midwife know so they can check for a possible bladder infection.

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

If you experience incontinence (leaking urine), which may have begun during pregnancy as a result of your growing pregnant belly continually applying pressure against your bladder and/or the normal relaxing hormonal effects of pregnancy itself, then you should seek advice from the midwife, or physiotherapist, about exercises that you can perform to increase your ability to maintain bladder control (pelvic floor exercises, etc)⁸. *Note – Pelvic floor exercises are a good idea for all women to perform. We can all experience some weakness of our pelvic floors, and resulting incontinence, even if we haven't actually experienced pregnancy or childbirth.

One other problem, sometimes experienced, is a lack of sensation telling you that your bladder is full and you need to urinate. This is also something that needs to be brought to the attention of your doctor/midwife.



Planning Future Births After A Caesarean/s.

There are basically two choices of birth mode:

- A repeat caesarean
- A vaginal birth

If you choose a repeat elective caesarean, or your professional caregiver recommends an elective caesarean, for medical or social reasons, then the information contained previously in this booklet will help you to make an informed choice about the pros, cons, risks and consequences of this mode of birth.

Not all women can achieve a vaginal birth, for their own specific reasons and VBAC may not always be a viable option when each pregnancy/birth is considered independently. Birth is a sacred life event, even when it is surgical, and most Mothers would appreciate it being treated as such. This is the birth of a child, a completely different surgical experience than any other, an experience to be treated as similarly to a vaginal birth experience as is humanly possible.

“The results of the tests weren't as good as we would have liked, the baby was showing signs of distress, and it had to be born today. With plenty of discussion and thought we decided that a Caesarean was absolutely necessary for the health of our child.”

Below are just some suggestions to make your caesarean more acceptable to both yourself and your baby. They are from the Birthrites website “Planning a positive caesarean” page.

- If you do need a caesarean, then it would be better for you to receive a spinal/epidural anaesthetic and remain conscious during the operation, participating in the birth of your child.
- If an emergency caesarean is necessary, under general anaesthetic, then be sure your baby is given to your partner as soon as possible after birth and held by him (hopefully next to his naked chest - skin to skin contact) until you are awake and can be told of the baby's sex and well-being (by your partner).
- If an elective caesarean is necessary, then you can request that you be

The consequences of caesarean birth.

Birth by caesarean, especially when repeat caesareans occur, can have some undesirable physical effects. As technology has improved, the problems associated with caesarean birth have been dramatically reduced. But there are still a few common consequences to birthing in this way.

One consequence is the scarring and adhesions that will occur as a result of the surgical trauma. No matter how gently the surgery is performed, internal organs will develop some adhesions that may cause problems later in our lives.

The adhesions may cause pain in future pregnancies, as the increasing size of the uterus pulls, stretches or breaks adhesions formed earlier between the uterus and surrounding organs, or the abdominal wall.

They can also cause pain in a non-pregnant woman, especially around the time of menstruation, when inflammation and contractions of smooth muscle (related to menstruation) may irritate adhesions and scarring.

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

For each subsequent caesarean birth a woman experiences, the surgery becomes more complicated, as the surgeon must negotiate his/her way more carefully through the scarring and adhesions formed from previous surgeries.

Caesarean birth also holds all the consequences normally associated with major abdominal surgery. That is, anaesthetic and other drug risks to both mother and child, the risk of excessive blood loss, surgical damage to adjacent organs, etc. These need to be acknowledged and taken into account when planning a caesarean birth.



Bowel movements after a caesarean.

Within the first couple of days of your caesarean, you should feel the need to move your bowels. This can be a scary experience in itself, as you will feel unsure as to how much pushing your wound can withstand. It can be reassuring to apply gentle pressure, with the palm of your hand, over the wound area while you gently 'breathe out' to allow a bowel motion. It is important not to strain.

Avoid constipation by drinking lots of water, eating a good fibre-rich diet (perhaps adding extra fibre to your meals) and limiting Narcotic use. If you continue to have problems with constipation, then your midwife will be able to assist you by suggesting medications that will help soften your stools. Ask for assistance sooner rather than later to prevent unnecessary distress and discomfort to the Mother.

Vaginal blood loss after a caesarean.

Your midwife may ask to view your sanitary pads over the first day, or so, to check the amount and colour of the blood you lose via your vagina.

The flow may increase when you actually breastfeed your baby, as the hormones released by the stimulation of breastfeeding encourage uterine contractions to occur. When you stand up, as a result of gravity, your flow may suddenly increase as well. You may also pass some clots, though they shouldn't be too big. If you are concerned at all, about anything to do with the amount or consistency of your blood loss, then ask your midwife to check your discharge for you.

At first, your blood loss will be bright red, and slightly heavier than a normal period – though it shouldn't exceed a sanitary pad per 4 hours (if it does exceed this, then advise your midwife). The loss will decrease over the next week, and the colour will alter to a paler red, then a brownish-red colour. The flow should stop after a week, or so, though light blood loss may last for around 6 weeks after the birth and is not a cause for concern. It differs for each woman. If worried, contact your midwife or doctor for advice.



Caring for your wound.

You may have received antibiotics while still in theatre. A sterile dressing will cover the incision site, placed there by the surgeon. These safeguards should help reduce the likelihood of infection.

During that first day of recovery, within hours of your surgery, your midwife will offer you a bed-bath, where she will sponge you down with warm, soapy water and clean away any traces of blood or surgical fluids. Then she will help you get dressed in your nightie and make you more comfortable. She won't remove the sterile wound dressing at this stage.

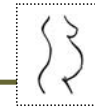
The day after your caesarean you will be encouraged to get up and have a shower. This is usually when the sterile dressing is removed – by your midwife, or yourself. You should gently wash away any dried blood from your wound, with water (soap may irritate), then gently pat the area dry with a clean towel. If it's possible then allowing the wound area to air-dry is best.

A great way to protect the wound area is to place a sanitary pad, sticky side on your underpants, over the wound. This will help to prevent your clothes rubbing directly on the area. Also, for this reason, your pregnancy clothes (with the lovely elasticised belly section) will be really comfy for the first few weeks. Wearing big, comfortable underpants, rather than bikini briefs, avoids the elastic waistband being right on the wound area – you can send your partner, or a friend, out to buy you some if you are unprepared.

A healthy diet will encourage healing, as will gentle exercise (discussed in the next section). You should maintain good hygiene, and try to avoid getting very hot, as perspiration will aggravate the wound area.

Your wound may continue to feel uncomfortable for some period after the delivery. Some women experience mild pain and pulling sensations for some months afterwards when performing some actions. This does go away in the majority of women after a time. If you are worried discuss these sensations with your midwife or doctor.

If you notice any swelling or redness, or if your wound weeps blood or other fluids, please bring this to the notice of your midwife or doctor, ASAP, especially if these symptoms are associated with pain.



Baby Massage

This massage is extremely enjoyable to both Mother and child, and can help to replace the uterine contractions your baby may have missed out on experiencing during a natural birth

Touch your baby, spend time massaging his/her skin, this is great... especially just before your baby's bath-time, or just after a lovely bath.

You can lay your baby on a towel or rug (somewhere warm if it's a cold day) and spend time gently massaging him/her all over with a product, like Sorbolene cream which washes off in water, or a gentle oil blend.

Start by very gently caressing your baby's head and face, then caress him/her all over in an outwards direction, moving down his/her body – front and back.

Gently squeeze his/her little legs and arms like sausages – working from the body to the toes/fingers, massaging each digit gently.

Try it - you, and your baby, will love it!



“If I could go back and change things I would have walked out of the hospital at this point but all I wanted was my baby.”

Educate yourself. This will enable you to put everything you experienced into some perspective. Read books about caesarean and VBAC birth, as well as books about natural childbirth. Search the Internet, and join some ‘chats’ specifically designed for women who have experienced caesareans. Discover the support that is there, in your birthing community, whether that is a midwife, a doctor or a group such as Birthrites.

It’s normal to want to rewind the whole experience, saying to yourself “If only I had done...” But we can’t control time, so we need to **forgive ourselves**, and try to also **forgive others involved**, if you feel that you could have changed what happened with some forethought. Try to turn the experience into a positive one; in that you gained some valuable knowledge about childbirth that you can use to educate other women who may be about to experience a similar situation.

It’s also normal to feel jealous of friends or family who birth vaginally. You feel so happy that everything turned out so well for them, but you ask yourself “Why couldn’t it have turned out like that for me?” Even a vaginal birth that had lots of interventions sounds great! As long as it was vaginal... This jealousy will ease, over time, though your longing for a vaginal birth may never totally disappear.

A beautiful suggestion for healing after a caesarean (listed on the healing page of the Birthrites website) is:

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



Exercising after a caesarean.⁸

A great resource, which was used to find relevant information to include in this section of the booklet, is the website titled “The Pregnancy Centre” which deals specifically with physiotherapy issues related to pregnancy and birth. It is found on the internet at: <http://www.thepregnancycentre.com>

Even before you venture out of bed, after your surgery, you should begin to gently exercise. You can do this by working your leg muscles by stretching and moving them around (after feeling has returned), and by rotating your feet. This will encourage blood flow and discourage the formation of blood clots in the deep veins of your legs – which is a concern after surgery.

It is important to regain your physical strength, and flexibility, as soon as possible after the surgery. Lying motionless in bed will only encourage the risk of blood clot formation in your legs and/or fluid forming on your lungs. Besides you have a little baby that needs you to take care of him/her!

On the first day, when feeling has returned to your lower body and you have tried some leg exercises, you should try sitting up in bed. You may need to organise a ‘triangle’ hand-pull to help you get into this position, and lots of pillows to maintain it for any length of time. Your midwife will help you get there the first time you try. You may even wish to sit in a chair, getting out of your actual bed with your midwife’s help.

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

Don’t rush yourself, but do try to become more active everyday. Walking around your room is a good start, then down the corridor. But always make sure that you don’t push yourself beyond what your body can physically cope with. And when you do walk, try to stand up as straight as possible (don’t do the ‘caesarean stoop!’) as good posture will strengthen your tummy and back muscles, and reduce strain on your back – which leads to backache, something you don’t want when your tummy is already sore.

Most hospitals have physiotherapy classes, and it would be worthwhile

attending at least one of these prior to discharge. The physiotherapist may have already visited you in your room, to get you started on some gentle post-surgery exercises. She/he can give you advice on ways to:

- Strengthen your 'pregnancy' tummy muscles
- Help with any back pain being experienced – suggestions to improve posture and stretching exercises to relieve tension
- Improve your bladder and bowel control – ie, pelvic floor exercises

A physiotherapist can also advise you about when:

- It is safe/advisable to return to your favourite sport. Some good sports to do as alternatives until you are fully recovered, are -
 - Swimming. Which is good once your wound is fully healed
 - Yoga. With an instructor experienced in teaching postnatal exercise
 - Walking. Gently increasing distance as you gain physical strength
- To return to home duties:
 - Light chores are okay early on, but avoid being on your feet for too long without resting
 - Wait at least 6 - 8 weeks before beginning to vacuum, or do heavier work. Take care of yourself, especially in regard to any lifting that you attempt. If you are straining to pick up your toddler, or move furniture, etc, then you may cause yourself damage. Think of alternative ways of managing, or get some help!

Basically you should not do anything that you find physically distressing during the early weeks of healing. Gently, gently...

A very clear sign that you need to rest is when your wound or your stitches ache (especially if you feel the need for pain killers after a break without them), if you feel tired and unable to cope or when you notice an obvious increase in vaginal discharge – you should inform your midwife or doctor if your discharge suddenly increases.

Your body needs time to heal, and it takes several weeks for internal healing to occur. So, though it's important to resume physical activity, you need to find a balance between gently exercising and pushing yourself too hard.

There will be plenty of time to exercise to lose that 'pregnancy belly', or resume your fitness level, after your body has had a chance to spend a little energy healing all the physical traumas associated with the surgery you have experienced.



much more complex.

An important part of this aspect of healing is being able to talk about your feelings. Your partner, family and friends may become distressed if they see your emotional pain, and they will generally try to get you to focus on the positives (healthy baby and mother) to avoid the concerns over your inner well being. With this in mind, it may be important to discuss your feelings with people who are not so close to you. Some suggestions are:

- **To talk to the staff involved in your child's birth experience.** You can either organise a chat while you are in hospital, or take their names down (midwife, doctor, etc) so that you can contact them at a later date. In going over the progression of your labour, which ended in a c/section, you can better understand why the surgery happened, and you may be able to plan your next child's birth with a better understanding of this previous experience to guide you.
- **Contact a support group, such as Birthrites** (contacts listed at the back of this book) **by phone, email or letter.** You can then receive Mother-to-Mother counselling from someone who has experienced the same, or a similar, situation to you. Birthrites also supplies women who contact them with information about future birth choices, and many of the contacts listed organise 'get-togethers' where women can meet (usually in someone's home) to share stories, knowledge and support.
- **Professional counselling.** It helps if the counsellor specialises in postnatal problems, as she/he will be better able to relate to what you are experiencing. But you must remember that, though your symptoms may be similar, you may not be suffering from post-natal depression, just grieving for the loss of a priceless life experience.

It's good to give yourself a little time in which you can remember the whole

experience. During this time you should just let the feelings 'come and go' as you think about the birth. Don't bottle them up; allow them to be released by actually *feeling* and acknowledging them.

Allow yourself to be sad. Don't drown in this emotion, but allow the grief to be released. It's a valid emotion when we lose someone or something. You may have been planning the birth for your whole pregnancy, visualising how it was going to be, and the loss of that irreplaceable envisioned experience can be a great loss.

counsellor on staff that I can talk to. After the birth I was shell-shocked and I was not thinking straight. I really needed someone to explain what had happened and listen to me. My obstetrician visited me but it was all so brief and there was the baby to think of. I was just focussing on his well-being. I needed someone to ask about me - not the stitches or the pain but my mental well being."

These feelings may not arise immediately following the birth of our child. We may be too busy being grateful for the safe arrival of our little one, and thanking the technology that enabled us to be holding a healthy, beautiful child in our arms. It may be a few weeks further on that we become aware of a feeling of loss.

Women may discover they feel happy to have a healthy child, but they still feel distress at the way their child was born. They can acknowledge the positive outcome, but they have problems accepting the way in which this same outcome (of a healthy child) was achieved.

Family and friends may not understand why the Mother feels this way. They may encourage her to focus on the healthy baby, and forget about the issues she has with the caesarean birth of her child. Or they may disregard her yearnings to have experienced a natural birth for her child, pointing out the positives of caesarean birth (organising day, no pain during labour, etc).

Speaking to a counsellor about the past experience may help, as will contacting an organization such as Birthrites, which is made up of women who have experienced caesarean birth and felt as you do, and can therefore empathise with and understand your emotional state.

Birthrites organises get-togethers, where you can speak to like-minded women and gain knowledge about how others have coped with their own experiences of caesarean birth. Contact details are listed on the back page of this booklet.

Suggestions for Emotional Healing.

In the words of one mother,
"I certainly did not want to maintain the aggression and bitterness; I was missing out on my beautiful little boy! I missed smiling..."

One small note here: A vaginal birth is no guarantee of healing. You may need to do work on your past birth experience/s to find a sense of peace. This work may be as simple as being able to "talk" about the experience with someone, or it may be



Finding time to rest...

After experiencing a caesarean, your body has an increased need to rest and regenerate. There's no denying this basic need, and not doing so will only extend the length of time needed to achieve full healing.

The feeling of tiredness may continue for months, long after the external scar of your caesarean has healed and become a silvery reminder of your baby's birth. You need to acknowledge the nurturing you deserve, and not feel guilty at having an afternoon snooze (snuggled up with your little one) or leaving the housework until you feel more energetic.

This becomes more difficult when your newest little one has older siblings who continue to demand your attention. This is when you need to call on/accept the offered help of family and friends. You could even ask a friend/family member to make up a roster, while you are still pregnant, of people who may like to come around for a visit with a meal, or spare a few hours to help by cleaning up around your house. You especially need this extra support when you are recovering from a caesarean birth.

A "Do not disturb" sign is great; both in hospital, and at home. You can make your own personal one during your pregnancy, with an explanation that Mum and Baby are having a nap. Take the phone off the hook and catch up on some lost sleep!

In hospital you can ask your partner to remind visitors to not stay too long. It can be exhausting entertaining when you should be resting. The same applies at home, for those first few weeks of recovery.

Keep your baby close-by, not in another room, during the night, at least for the first few weeks. If you keep your baby's cot near your bed, you don't have far to go to attend your baby's needs.

If your baby's presence keeps you awake (those little sniffling noises can be daunting to a new Mum) then organise some time during which your partner, or someone else you trust, can care for your baby while you have a nap all by yourself.



Can I breastfeed after a caesarean?^{9, 10}

Two great resources, used to compile the information contained in this section of the booklet, are:

Australian Breastfeeding Association Website -
<http://www.breastfeeding.asn.au/index.html>

La Leche League International Website - <http://www.lalecheleague.org/>

Of course you can, if you want to. Breastmilk is the best food for your baby, fulfilling all his/her nutritional needs in an easily digestible form.

The best way to make sure your baby and you get off to a good start is to:

- Breastfeed as soon as you feel able to after the caesarean – It's even possible in the theatre, or recovery room, if you are keen.
- Unwrap your baby and place him/her next to your naked skin. Breastfeeding will be the next natural impulse.
- Find a breastfeeding position that suits you – one that doesn't place your baby directly over your wound area, such as, lying down on your side, with the baby raised to your breast on a pillow or using the football hold
- Make sure you have your post-surgical pain under control, as tension may affect your let-down reflex
- Get help to make sure your baby is correctly attached to your breast – this will help prevent sore nipples and a frustrated baby! Your midwife can direct you, or you can seek the assistance of a lactation consultant (many hospitals employ their own consultants)

If you have problems breastfeeding, then you need to seek help straight away, otherwise it might all just seem too difficult when it becomes yet another challenge you are facing while recovering from your surgery. If the hospital employs a lactation consultant, then this would be the person to contact for advice, remembering that she may not be available on the weekends – so don't hesitate if you need her help during the week and the weekend is approaching! Remember most Mothers *can* breastfeed, with the right support, and it may be beneficial to contact a lactation consultant during pregnancy about doing a short course, which will inform you of everything you need to know to get a positive start once your baby arrives (i.e., increase confidence and learn breastfeeding techniques).



- o Many other reasons

Each of these situations can impact on our emotions and how we deal with the caesarean we experienced.

“Midwives started taping my rings and removing my jewellery, the doctor gave me ‘a little something to stop the nausea’ into my drip-line, the anaesthetist arrived, the doctor was talking at me about the pro’s and con’s of surgery and then he gave me a form to sign. Then the anaesthetist explained the pro’s and con’s of the epidural before they got that set up - all this during powerful contractions when I wasn’t really with it. Most of the time they were talking to me I had my eyes shut, and it was impossible to open them and concentrate on what they were saying.”

It is extremely distressing to be rushed to theatre from labour ward, not knowing if your baby will survive. The sterility needed, and the need for emergency action, may be bewildering and confusing. The loss of your support people, as they either gown up, or are denied admittance to the theatre if you are having a general anaesthetic, can be devastating. It is normal for your body to suffer some emotional trauma after such an experience. Thankfully, not many caesareans occur in such a setting.

How you react emotionally to the surgery, whether you understand the need for technology to intervene, and accept the fact that your child is to be born in this way, will determine how well you cope afterwards.

It is quite normal to experience some ‘baby blues’ about the time that your milk comes in – around day three. But if the feelings of depression don't become lighter over the next day, or so, then speak to your midwife about how you may not be coping with the emotional issues that surround the birth of your child.

You may find some relief by talking of your feelings to your partner, family, friends, the midwives and the doctors who were involved in your care. By reliving the event, in this way, you may desensitise yourself to some of the stronger emotions attached to your memories.

If you were planning a natural birth, then it is normal to experience some grief at the loss of such an integral life experience. We envision how our children's births will unfold on the day, and when things don't go as planned we can feel grief at the loss of an important life experience.

“In the future, I will be asking the hospital if there is a

What to expect emotionally after a caesarean.

The emotions that you may experience after a caesarean will depend very much on whether you chose to birth in this way, or whether you were aiming for a natural, uncomplicated vaginal birth. They will also depend on what actually occurred during the caesarean birth of your child.

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

If you planned a caesarean birth, but something 'happened' on the day that wasn't expected (i.e., your child needed paediatric help, your anaesthesia didn't work as well as expected, etc) then you may need to deal with the emotional trauma that is connected to these experiences.

You may have been planning a natural birth and events did not go as planned, in late pregnancy or on the day, so an emergency caesarean became necessary.

"There was a moment of silence. The Doctor then told me that I was to have a caesarean section. Things moved pretty fast after that... I was in no position to make any decisions. I just felt numb with exhaustion and relieved that the end was near."

The degree of emotional trauma associated with each of these situations tends to relate back to how much of an emergency the caesarean actually was, how much control the Mother retained over the birth experience and the progress and outcome of the surgery. That is, the caesarean could have occurred because:

- You chose to birth this way – for medical or social reasons – prior to labour starting
- Or, if you chose to birth vaginally, you may experience a caesarean because -
 - You were induced, but labour didn't establish
 - You were in labour, but it wasn't progressing
 - You baby wasn't coping well with labour, or was thought to not be coping
 - You began to haemorrhage
 - The cord prolapsed



It can be enormously rewarding, to both Mother and Child, to establish breastfeeding. The knowledge that your body is able to totally care for all your baby's nutritional needs during the first 6 months (or more) of his/her life is wonderful. This knowledge is especially valuable when you may feel that your body had not been able to birth your baby naturally (this time). The naturalness, bonding and feelings of nurturing that are gained from being able to fully breastfeed your baby cannot be over-emphasized.

The drugs you received during your surgery, and for pain relief afterwards, may affect your letdown reflex, or even your milk supply. So it's worthwhile questioning this if you are experiencing difficulties. These drugs may also pass into your milk supply, and therefore to your baby. If you are concerned then ask your midwife, doctor or the pharmacist for information about the properties of the drugs you are receiving, or have received.

For advice on breast-feeding concerns, after leaving hospital or while still at hospital, you could contact the below organizations:

- The hospital's breastfeeding centre/lactation consultant
- Australian Breastfeeding Association (formerly Nursing Mothers Australia Association)
 - *24 Hour service – (08) 9340 1200 - Perth (check the phone book for local numbers)
- La Leche League – (08) 9321 4631 - Perth (check the phone book for local numbers)
- Your child health nurse
- Your GP – family doctor or the doctor involved in the birth of your child
- Your independent midwife
- Local parenting centres
- Your baby's 'Personal Health Record' booklet often lists local services that you can access

If you choose to bottle-feed your baby, or find that breast-feeding is not possible for some reason, then the midwife can assist you in finding comfortable positions in which to do this. She will also explain sterilisation techniques and formula mixing, etc.

Even bottle-fed babies love skin-to-skin contact. So don't deny yourself, or your baby, the joy of this sensory experience.

What about sex?

The same rule applies to women who've experienced a caesarean birth, as to those who birth vaginally. You resume sexual relations with your partner when **you** feel ready. Before you do, though, organise with your GP/Ob. what sort of contraceptive you will be using, as it's a good idea to give your body a reasonable amount of time to physically heal from your caesarean before becoming pregnant with your next child. Your childbirth professional will be able to advise you what time frame this involves, in regard to the latest research available.

You may have to be inventive with the positions used during sex, to prevent pain, or pressure, on the wound area. And your partner should be prepared to stop if you do not wish to continue, so it may be worthwhile discussing this possibility with him prior to initiating sex.

The wound, and the area surrounding it, may remain numb for months (may be up to a year) after the surgery. This is due to nerve stretching, or damage, resulting from the incision, and surgical trauma to the area. Feeling should eventually return.

It may be a good idea to explain this numbness to your partner, as it can be disturbing to be touched, or caressed, on this numb area. Women may also find it impossible to wear tight clothes, for this reason, as the cloth rubbing on the numb area can actually cause nauseous sensations.

Please remember that if you are breastfeeding, then the lowered oestrogen levels (whilst breastfeeding) may reduce vaginal secretions that are normally present during sexual activity. If this is the case, then you may need to purchase a water-based lubricant gel to replace your natural secretions and enable sex to be more enjoyable.

Also realise that it is normal for you to feel very tired. You have just experienced major abdominal surgery and all the emotions that surround such an experience, as well as possibly experiencing some labour, and your body is healing – physically and emotionally. You have a little baby to care for, that is demanding a lot of your time and energy (day and night!) You will spend so much of your energy nurturing your baby that you may feel emotionally 'all out of nurturing' by the time you hop into bed at night. This is the time that you will enjoy either a good sleep, or a little nurturing yourself (i.e., gentle massage, a big cuddle, etc) and sex sometimes just seems too hard. Your partner may not



understand this, especially if your loss of interest lasts a long time, but it will help if you can explain these aspects to him... It may encourage him to help a little more, and cuddle a little more. If he becomes more supportive, you may find yourself becoming more attracted to your lovely man, all over again!

One other thing that may cause a loss of interest in sex is depression. This can be caused by either a:

- Hormonal problem – True postnatal depression. Please mention it to your professional caregiver for advice/diagnosis.
- Grief - if you did not wish to birth by caesarean it is normal to grieve for the loss of experiencing natural birth
- Type of 'Post Traumatic Stress' reaction, especially if the caesarean occurred in an emergency situation, or in a sudden or emotionally/physically traumatic way.

Whichever of these you may be experiencing, you should seek some help (it's good to try counselling first, after checking with your medical caregiver) in overcoming the feelings that these reactions to your caesarean, or the birth of your child, may be causing.

It's hard to truly 'enjoy' your new baby, when you are struggling to overcome feelings of anger, frustration, resentment, etc. Please realise you are not alone in feeling this way, though sometimes you may search desperately for understanding. Again, if your partner is understanding of what you are experiencing, and what you need emotionally and physically, then that will really help you both build a stronger relationship as you learn how to work together in parenting your new child.

