

WestCoast Midwives

Client Handbook

**To be read in conjunction with
'Babies Best Chance'**

Please return this book to

**WestCoast Midwives
2823 Dysart Rd
Victoria BC
V9A 2J7**

(250) 384 5940

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**Welcome to
WestCoast Midwives**

Registered Midwife

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384-5940

Contents

	<u>Page</u>
<u>Introduction Introduction</u>	
Welcome to WestCoast Midwives	1
What is midwifery care?	2
When to contact your midwife	4
Reading List	5
Resources in Victoria	7
Employment Insurance & maternity, parental & sickness benefits	9
<u>Prenatal information</u>	
Miscarriage – What to do if you start bleeding!	11
Screening tests for the mother in early pregnancy	12
What is Maternal Serum Screening?	13
Prenatal Diagnostic tests	16
Diet	18
Treatment for Common Discomforts in Pregnancy	23
Pregnancy Teas	27
Sex during Pregnancy	29
The Super Kegel	32
Screening tests in late pregnancy – you decide!	
Gestational Diabetes	33
Group B Strep	35
Newborn Procedures - you decide!	
Prevention of eye infections	38
Prevention of Haemorrhagic disease of the newborn	38
Newborn screening for rare disorders	39
Circumcision?	41
<u>Preparing for Labour and Birth</u>	
How a Doula can help you!	50
Avoiding Perineal trauma	51
Perineal massage	52
Where will you have your baby – at home or in hospital?	53
Preparing for a Homebirth	56
Three variations of labour	58
Labour & birth: Questions & Answers	59
<u>After the birth</u>	
After the baby is born!	61
Common postpartum discomforts	63
Newborn guidelines for parents	66
Vitamin D & the breastfed infant	67
The Seclusion Period	67
Breastfeeding – starting out right	68
When latching	70
Is my baby getting enough milk?	73
Expressing milk	75
<u>Appendices</u>	
Measure of attitude towards undergoing screening for Down Syndrome, spina bifida and Edward's syndrome	Appendix 1
Measure of knowledge about Down syndrome	Appendix 2
Bleeding during pregnancy – An overview	Appendix 3
EPDS Scale	Appendix 4
Miscarriage	Appendix 5

Welcome to WestCoast Midwives!

A little bit about us

Kim began her career in midwifery following her experience of having a midwife for her 2nd child. She went on to become a certified childbirth educator, a breastfeeding counsellor and then apprenticed as a midwife before going to the University of Utah to complete a Masters degree in nurse-midwifery. She holds an RN and baccalaureate degree in nursing in BC and has spent many years teaching obstetrical nursing in Victoria.

Kim is a registered midwife with the College of Midwives of BC

Heather became a doula and breastfeeding counsellor following the birth of her 4th child. She is certified through Childbirth and Postpartum Professionals Association (CAPPA). In addition to doula services, Heather also teaches private prenatal classes.

Feel free to ask Heather about her services when you come in to the clinic.

What is Midwifery care?

Midwives are experts in normal childbirth. The focus of midwifery care is to promote a healthy pregnancy, labour, birth and newborn. Attention is given to prevention of complications and to early diagnosis of potential problems and appropriate intervention to prevent problems from worsening whenever possible. By the time a woman who is cared for by a midwife goes into labour, she has had 9 months of comprehensive care in which she has learned about the processes of labour and birth and has come to a greater understanding of her own body. Through this approach, most midwife attended births are accomplished without intervention and with the woman feeling confident of her own body's abilities.

Midwives have standards that guide our practice in providing care and directing when it is appropriate to consult or transfer care to a physician. Midwives may consult with each other for unusual situations. When a woman is no longer within the parameters of 'normal' either a family practitioner or an obstetrician is consulted. If it is appropriate for care to be transferred to a physician, the midwife will continue to attend the woman in a supportive role.

Midwives provide 24 hour 'on-call' care. Midwives use comfort measures to reduce the need for invasive medical methods of pain relief during birth/birth. However, sometimes the use of technology and drugs are necessary. Such interventions are accessible to midwifery clients when needed or wanted.

Midwifery care is based on the following beliefs:

- Pregnancy, labour and birth are normal physiological processes that requires physical, emotional and social adaptations by the woman and her family
- Midwives are trained to recognise deviations from normal, while at the same time protecting and respecting normal pregnancy, labour and birth.
- Enhancement of the family's sense of responsibility for their own healthcare is an important aspect of the professional relationship. Midwives promote decision making as a shared responsibility between the woman, her family and her caregiver, but the woman is recognised as the primary decision-maker. She is encouraged to actively participate in and make choices about the manner in which her care is provided throughout her pregnancy, birth and post-partum experience. Midwifery care includes education and counselling which enable a woman to make informed choices about her care, and where, how and with whom she will give birth
- Fundamental to midwifery care is the understanding that a woman's caregiver will respect and support her so that she may give birth with power and dignity. Continuity of care is an important aspect of midwifery. This is accomplished by the presence of known and trusted caregiver

Midwives provide care throughout pregnancy, labour, birth and the first 6 weeks postpartum

Prenatal appointments

A woman can expect to see a midwife about once per month until 8 months, twice a month during the 8th month and thereafter weekly until the birth. At each appointment we will assess your baby's growth, your general health and discuss issues such as diet, relief of pregnancy discomforts, work adjustment, preparation for breastfeeding etc. During these visits you will have an opportunity to discuss any questions or concerns you may have. Appointments are approximately 30 mins long.

***Please note:** due to the unpredictable nature of labour and birth, there may be rare occasions when your clinic appointment will have to be rescheduled at very short notice.

Labour, Birth and Follow-up care

Early labour: Please call your midwife when you think your labour has started. Depending on your individual circumstances, we will arrange to assess you at an appropriate time and place. Even if you have chosen a hospital birth, early labour happens at home.

Active labour and birth: the midwife will provide you with continuous care, support and assessment during the

active phase of labour and birth. If you have chosen a home birth, a backup midwife will be called close to the time of birth. If you choose a hospital birth, you will stay at home until you and your midwife decide it is time to leave for the hospital. In hospital, your midwife will continue to provide one-to-one support and will stay with you and deliver your baby. Regardless of your place of birth, your midwife will be with you for the birth and for a couple of hours afterwards. Midwifery clients who have a normal vaginal birth in hospital have an option of going home a few hours following the birth or staying for a day or two depending on individual circumstances and preferences.

Postpartum Care: regardless of where the birth takes place, we strongly encourage you to plan to have practical support available at home. Your midwife will visit you in your home for the first week after your baby is born, to provide support and assistance with breastfeeding.

After the first week, appointments are scheduled in the office at one to two week intervals. After 6 weeks a final assessment is done and a copy of your medical records is sent to your family physician for any further care.

Pap tests can be done in the midwives office at any time according to your wishes.

What if complications develop?

The vast majority of the births we attend involve healthy mothers and babies and are uncomplicated, spontaneous vaginal births. Complications can occur in any birth, regardless of the site or caregiver. If a complication develops, we will discuss choices, consult with an obstetrician and, if necessary, transfer your care to a specialist. If possible, we will continue with shared care. If you are later in your pregnancy and a transfer of care is required your midwife will stay involved in a supportive role.

Midwives are trained and skilled in detecting deviations from the normal in both mother and baby, and in those situations, we refer to an appropriate physician. We are thoroughly trained and prepared to use emergency measures when necessary.

The Client's role and responsibility

The midwife-client relationship is based on mutual trust and respect. We will respect and facilitate your choices, but we ask our clients to recognise and respect our professional guidelines as set out by the College of Midwives of British Columbia (CMBC). These guidelines have been made to facilitate safe care for you and your baby.

We request that all our clients actively participate in decision making about their care. We expect our clients to do their best to maintain good health during their pregnancies. A balanced diet, plenty of fluids, adequate rest, relaxation, exercise (and complimentary therapies) all contribute to healthy pregnancies. We endeavour to provide clients with reading & information appropriate to the stage of pregnancy, as the pregnancy progresses.

We ask that parents acquire knowledge and skills necessary for labour, birth and early parenting. We are able to supply information about organized prenatal classes in your area. Clients must also make plans to have support for the first couple of weeks following the birth.

Midwifery care is individualized according to the needs and circumstances of our clients. It is important for you to make us aware of your expectations and lifestyle. In order to be effective as your primary caregiver, we require that you keep us well informed about problems or situations that may affect your care.

We are pleased and honoured to share this special and very memorable time in your life with you

When to Contact your Midwife

For all **NON-URGENT** concerns, please leave a message at the office **384 5940**

For all **URGENT** concerns **DO NOT GO TO THE HOSPITAL**, please contact your midwife:

KIM

216-2823

You need to contact your midwife without delay if you experience any of the following:

- Vaginal bleeding
- Abdominal pain
- Fever of 38 C or greater (not easily reduced without the use of medication)
- Leaking or sudden gush of fluid from the vagina
- Persistent nausea and vomiting
- Severe persistent headache, visual disturbance and/ or dizziness
- Notable decrease in or the absence of fetal movements
- Pain, burning or urgency with urination (or other signs of a UTI or kidney pain)
- Signs of labour or suspected signs of labour prior to 37 weeks, such as menstrual-like cramps, low dull backache (often also menstrual like), marked increase in vaginal discharge, abdominal pain or contractions
- Pain, redness or swelling in one or both legs
- With anything that you are seriously worried/ concerned about
- And of course, when you go into labour at term (37 to 42 weeks)...& you are experiencing regular, consistent & increasingly painful contractions and you are ready to speak with a midwife

Reading List for Pregnancy & Childbirth

Nutrition

*Anne Lindsay's New Light Cooking	Lindsay A
Nourishing your Unborn Child	Williams
The Whole Grains Cookbook	Rich D
*The New Laurel's Kitchen	Robertson L et al

Pregnancy – Childbirth Preparation

Precious Lives, Painful Choice– a prenatal decision-making guide	Ilse S
The Tentative Pregnancy	Rothman B K
Birthing from Within	England P & Horowitz R
Childbirth without Fear	Dick-Read G
The Pregnancy Book	Sears W & Sears M
*Pregnancy and Birth: The Best Evidence	Barrett J & Pitman T
*The Complete Book of Pregnancy & Childbirth	Kitzinger S
*The Birth Partner	Simkin P
The Birth Book	Sears W & Sears M
Labor Support Guide	Simkin P
*Pregnancy, Childbirth & the Newborn	Simkin P
*A Child is Born	Nilsson L
*Giving Birth: How it really feels	Kitzinger S
*Being Born	Kitzinger S
*Pregnant Fathers	Heinowitz
*Active Birth	Balaskas J
The Water Birth Book	Balaskas J
The Waterbirth Handbook	Lichy, Roger & Herzber
Baby's Best Chance (ask for your free copy at our office)	BC Ministry of Health
Pregnancy and Childbirth Tips	Dahl G
Visualisation for an Easier Childbirth	Jones C
What to expect When your Partner is Expanding	Hill T
Ina May's Guide to Childbirth	Gaskin I M
After the Baby's Birth	Robert Lim

Sexuality

Making love during pregnancy	Bing E & Coleman L
*A Woman's Experience of Sex	Kitzinger S

Unexpected events of pregnancy and birth

Caesarean Birth Experience	Donovan
Premature Labour Handbook	Henning Robertson
The premature Baby Book	Harrison H
*The truth about Herpes	Sacks S
*Kangaroo Care	Ludington-Ho

Breastfeeding

Dr Jack Newman's Guide to Breastfeeding	Newman J & Pitman T
The Nursing Mother's Companion	Higgins K
*Breastfeeding your Baby	Kitzinger S
*Bestfeeding: Getting Breastfeeding Right for you	Renfrew, Fisher & Arms
*Womanly Art of Breastfeeding	La Leche League

Sibling Preparation

*Mom and Dad and I are having a Baby	Maleki
*Welcoming your second baby	Lansky V
*Facts of Life	Miller

Postpartum

*The Year after Childbirth	Kitzinger S
*Mothering the New Mother: Your postpartum Resource Companion	Plackson S
*Postpartum Survival Guide	Dunnewold
Postpartum Depression	Roan S

Parenting

The Baby Book	Sears J et al
*Nighttime Parenting	Sears W
*The Fussy Baby	Sears W
The no-cry sleep solution	Pantley E
*The Book of Baby Massage	Walker P
The Happiest Baby on the Block	Karp H
The Family Bed	Thevinen T
*Infants and Mothers	Brazelton B
*The Earliest Relationship	Brazelton B
*Working and caring	Brazelton B
*The book of baby massage	Walker P
*Your amazing newborn	Klaus M & Klaus P
*The Secret Language of your Child	Lewis
Women as mothers	Kitzinger S
Your Baby and Child: Birth to age five	Leach P
Healthy sleep habits – Happy Baby	Weissbluth M
Super Immunity for kids	Galland L
Vaccine Guide	Neustaedter R
What your doctor may not tell you about Children's Vaccinations	Cave S

*Available at the Greater Victoria Library

Other Useful Resources:

Maternity & Parental Benefits	www.hrsdc.gc.ca/en/ei/types/special.shtml
Jack Newman's Breastfeeding Handouts	www.bfirc.com/newman/articles.htm
KellyMom: Breastfeeding & Parenting Information	www.kellymom.com
Motherisk (1 800 436 8477): Relief from nausea & vomiting	www.motherisk.org
Welcome to the Parent Soup	http://parentsoup.com
La Leche League International	www.la lecheleague.org
Health Files, BC Ministry of Health	www.hlth.gov.bc.ca
Kidsource	www.kidsource.com
Kids In Victoria	www.kidsinvictoria.com
Circumcision Information for parents	www.cirp.org/

Resources In Victoria

* Please see additional information resources in 'Babies Best Chance' (p140)
We can also recommend local physios, chiropractors & acupuncturists as needed

Childbirth Preparation Classes

- Birth & Beyond (private classes only) www.birthandbeyond.ca 889 6009
- Mothering Touch Centre (Childbirth Preparation for Midwifery Clients) 595 4905
- YMCA – Laura Warren, Emma Dooley 386 7511
- Camosun College 592 1556
- Queen Alexandra 721 6751
- Island Childbirth Education www.islandChildbirth.com 889 2760
- HypnoBirthing - Childbirth Classes with Moira Campbell 361 4155

Prenatal Fitness

- Shannon Christmas (Registered physiotherapist) 881 1199
- Functional fitness & personal training 858 7972

Doula Services (*speak with Heather at our office or visit www.DoulasofVictoria.ca)

- Mothering Touch Centre 595 4905
- Birthpoint Doula & Acupuncture Group 361 4340 / 383 2626
- Island Childbirth Education www.islandChildbirth.com 889 2760
- Birth & Beyond Doula Services www.birthandbeyond.ca 889 6009

PostPartum (Visit www.doulasofvictoria.ca)

- Post Partum Support Program (Tracy McGee) 885 6760
- Bereavement Program (Joan Wale) 598 5791
- La Leche League 727 4384
- Living and Learning with your Baby 721 6751
- Postpartum Health for Moms (#102-4420 Chatterton Way) 881 1199

Mental Health & Addiction Services

- Quadra Street Clinic (2nd floor – 1250 Quadra St) 727 3544
- Pacific Centre (3221 Heatherbell Rd) 478 8357
- Cool Aid Community Health Centre (465 Swift St) 385 1466
- Salt Spring Island Community Services Society (268 Fulford-Ganges Rd) 537 9971
- Native Friendship Centre (610 Johnson St) 384 3211
- Victoria Youth Clinic (ages 12 – 24 yrs) 388 7841
- Catching Our Breath (help to quit smoking) -contact local Public Health Unit (see below)

Best Babies Programs

(Support programs for expectant and new parents)

- Esquimalt 385 2635
- Victoria 385 8979
- Peninsula 656 0134
- First Nations Best Babies 384 3211

Neighbourhood Family Resource Centres

(Resources and support programs)

- Blanshard Community Centre (901 Kings Rd) 388 7696
- Burnside Gorge Community Place (3130 Jutland Rd) 388 5251
- Esquimalt Neighbourhood House (511 Constance Ave) 385 2635
- Fairfield Community Place (1335 Thurlow Rd) 382 4604
- Fernwood Community Centre (1240 Gladstone St) 381 1552
- Goldstream Neighbourhood House (555 Goldstream Av) 478 1122
- James Bay Community Project (435 Simcoe St) 361 9757
- Sooke Family Resource (P.O. Box 1082, Sooke) 642 5152
- Western Saanich Community Place (3170 Tillicum Rd) 479 4633

Military Family Resource Centre www.esquimaltmfrc.com (Support, resources and programs for military families in Victoria)	1 800 353 3329
MFRC 24 hour Information Line	363 2640
Native Friendship Centre www.vnfc.ca (resources including prenatal classes & care, parenting support & workshops, activities for children & youth)	384 3211
Public Health Units	
Support & education from public health nurses. Services include breastfeeding support, breastfeeding clinic, postpartum depression support, mother & baby groups, immunization clinics & more.....	
• Esquimalt	360 5600
• Western Communities	478 1757
• Peninsula	544 2400
• Saanich	744 5100
• Salt Spring Island	538 4880
• Sooke	642 1600
• Victoria	388 2200
Breastfeeding Counsellors	
• Heather Minielly (Birth & Beyond)	889 6009
• Mothering Touch Centre	595 4905
• Heather McCue (Island Childbirth)	889 2760
• Dr J Wickens (IBCLC)	479 6721
Yoga	
• Helga Beer	370 0464
• Florance Simpson	595 4905
• Moksana	385 2105
• Victoria Yoga Centre	386 9642
• Linda Cirella	472 1645
• YM-YWCA	386 7511
Dancing	
• Belly Dancing (Carol Sokoloff)	361 9941
• Birth Dancing (Florance Simpson)	595 4905
Parenting	
• Raising Parents - Linda (www.raisingparents.net)	386 2042
• Baby Group – James Bay Community Project	388 7844
• Living and Learning with your baby	721 6751
Miscellaneous:	
• Celebrating Pregnancy Birth Art Classes (Florance Simpson)	595 4905
• Child Seat Inspection Clinic	1 877 247 5551
• Best Hand Breast Pumps; Medela (Mothering Touch)	1 800 542 8368
• Avent (London Drugs, Toys R Us), Avent Breast Pump repairs & replacements	
• Electric Breast Pump rental; Mothering Touch – 595 4905 or Carol Arndt – 642 4846	

Employment Insurance (EI) and maternity, parental and sickness benefits

*For more information please call **1 800 206-7218** from 8:30 am to 4:30 pm and press "0" to speak to a representative or contact your local [Service Canada Centre](#). Alternatively visit www.hrsdc.gc.ca/en/ei/types/special.shtml

Who is eligible?

To be entitled to maternity, parental or sickness benefits you must show that:

- your regular weekly earnings [have been decreased by more than 40%](#); and
- you have accumulated 600 insured hours in the last 52 weeks or since your last claim. This period is called the [qualifying period](#).

If you have been paid EI benefits in the past and you received a written notice, for example, a warning letter or a penalty letter, for making a false statement, the required number of hours worked to claim maternity, parental and sickness benefits will be higher.

Qualifying period

The qualifying period is the shorter of:

- the 52 week-period immediately before the start date of a claim, or
- the period since the start of a previous EI claim if that claim had started during the 52 week-period.

In certain situations, the qualifying period may be extended up to 104 weeks.

How, where and when to apply

To receive maternity, parental or sickness benefits you must submit an [EI application on-line](#) or in person to your [Service Canada Centre](#). You should apply as soon as you stop working, even if you receive or will receive money when you become unemployed.

You must request your Record of Employment (ROE) from your last employer. If you have your ROE from your last employer, apply immediately. If you did not receive your last ROE, submit your application along with proof of employment — for example, pay stubs. If one or more ROE covering periods prior to your last employment are missing, you must still submit your claim for benefits.

At the same time you are applying for maternity benefits, you and your partner can also apply for parental benefits.

How long can you receive maternity, parental or sickness benefits?

A **combination** of maternity, parental and sickness benefits can be received up to a combined maximum of **50 weeks**.

You have received sickness benefits before or after your maternity benefits!

You could receive up to a maximum of 65 weeks of combined sickness, maternity and parental benefits instead of the normal combined maximum of 50 weeks. In order to be eligible for the increased number of weeks, the following conditions must be met **during your benefit period**:

- you have not been paid regular or fishing benefits;
- you have been paid [sickness](#), [maternity](#) and [parental](#) benefits; and
- you have been paid less than the maximum of 15 weeks of sickness benefits or less than 35 weeks of parental benefits.

How much will you receive? (as of June 2006)

The basic benefit rate is 55% of your **average insured earnings** up to a **maximum amount of \$413 per week**. Your EI payment is a taxable income, meaning federal and provincial or territorial taxes, if it applies, will be deducted from your payment. You could receive a higher benefit rate if you are in a low-income family — net income up to a maximum of \$25,921 per year — with children and you or your spouse receive [the Canada Child Tax Benefit \(CCTB\)](#), you are entitled to [the Family Supplement](#).

Maternity benefits

Maternity benefits are payable to the birth mother or surrogate mother for a maximum of **15 weeks**. To receive maternity benefits you are required to have worked for **600 hours** in [the last 52 weeks or since your last claim](#). The mother can start collecting maternity benefits either up to 8 weeks before she is expected to give birth or at the week she gives birth. Maternity benefits can be collected within 17 weeks of the actual or expected week of birth, **whichever is later**. Please note that the date you file your claim is very important in order for you to receive the maximum maternity benefits you are entitled to. If you are unsure about your most advantageous maternity period to receive maximum benefits, please talk to one of our service agents (see above). If the actual date of birth is different from the expected date of birth, it is very important that you provide this date as soon as possible after the birth of your child. **If your baby is hospitalized**, then the 17 week limit can be extended for every week your child is in the hospital up to 52 weeks. You will still receive benefits for a maximum of 15 weeks, but payments can be delayed until your child comes home.

Parental benefits

Parental benefits are payable either to the biological or adoptive parents while they are caring for a newborn or an adopted child, up to a maximum of **35 weeks**. To receive parental benefits you are required to have worked for **600 hours** in [the last 52 weeks or since your last claim](#).

Parental benefits can be claimed by one parent or shared between the two partners but will not exceed a combined maximum of 35 weeks. Parental benefits for biological parents and their partners are payable from the child's birth date, and for adoptive parents and their partners from the date the child is placed with you.

When determining how you and your partner want to take advantage of your parental leave **several choices can be made**, here are some examples:

Example 1

You and your partner are sharing parental benefits, you can take the time together, the 35 weeks would be shared between the two of you.

Example 2

You may want to go back to work after your maternity leave is finished and let your partner take the full 35 weeks.

Example 3

You may only want to take a few weeks of parental benefits and then return to work, while your partner takes the remaining time choice.

Example 4

You may decide to go back to work after you have taken a couple of weeks of parental leave. Then, a few weeks later you realize you would like to be home with your child. You can still use the weeks of parental benefits you have left as long as the weeks you take do not exceed the 52 weeks since your child's birth or placement with you for adoption.

Miscarriage – What to do if you start bleeding!

About one out of every six pregnant women miscarry (also called a spontaneous abortion). Usually this happens because the pregnancy is not growing or developing properly. There is nothing you can do to prevent this kind of miscarriage. There are a few rare kinds of miscarriage, such as subchorionic haematoma (a blood clot under the placenta) or incompetent cervix (where the cervix gradually opens too early) which sometimes can be treated successfully with bed rest, and for an incompetent cervix, with a special stitch put in by an obstetrician. Most of the time, it doesn't matter what you do: a healthy pregnancy will stay inside you and grow.

The first sign of a miscarriage is usually bleeding with cramps. In normal pregnancies one can also have some bleeding and cramps so don't panic if this happens to you. You don't need to go to bed or to Emergency but take it easy until you talk to your midwife. Usually we suggest that you do no heavy work and do not have sex until you can be examined and have an ultrasound to find out what is going on. After the examination and ultrasound, you will find out from your midwife one of three things. You may have a perfectly normal pregnancy and may go back to your usual activities. You may have a rare condition which needs bed rest and special treatments, or you may be miscarrying.

If you are miscarrying because the pregnancy is not growing properly, there is nothing you can do to stop it. Miscarriage is a natural process and is rarely dangerous. Most women will start with a little bleeding and a few cramps. This bleeding will get heavier than a period and the cramps may get severe. A hot water bottle will help. You may take acetaminophen (Tylenol) or ibuprofen (Advil) for the pain or your doctor may prescribe a stronger painkiller. The bleeding may include big dark red blood clots and then you may see the pregnancy tissue, which is usually pink or greyish. Once the pregnancy tissue has passed, the cramps will go away and you will feel better. After that, you will bleed like a normal period. Your next period may be a bit late.

Some women may need to go to the hospital for a D&C (dilation and curettage). This includes having an anaesthetic and having the uterus emptied with a suction machine. This is necessary if the bleeding is too heavy for too long, the pain cannot be controlled or if you have signs of infection.

Call your midwife or go to the hospital if.....

1. You are soaking more than 2 pads per hour for more than 3 hours.
2. Hot water bottles and painkillers are not working and the pain is more than you can handle.
3. Your temperature is more than 38 degrees Celsius or 101 degrees Fahrenheit for 2 readings half an hour apart.

Having a miscarriage is a sad, upsetting experience. Share your feelings with your partner, family or friends. Discuss any concerns and plans for future pregnancies with your midwives.

Dr. Ellen Wiebe

Screening Tests for You & Your baby

Early in the pregnancy you will be offered a number of tests. The purpose of these tests is to check whether you have any conditions or infections that could affect you or your baby's health. You do not have to have a particular test if you do not want it, however, the information these tests can provide may help us provide the best care possible during your pregnancy and birth. The test results may also help you to make choices during pregnancy. It is important to let us know if you think you have been exposed to any infection. Further information on many of these tests can be found in 'Babies Best Chance'

NOTE: HIV, Syphilis, Chlamydia, Gonorrhoea, Herpes, Hepatitis & Rubella are all *reportable* diseases in BC which means that if you have a positive result, the laboratory automatically informs the Public Health office so they can track & record the treatment of these conditions.

Early Pregnancy – tests for the mother

We offer screening tests for;

1. Anaemia
2. Blood group and Rhesus (Rh) status
3. Rubella immunity
4. Hep B
5. Asymptomatic bacteriuria
6. HIV
7. Syphilis
8. Chlamydia
9. Gonorrhoea
10. Herpes simplex
11. Cervical pap smear

Additional screening tests we may offer (depending on individual case history);

1. Ferritin and B12
2. Hep C
3. Toxoplasmosis
4. Chickenpox
5. Bacterial vaginosis
6. Parvovirus

WHAT IS MATERNAL SERUM SCREENING?

The Maternal Serum Screen (MSS) is an optional blood test that is available to all pregnant women in British Columbia. This test, which poses no risk to the pregnancy, estimates a woman's chance of having a baby with Down Syndrome, Spina bifida and Edwards syndrome (trisomy 18). It is very important to understand that this screening test is NOT a diagnostic test, and can only indicate if a pregnancy is at a greater or lesser risk of the above conditions. Women who are found to be at increased risk are offered further diagnostic testing such as detailed ultrasound examination and/or amniocentesis.

Not all affected pregnancies are detected by the MSS. The screen can detect approximately 75% of cases of Down syndrome, 85% of Open spina bifida and 60% of Edwards's syndrome.

How and when is the test done?

The MSS is a blood test that can ONLY be done between 15 and 20 weeks of pregnancy. The test measures the levels of 3 proteins: alpha-fetoprotein (AFP), unconjugated estriol (uE3), and human chorionic gonadotropin (hCG). These are made by the baby or the placenta, and are measured in the expectant mothers blood. The levels of these proteins are different in some pregnancies affected with Down syndrome, Open spina bifida or Trisomy 18. These protein levels in combination with maternal age, weight and other factors are used to estimate the risk in each pregnancy.

What does a 'negative' result mean?

Negative results ('below the screen cut off') are reassuring. These results indicate that the baby's chance of having Down syndrome, Open spina bifida or Edward's syndrome is low. A negative result is correct over 99% of the time, however, the chance that the baby is affected is not zero. In this situation, further diagnostic testing by amniocentesis would not be offered unless a woman is already eligible for amniocentesis based on age alone (age 35 or over). This is because the chance that the baby is affected is lower than the risk of pregnancy loss associated with the amniocentesis procedure itself.

What comes after a 'positive' result?

About 8-10% of all women who have MSS will have a 'positive' result or in other words a result which is above the screen cut off. Even with a 'positive' screening result, most fetuses do not have a problem. It simply means that the chance for Down syndrome, Open spina bifida or Edward's syndrome is increased to a level which is sufficient to offer further testing (detailed ultrasound and/or amniocentesis). The vast majority of women who have a positive MSS result have healthy, unaffected babies.

How and when are results available?

Results are usually available within 7-10 days. All results above the screen cut off (positive) are telephoned to the midwife's office for discussion. Accurate pregnancy dating is essential for this test, so a dating ultrasound is sometimes recommended before further follow-up. Options for follow up include genetic counselling to review the results and discuss further testing options and diagnostic testing (such as detailed ultrasound and/ or amniocentesis). Results below the screen cut off are sent by mail to the midwifery office and the result given to you as soon as possible by telephone.

Maternal Serum Screening (MSS) – Key points!

1. The test is offered to all women
2. The test is performed at 15-20 weeks of pregnancy
3. Maternal blood sample is used for the test
4. If the screen result is 'positive' follow up would include genetic counselling & the option of further testing by detailed U/S and amniocentesis
5. If dates are uncertain, a dating U/S performed early in the pregnancy can reduce false positives from 8 to 4%
6. Women who will be 35 years of age at delivery can forego maternal serum screening as they can choose to go directly for amniocentesis if they wish

Advantages of MSS

1. A negative result may offer some reassurance
2. It may help in decision making. For example, if Open spina bifida is detected before birth, health care professionals can provide parents with information and support. They can plan for delivery in a specially equipped medical centre so that the baby can have any necessary surgery or treatment soon after birth.

Limitations

1. MSS only screens for 3 things (Down syndrome, Edwards syndrome and neural tube defects only) and does not pick up every baby with those problems
2. Results take about 7-10 days to come back. This is an anxious time for many parents
3. About 8-10% of all women get 'positive' results, however only 2-4% of all positives are true positives. Most women with a 'screen positive' result have normal babies
4. A negative result does not guarantee that everything is alright with the baby
5. Even if disability is confirmed by a diagnostic test (amniocentesis), it does not measure the degree to which the baby is affected
6. Advanced maternal age also increases the risk for chromosomal abnormalities other than Down's syndrome. There is no way of screening for all of these conditions.

Important questions to consider before choosing to have this screening test

(See Appendices 1 & 2)

1. How do you feel about having a baby with a disability such as Down Syndrome, Spina bifida or Edward's Syndrome?
2. Would you want the type of information that this screening test can provide?
3. If the result is 'above the screen cut-off' ('positive'), amniocentesis is an option. This test has a miscarriage risk of 1 in 200 (0.5 %). Would this be an acceptable option for you?
4. Consider whether knowing about a birth defect would change your medical, birthing or parenting plans. Would you consider termination if your baby had one of these problems?

What is Down Syndrome? (Trisomy 21)

Down syndrome is a condition caused by the presence of an extra chromosome. It is one of the most common genetic birth defects, affecting approximately 1 in 800 to 1000 babies. It can be hereditary or accidental. Down syndrome is a common cause of learning difficulty and is often associated characteristic facial features and certain medical problems. About 40-50% of affected individuals have congenital cardiac problems, and there is risk of ophthalmic (eye) and hearing impairment as well as thyroid and gastrointestinal problems. Life expectancy is sometimes reduced, however, many adults with this condition are now living into their 50's and 60's. The degree of learning difficulties is variable. There is no way to predict how serious any of the disabilities will be.

Children with Down syndrome usually can do most things that any young child can do, such as walking, talking, dressing and being toilet-trained. However, they generally start learning these things later than other children. However, the outlook for these children is far brighter than it once was. Today, an increasing number of adults with Down syndrome live semi-independently in community group homes where they take care of themselves, participate in household chores, develop friendships, partake in leisure activities and work in their communities.

Any woman at any age can have a baby with Down syndrome. However, the chance is higher the older the woman is. A woman who is 40 has a much higher chance of having a baby with Down syndrome than a woman who is 20. However, since most women have their babies between 20 and 30, most babies with Down syndrome are born to younger women.

What is Edwards's syndrome? (Trisomy 18)

This is a rare disorder caused by an extra chromosome at the 18th pair. Like trisomy 21 (Down syndrome), trisomy 18 affects all systems of the body and causes distinct facial features. It is estimated to occur in 1 in 6000 – 8000 live births. Most babies (95%) die before birth. Babies with this condition have severe mental disability and major physical problems and require skilled medical care. Infants have a 5% chance of surviving to age 1 year.

What is open Spina bifida?

This occurs when there is an opening in the spine which can cause nerve damage. Spina Bifida affects 1 in every 2000 live births each year in the US. It occurs more frequently among Hispanics and whites of European extraction and less commonly among Ashkenazi Jews, most Asian ethnic groups and African-Americans.

Spina bifida varies in severity and in the level of disability. There is no way to predict exactly how serious these problems will be. This can range from individuals that lead full and active lives to individuals with physical disability which can include weakness or paralysis of the legs, incontinence and hydrocephaly (fluid on the brain) which can cause mental retardation.

With treatment, children with spina bifida can usually become active individuals. At least 70% of children with spina bifida have normal intelligence, although some do have learning difficulties. A baby with the most severe form of spina bifida, usually requires surgery within 24 to 48 hours after birth to tuck exposed nerves and spinal cord back inside the spinal canal and cover them with muscle and skin. Prompt surgery helps prevent additional nerve damage from infection or trauma.

There appears to be a hereditary factor and an increased risk for women who have had a previously affected pregnancy. However, 95% of babies born with spina bifida and other Neural tube defects are born to parents with no family history of these disorders. There is also a possible increased risk for women who take anti-epileptic medications. The chance does not depend on the age of the mother. Ensuring adequate folic acid intake before and during early pregnancy is hugely protective.

Prenatal Diagnostic Tests

Diagnostic testing may be offered to you (all are optional) to see if your baby has a birth defect.

Who is offered diagnostic testing?

- Women of advanced maternal age. This is considered to be pregnant women who will be 35 years or older at the time of delivery. However, in twin pregnancies, amniocentesis will be offered to women who are or will be 32 years or older at the time of delivery.
- Couples who have received a positive maternal serum screening result
- If this pregnancy was initiated by intracytoplasmic sperm injection (ICSI)
- Couples in which either person has had;
 - Another child or stillbirth with a chromosome abnormality
 - Another child with a neural tube defect such as spina bifida or anencephaly, or a close relative (brother, sister, niece or nephew) with a neural tube defect
 - Another child with a known or suspected genetic disorder, birth defect or developmental delay
- Couples in which an ultrasound test has shown a problem in this pregnancy
- Couples in which either person is known to have a chromosome rearrangement
- Couples in which one or both partners have a known or suspected genetic disease or birth defect
- Couples in which both partners are carriers of a genetic disorder, for example
 - Thalassaemia (more common in Mediterranean, Asian and East Indian populations)
 - Tay Sachs (more common in the Ashkenazi Jewish population)
 - Sickle cell anaemia (more common in the Black population)
 - Cystic fibrosis (more common in the Caucasian population)
- Women who have been exposed during pregnancy to certain drugs or other chemicals that may cause birth defects. This exposure could include women who have taken Accutane (acne drug) or those who have used cocaine or alcohol heavily during pregnancy
- Family history of known or suspected genetic disorders, for example; Duchenne Muscular Dystrophy, Haemophilia, Myotonic Dystrophy or Fragile X syndrome

What tests are used?

- Chorionic villus sampling (CVS) (not available in Victoria)
- Amniocentesis
- Detailed ultrasound

What is chorionic villus sampling? *(not available in Victoria)*

This is a newer alternative to amniocentesis for prenatal diagnosis. Chorionic villi form a tissue surrounding the amniotic sac and form the placenta.

CVS can be done as early as 10 weeks of pregnancy. The procedure involves inserting a narrow plastic tube through the vagina and cervix (done at 10 – 12 weeks) or by inserting a slender needle through the abdominal wall (done at 10 weeks to term). As with amniocentesis, ultrasound is used to guide the catheter during the test. A small sample of placental tissue is then removed by gentle suction. The tissue is grown in the laboratory and examined under the microscope. Final results take approximately 2 – 3 weeks.

Advantages

- CVS can detect chromosome abnormalities
- As with amniocentesis, if there is a family history of a known problem, other special tests may be done on the sample, however these have to be arranged in advance

Disadvantages

- CVS cannot detect neural tube defects. Further testing with detailed ultrasound and MSS are offered for this
- Mild problems including cramp and spotting happen occasionally. Vaginal spotting (bleeding) is more common after Tran cervical CVS tests and is usually not serious
- Approximately 1 in every 100 women who have CVS will have a miscarriage due to the procedure
- There is a possible increased risk of limb abnormalities in the baby following CVS (a rise from 6 per 10,000 births (no CVS) to a risk of 9 per 10,000 births after CVS).
- CVS results are sometimes difficult to understand. In such cases, an amniocentesis test is usually offered to clarify the results.

What is Amniocentesis?

Amniocentesis is the most common test used for diagnosing a chromosome problem with the baby. It involves removing a small amount of the fluid which surrounds the baby in the amniotic sac. The test is relatively painless and is usually done after 15 weeks of pregnancy.

How is it done?

Amniocentesis is performed by an experienced obstetrician in a hospital on an outpatient basis. It involves inserting a needle through the mother's abdomen (not through the navel) into the amniotic sac to take some of the fluid which surrounds the baby. Ultrasound is used to locate the baby and placenta. With the ultrasound picture on the screen, the specialist finds the safest and easiest place to insert the needle. The needle is then carefully guided to the selected spot and a small sample of fluid is slowly withdrawn through the needle. The fluid sample holds cells, which the baby has shed, from its skin and bladder. These cells are grown in the lab and then examined under a microscope. It takes 2 to 3 weeks before the results are available.

Advantages

- It is a diagnostic test. It can detect Down syndrome and other major chromosome abnormalities as well as Spina bifida.
- If there is a family history of a known problem, other special tests may be done on the sample, however these have to be arranged in advance
- It is considered a safe test for the mother

Disadvantages

- Although not usually serious, mild problems including cramping, bleeding and slight leakage of amniotic fluid happen occasionally in the mother
- Although rare, there is a risk of injury to the baby
- Approximately 1 or 2 women in every 200 (0.5 – 1%) will have a miscarriage caused by the procedure

What is ultrasound?

Ultrasound is helpful in giving important information about a pregnancy. It may be used early in a pregnancy (8-12 weeks) to find a normal heart beat, to identify twins or to predict the baby's due date. A detailed ultrasound can be done later in the pregnancy (18 weeks) to look for structural problems in the baby and to see if the baby is growing normally. Ultrasound is also used during amniocentesis and CVS (see below) to locate the baby and placenta during the tests.

What are the risks?

Ultrasound is not an x-ray. Long term follow up has shown no differences in growth or development between those children whose mothers had a prenatal ultrasound and those who did not.

Diet

*Please see 'Babies Best Chance' pages 36 – 43 for additional information including Food Safety

*If you are on a tight budget, please let us know – there are community resources to help you

A Healthy Pregnancy Diet

Work out your ideal weight gain for this pregnancy!

Body Mass Index (BMI) = prepregnant weight in kgs/ Metres in height squared

	BMI	Recommended wgt gain in Pregnancy
Underweight	< 20.0 kg/m ²	28 – 40 lbs
Normal	20.0 – 25.0	25 - 35
Overweight	>27	15 - 25
Obese	> 30.0	≤ 13

Every day you should have;

- 2 – 4 fruits
- 3 – 5 vegetables (including dark green/ deep orange vegetable)
- 4 – 5 low fat dairy products
- 3 servings of meat or meat alternatives
- 6 – 11 whole/ enriched grain products

*Recommended daily dose of folic acid is 400mcg from preconception until 12 weeks gestation

Remember

1. Eat small frequent, nutrient rich meals
2. Home cooked meals are best
3. Eat fresh foods as much as possible & don't overcook
4. Eat recommended 'safe' fish twice a week
5. Eat yellow/ orange coloured vegetables 5 times a week
6. Sweeteners such as saccharin & cyclamates are not recommended during pregnancy & lactation...always read the label
7. Drink tea or coffee between meals & not with meals (try to limit both)
8. Cigarette smoking reduces absorption of nutrients (as well as other risks to the baby)
9. Vegetable sources of iron need a little help to be well absorbed. This can be done by eating meat, fish or poultry at the same time as you eat your iron rich vegetables
10. Vegetarians need more iron foods in their diets. Eating a food rich in Vit C (see below) at each meal helps.
11. Calcium and Iron supplements should be taken at separate times of the day
12. Use butter or oil in small quantities
13. Drink 8 – 10 glasses of water daily

Vegetarian Pregnancy Diet

In 'Becoming Vegetarian', Vesanta Melina (registered dietician) recommends that pregnant vegetarians consume each day;

- 5 – 12 servings of whole grains, such as bread, cereal, pasta or rice
- 5 – 10 servings of vegetables & fruit, including juice
- 3 – 4 servings of beans, and bean alternatives (including legumes, tofu, nuts, seeds, eggs)
- 6 – 8 servings of milk (1/2 cup) & milk alternatives such as tahini, almond butter, kale, collards, broccoli, blackstrap molasses
- 2 servings of omega-3 fatty acid sources, like walnuts, flax seeds or canola oil
- A reliable source of Vit B12. Lacto-ova vegetarians can have 3 cups of cow's milk, or 1 egg & 2 cups of milk. Vegans – 1 tbslp of nutritional yeast like 'Red Star', Also fortified soy and rice beverages or a daily B12 supplement
- Vit D fortified food (cow's milk, margarine and soy milk) or a supplement containing 2.5 to 10 mcg Vitamin D. 10 – 15 mins of daily sun exposure for a light skinned person, or 1/2 hour or more for someone with dark skin

Reference:

Vesanto M, Davis B & Harrison V (1994) Becoming Vegetarian MacMillan Canada

KEEPING BLOOD SUGAR LEVELS STEADY

Reasons for keeping blood sugar levels from getting too high during pregnancy include:

1. preventing your baby from being born excessively large
2. keeping your baby from having to make an adjustment from high to normal blood sugar levels after birth
3. avoiding being treated as a higher-risk patient
4. feeling better during your pregnancy

Blood sugar levels normally go up right after eating, drop several hours after eating, and drop further with exercise. The hormones of pregnancy can cause levels to fluctuate even more than usual. But by paying attention to what you eat, when you eat it, the amount of exercise you get, and a few more things, you can help keep blood sugar levels from getting too high, leading to greater health for you and your baby.

Here are some suggestions for doing this:

1. Eat small frequent meals. Five or six meals, spaced evenly through the day, help keep blood sugar constant. If possible, eat right before bed and right after getting up. Don't skip meals.
2. Especially if your midwife says you're growing a very big baby, don't eat more than you need. Talk with your midwife or nutritionist to figure out how much this is. For most pregnant women, aim for an average weight gain of about 7-10 pounds per trimester. Hopefully your appetite will help you to do this naturally, with help from regular exercise and a low-fat high-fiber diet. Pregnancy is not a time to severely restrict your food intake.
3. Eat healthy foods, low in fat, high in fiber, including lots of complex carbohydrates (whole grains and vegetables) protein foods (particularly beans and fish), and low-fat dairy foods. Limit sweets, including fruit juices and dried fruit. A diet containing 30-40 grams of fibre, with 20% or fewer of the calories coming from fat (for a total of 50 grams of fat or less) would be great.
4. Eat foods as whole and as raw as possible. Apple juice causes a greater blood sugar rise than applesauce, which causes a greater rise than a raw apple. Rice cooked until mushy causes a greater rise than when it's cooked only until chewy. Instant rice and instant potatoes cause an especially high rise.
5. Eat legumes (dried beans of all kinds, lentils, and peas) every day if possible. The kind of starch they have seems to be particularly effective in keeping blood sugar low and constant for a long time. If you

want to eat bread or potatoes or something sweet, do so with or after a serving of beans. Consider Mexican foods made with black beans, chilli with beans, lentil soups or patties, hummus, marinated beans in salads, or tofu in a stir-fry. If you need recipes, try a good **vegetarian cookbook such as The New Laurel's Kitchen** or a good basic cookbook such as Anne Lindsay's New Light Cooking. Remember that soy flour and tofu are bean products and may be added to other foods, including breads, desserts and salad dressings. Oats (including oatmeal and oat bran), barley and apples have a related kind of fibre, which is similarly useful.

6. In addition to these basics, there are a few otherwise-healthy carbohydrate foods, which, for reasons that are not completely understood, cause blood sugar to rise more than is desirable. These include wheat bread and crackers (both whole grain and white), most commercial breakfast cereals, potatoes and carrots. Eat these foods only in small quantities, or with a meal that contains beans, or try substituting these foods: rye bread; wheat bread with added wheat berries, oats, oat bran, soy, or seeds; pasta; buckwheat; bulgur; and sweet potatoes and yams.
7. Almost all other vegetables are fine (see chart on p), as are most fruits, especially cherries, citrus, peach, pear, and plum. New potatoes cause less of a blood sugar rise than large ones. Dairy is fine, especially if low fat. Cereals that are okay include ones with oat bran, wheat bran, or rice bran. Regular oatmeal and muesli are good. Special K is pretty good, but Cheerios, puffed cereals, and instant oatmeal are not. Popcorn is fine, if you don't add (much) butter.
8. Exercise every day. Exercise helps you take the sugar out of your blood and put it into your cells where it can be used, thus preventing high blood sugar. Twenty to thirty minutes of aerobic exercise (walking, swimming, dancing etc.) can help prevent high blood sugar for the next eight hours. Every time you climb the stairs instead of taking the elevator can contribute to this effect, so practice getting little bits of exercise all day long. Zinc, found in protein and dairy foods, whole grains, and nuts and seeds, is involved in all aspects of insulin metabolism. Chromium found in whole grains, particularly barley, and in brewer's yeast (but not nutritional or tortula yeast, which we often mistakenly call "brewer's yeast") is a part of the "gate" that works with insulin to put the glucose into cells. Lots of people seem to be deficient in both of these nutrients, so supplements (125 mg of zinc, 100-200 mcg of chromium) might be in order. Both are toxic in high doses, so don't take more than this, and keep them out of reach of children.
9. Several foods have particular components, which may help stabilize blood sugar. These include garlic, onions, and others in that family, eaten either raw or cooked, the Asian vegetable bitter melon, and fenugreek seeds.
10. Reduce stress. Take time every day to consciously relax, breathe, let yourself be quiet inside, and tune in to your body and your baby. Practicing relaxation is also excellent preparation for childbirth.

Don't be afraid to eat! We don't want your blood sugar to soar, but we don't want it at zero, either. As always, eating well is one of the most important ways that you can take care of yourself and your baby. Enjoy your food and appreciate it for all that it gives you.

Acknowledgement: Betsy Walker, Ph.D. 1997

HEALTHY EATING - Sample Day

Breakfast

Egg, cheese or peanut butter
 1 slice whole grain toast
 1/2 cup cereal (bran flakes, oatmeal, muesli)
 1 cup milk

Mid-Morning Snack

Choose 1 or 2 of these snacks

Small fresh fruit
 1 cup milk
 1/2 sandwich
 2 arrowroot or digestive biscuits
 1 slice whole grain toast and peanut butter
 cheese and 6 small or 3 large crackers (rice or other whole grain)

Lunch

Lentil or bean and rice soup
 Green salad
 1 cup milk
 small fresh fruit

Mid-Afternoon Snack

Select 1 or 2 items from mid-morning snack list

Dinner

Meat, fish or chicken
 1 small sweet potato or 1 cup cooked brown rice or whole wheat noodles
 raw or cooked vegetables
 small fresh fruit

Bedtime Snack

Choose one of these snacks:

1 cup of milk sandwich	or	1 cup of milk cheese crackers (12 small or 6 large)	or	1 cup of milk 1 cup of cereal (bran flakes, oatmeal, cream of rice, muesli)
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Good Food Sources of Nutrients

Protein: Alfalfa sprouts (contains 150% more protein than other grains), whole grains, legumes, nuts, yoghurt, avocados, cheese, eggs, whole milk, cottage cheese, meats, fish, poultry, tofu

Iron: Dark leafy greens, comfrey leaf, raisins, dried fruit & apricots, blackstrap molasses, wheat germ, oats, kelp, seeds, eggs, fish, red meat, yellow dock, parsley, dandelions, nettles

Calcium: Dark leafy greens, sesame seeds, almonds, sunflower seeds, cheese, yoghurt, milk, soybeans, watercress, raw beet juice, molasses, whole grains, alfalfa, nettles, eggs, dried fruit, parsley, dried sea kelp powder, tofu, nettle tea

Vit C: Rose hips, citrus fruits, dark leafy green vegetables, green peppers, cabbage, broccoli, tomatoes, alfalfa sprouts, cantaloupe, strawberries, nettles

Vit D: Egg yolk, bone meal, sunflower seeds, fish liver oils (*see note below), tuna, salmon, nettles & sunshine

Vit E: Dark leafy green vegetables, wheat germ, eggs, sunflower seeds, nuts, molasses, sweet potatoes and yams

Vit B6: Green leafy vegetables, wheat germ, nutritional yeast, blackstrap molasses, prunes, nuts, cabbage, sunflower seeds

Vit B12: Meat, eggs, cheese, milk, soybeans, wheat germ oil, comfrey, fish, pickles, spirulina

Vit K: Alfalfa, nettles, kelp, shepherd's purse, egg yolk, safflower oil, cauliflower, kefir, leafy vegetables

Folic acid: Uncooked dark green leafy vegetables, nutritional yeast, mushrooms, milk, cheese, dates, dried beans (fava, kidney, pinto, romano, soy, white, chickpeas, lentils), cooked spinach, asparagus, romaine lettuce, fortified products including orange juice

Niacin: Legumes, nutritional yeast, milk products, rice bran, seeds, whole grains, lean meats, poultry

Riboflavin: Leafy greens, mushrooms, brown rice, blackstrap molasses, nutritional yeast

Thiamin: Brown rice, nutritional yeast, whole grains, blackstrap molasses, meat, fish, poultry

Phosphorus: Nuts, seeds, legumes, grains, eggs, yellow cheeses, fish, meat, tofu, poultry

Iodine: Kelp, dulse, leafy greens, iodized salt, sea salt

Magnesium: Honey, green leafy vegetables, nuts, dried beans

Zinc: Soybeans, spinach, sunflower seeds, nutritional yeast, comfrey, whole wheat, oysters, bran

* Always look for a Drug Identification Number (DIN) on fish oil & other supplements which indicates that Health Canada has deemed it safe from contaminants. Never exceed the dosage indicated & avoid fish oils high in Vitamin A.

Treatment for Common Discomforts in Pregnancy

Discomfort	Possible Cause	Possible Remedies
Abdominal achiness	Stretching of the muscles & ligaments supporting the uterus	Sit down, put feet up, relax, flex knees towards abdomen, pelvic tilts, warm baths and heat
Abdominal cramp	Pressure on muscles, ligaments, veins & other organs Ligament stretching Orgasm Preterm labour	Experiment with different positions However, call your healthcare provider if you have cramping along with spotting, heavy bleeding, fever, chills, vaginal discharge, tenderness & pain, or if the cramps don't subside after several minutes of rest
Bleeding gums	Pregnancy hormones can cause gums to swell and become inflamed, which may lead to frequent bleeding especially while brushing teeth	Continue to floss and brush regularly Try a toothpaste for sensitive teeth. Apply ice to gums Avoid eating refined sugars Call your dentist if your gums are bleeding & painful. Decaying teeth can cause an infection that initiates preterm labour
Breasts, sore	Increased levels of oestrogen & progesterone. Increased size of breasts	Soreness often -but not always- decreases later in pregnancy Wear a good supportive bra and a sleep bra at night
Breathlessness	The uterus pushes on the diaphragm toward the lungs	A normal part of pregnancy, but if accompanied by chest pain, palpitations racing pulse or clamminess in fingers and toes, call healthcare provider; if asthmatic, also discuss with healthcare provider
Clumsiness	Carrying more weight, changing centre of gravity, relaxing of joints due to pregnancy hormones	No solution but watch out for wet, icy or uneven surfaces. Avoid wearing high heeled shoes. Don't carry things you can't safely drop. Call healthcare provider if accompanied by dizziness
Constipation	Pressure of the growing uterus on the rectum Pregnancy hormones (slow transit of food through digestive system Iron supplements	Eat high fibre foods (cereals, whole grain breads, fresh fruits and vegetables). Drink plenty of water (at least 6-8 glasses/day) Exercise
Dizziness	Pressure of the growing uterus on the rectum Hunger. Low blood sugar Standing too quickly (postural hypotension) Anaemia Allergies Hyperventilation	Healthy snack, water or juice Sit down Avoid lying on your back in late pregnancy If in a stuffy place, fresh air Call healthcare provider if dizziness is accompanied by blurred vision, headaches, palpitations

Edema (swollen extremities)	Pressure of the growing uterus on the rectum Extra blood flow during pregnancy Growing uterus puts pressure on pelvic veins, slowing down circulation Excessive water retention	Elevate feet Wear support stockings Exercise Eat properly, avoid sodium and salt foods
Fatigue	Developing placenta Rapidly changing hormone levels Low blood sugar Low blood pressure	Take naps Adjust schedule Eat healthfully May subside in 3 rd trimester
Finger pain & numbness	Carpal tunnel syndrome	Symptoms most often at night, so shift sleep position Avoid sleeping on hands Flex fingers and hands regularly If pain is persistent, surgery may be recommended Consult healthcare provider if numbness interferes with sleep or daily activities
Heartburn/ indigestion	Increased progesterone from developing placenta (makes digestion sluggish) Oesophageal reflux of stomach contents Growing fetes crowds abdominal cavity, slowing elimination and pushing up the stomach acids	Avoid rich or spicy dishes, chocolate, citrus and coffee Eliminate alcoholic beverages Eat small, frequent meals Take small mouthfuls and chew food well Avoid drinking large quantities of fluids during meals to avoid distending stomach Try not to lie down for at least an hour after eating Sleep propped up with several pillows or elevate the head of bed Over the counter antacid with magnesium or calcium Natural remedies (see below)
Haemorrhoids	Increased blood circulation, dilated veins Constipation	Sitz bath Ice pack or heating pad Avoid sitting or standing for long stretches Topical anaesthetic or medicated suppositories; over the counter remedies
Itchy skin, red & itchy palms and soles	Hormones and stretching skin Increased oestrogen	Apply moisturiser Oatmeal bath (available in drug & beauty stores) Wear loose clothing to avoid heat rash
Leg cramps	Added weight on leg muscles Excess of phosphorus (found in processed meats, snack foods, sodas) Shortage of calcium Pressure of expanding uterus	Stretch, massage Warm bath or hot water bottle Walk Increase calcium intake

Nausea	Pregnancy hormones	Eat 6 small meals per day rather than 3 large ones. Avoid drinking fluids with meals. Instead drink fluids ½ hour after meals. Try to keep a little food in stomach at all times. Carry crackers when out Vit B6 50- 75mg every day may be helpful to some Try Acupressure (sea bands) on wrists Red raspberry / Ginger tea (see recipe & dosage below) or capsules Omit prenatal vitamins until nausea subsides but keep taking folic acid 1mg during this time
Nosebleeds	Increased blood supply to nose's delicate veins Dry membranes, especially in dry weather	Avoid nasal dryness Blow nose gently Drink extra fluids
Rectal bleeding	Anal fissure caused by constipation Haemorrhoids	Avoid sitting or standing for long stretches Do daily kegels Sitz bath Thoroughly cleanse affected area Apply ice Topical anaesthetics or medicated suppositories Sit on inflatable ring Eat a fibre rich diet to avoid constipation
Sleep disturbances, insomnia	Cant get comfortable Bladder under pressure (frequent urination) Heartburn Anxiety Nausea	No smoking or alcohol Cut down on caffeine Don't exercise before bedtime Establish bedtime routine Relaxation techniques Snack before bed to avoid nausea Avoid heavy meals and spicy foods Drink fewer fluids in late afternoon, evening Natural remedies (see below)
Splotchy skin	Pregnancy hormones	Usually diminish after pregnancy Keep out of sun Get enough folic acid Apply concealing makeup
Stuffy nose	Allergic rhinitis of pregnancy	Inhale a bowl of steam before sleeping Hot shower Nasal spray (use sparingly)
Urination, frequent	Growing uterus shrinks bladder capacity Increased pressure on bladder	Avoid excessive liquid intake before bed Contact healthcare provider if urination is accompanied by burning, as it may indicate a urinary tract infection
Vaginal spotting	In late pregnancy, usually a sign of softening cervix or cervical dilation	Possibly, bed rest if it becomes excessive Consult healthcare provider - may suggest placenta previa, placenta abruptio, preterm labour

Varicose veins	Growing uterus puts pressure on pelvic veins, increasing pressure on leg veins, increase in progesterone, causing blood vessels to relax	Avoid putting too much pressure on legs and standing for long periods Exercise Elevate feet and legs Keep within recommended weight range during pregnancy Sleep on left side with feet on a pillow Support pantyhose
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Sleeplessness

- It is important to have a night time routine. This could include light exercise and having a set bedtime. Use lots of pillows as props.
- Try warm milk. It contains an amino acid called tryptophan which aids relaxation
- Calms forte is a homeopathic remedy found at most health food stores
- Valerian tincture in small doses. Take with food or drink
- An mien pien is a Chinese remedy for sleeplessness in pregnancy or postpartum. Follow directions on the box and wash the outer red coating off the pill with cold water

Heartburn & Indigestion remedies

- Ferrum phos; 6 or 12x dosage. Take 4-5 pills 2x daily. Available at most health food stores
- Lemon water, apple cider vinegar, celery, carrot juice, peppermint or chamomile tea. Any of these may work for some women.
- Acidophilus in pill or liquid form
- Alfalfa tablets: up to 6-8/day especially after meals
- DGL: a supplement in pill form that is very effective for some. Available in some health food stores
- Fruitin is very effective for some. Available in some health food stores

Anemia

Anemia Prevention Brew

1/2 oz dried nettle leaves
1/2 oz dried parsley leaves
1/2 oz dried comfrey leaves
1/2 oz dried yellow dock root
1/4 oz peppermint leaves

Place herbs in glass half-gallon jar. Pour boiling water over and steep for 8 hours. Drink up to 4 cups daily for one week of each month

Iron absorption is diminished by insufficient high-quality protein, coffee, black teas &/ or enemas. Herbal sources of iron include nettles, dandelion, alfalfa, yellow dock, chickweed, burdock, kelp, mullein, sorrel, parsley, comfrey, chicory, watercress and fennel.

Nettle, dandelion, alfalfa tea's (see below)

- Bob's Iron Formula is a formula that we have made at Pacific pharmacy that is exceptionally efficient at correcting iron deficient anaemia

- Chinese herbal remedies available are;

WOMEN'S PRECIOUS: take 8-16 pills 3 times daily

WUCHI PAI FENG: sometimes called "chicken eggs", is an ancient Chinese formula used to tone blood and energy, warm the uterus and nourish the mother. 12% of this formula is made from chicken. This is especially good if you are nervous, tense or exhausted. Do not take this remedy if there are any signs of infection anywhere in the body. Do not take if you have a fever, cold or flu.

SHOU WU CHI: the Chinese anaemia tonic for vegetarians

PREGNANCY TEAS

*See **Anaemia prevention Brew** - Page 31

Ginger tea

Brew fresh ginger by stirring and simmer on low heat for 20-30 mins. Add honey as desired and sip all day long. If vomiting has begun or nausea is becoming predominant, ginger capsules may be more effective. Fill size 00 capsules with powdered ginger and take 2-4 capsules every 3-4 hours. Up to 20 capsules per day can be taken safely. Reduce dosage as nausea diminishes. When nausea and vomiting are resolved, take a low dosage (1 capsule 3 times a day) and then stop ginger completely

Red raspberry tea

Brewed as a tea or as an infusion, Rubus is the best known, mostly widely used, and safest of all uterine/pregnancy tonic herbs. It contains fragrine, an alkaloid that gives tone to the muscles of the pelvic region, including the uterus itself. Most of the benefit ascribed to regular use of Raspberry leaf tea throughout pregnancy can be traced to the strengthening power of fragrine or the nourishing power of the vitamins and minerals found in the plant. Of special note are the rich concentration of vitamin C, the presence of vitamin E, and the easily assimilated calcium and iron. Raspberry leaves also contain vitamins A and B complex and many minerals, including phosphorous and potassium. Benefits of drinking Raspberry leaf brew before and throughout pregnancy include: preventing miscarriage and postpartum haemorrhage, easing morning sickness, providing a safe and speedy parturition, aids in delivery of the placenta, and assists in the production of breast milk.

Nettle tea

Urtica dioica is one of the finest nourishing tonics known. It is reputed to have more chlorophyll than any other herb. The list of vitamins and minerals in this herb includes nearly every one known to be necessary for human health and growth. Vitamins A, C, D, and K, calcium, potassium, phosphorous, iron, and sulphur are particularly abundant in Nettles. The taste is deep and rich. Benefits of drinking Nettle infusion before and during pregnancy include: aiding the kidneys, nourishing the mother and fetus, easing leg cramps and other muscle spasms, preventing haemorrhage after birth, reducing haemorrhoids, and increasing the richness and amount of breast milk.

Dandelion tea

In addition to vitalizing and healing the liver, Dandelion leaves help the kidneys function better, and are a good source of calcium and potassium. This combination of qualities makes Dandelion leaves a vitally important herb in the prevention and treatment of pre-eclampsia. Dandelion leaves contain vitamins A, C, B1, B12, calcium, potassium, iron, choline and many trace minerals.

Alfalfa

Taken throughout pregnancy, Alfalfa infusion or tea will increase available vitamin K and haemoglobin in the blood. Alfalfa also encourages a good milk supply. Contains vitamins A, B1, B12, D, and E.

Oat Straw

Useful in strengthening the capillaries that helps to prevent varicosities.

Premature Labour

BLACK HAW is an American herb which stops premature contractions and mid cycle bleeding. It may lower blood pressure so caution is required for women with low blood pressure.

If pregnant and having strong symptoms of:

- sore lower back
- cramps
- menstrual feelings
- loose bowels with sore uterus
- spotting

bleeding

Take 3-4 capsules (size 00) (or equivalent in tincture form) of Black Haw 4-5 times daily. As symptoms subside, reduce dosage:

Red blood: 4 capsules 5 times daily

Dark brown, old blood: 3 caps 3 times daily

A few drops of brown blood every other day: 2 caps 3 times daily

Mild cramps: 2 caps 3 times daily

Premature contractions: 4 caps 5 times daily

Weed S (1986) Wise Woman Herbal Childbearing Year Ash Tree Woodstock NY

SEX DURING PREGNANCY

by Sheila Kitzinger

“Should we make love or not?” . . . “I’m not enjoying it anymore. Will it always be like this?” . . . “He says I can’t love him or I’d want intercourse when he wants it.” . . . “The doctor says no sexual intercourse in case we lose this one! He doesn’t know Don. Already we’re getting on each other’s nerves and we have another five months of it.” . . . “He’s been put off sex by my pregnancy. Last night I tried to get him to make love. He began to get excited and came inside, and the baby moved, and he said ‘Oh! It’s alive in there!’ and after that he just couldn’t.” . . . Pregnancy involves emotional and social, no less than physiological, changes. Moreover, the psychological and social changes exist for both partners. Having a baby can either disrupt the relationship between a couple or can deepen and strengthen it.

These are some of the things women can worry about during pregnancy and there is often an implied conflict between sex and parenthood, as if it is all right to start the baby off, but after that you must settle down to being a mom and dad with only maternal and paternal feelings of tender protectiveness toward the baby; sexual passion is considered to be a bit risky, even endangering the developing life. But mothers and fathers are also partners and lovers and have a right to their sexual identities.

It is usually a good idea to share your thoughts with your partner. Talk together about what each of you feels and discuss any changes that it has meant in your life together. What would you say is the best thing about this pregnancy? What do you think is the worst thing about it? Some couples find it difficult to share this way, but if you don’t talk about these things, it can be even more difficult to tell each other how you feel about sex—what gives you pleasure, what does not—and work out together how you can enjoy each other more.

Cultural Attitudes

The ban on intercourse during pregnancy—or when the hunter is about to set out on a big hunt, the fishermen on an important fishing expedition, or warriors are going into battle the next day—is familiar among some (but not all) primitive and peasant peoples. They often believe that by prohibitions of this kind they guard something vital that is going to happen, whether it is the birth

of a new member of society, the killing and catching of animals and fish for food, or victory in war.

One idea behind these beliefs is that vital forces must be conserved. If a man is to become a father, for instance—with all that this implies of responsibility and power—he ought not to waste his substance in ejaculation. In this it is the father who is the central figure; he is the hero of the drama. Another idea is that because the mother is unclean, or perhaps sacred, she is removed from ordinary life. So intercourse may be banned because the expectant mother, the prospective father, or the baby may be endangered by intercourse. Many religions in different parts of the world regard the pregnant, like the menstruating, woman as being in some way threatening. In some African societies, a man must not even look at a woman when she has her menstrual period. Dire consequences are supposed to result from intercourse during the menstrual flow. For instance, in Jamaica, a piebald black and white child was thought to be the result. These ideas linger in our own society where notions of it being unclean may be based partly on hygiene, but often less so than they appear. They often have more magico-religious origins.

The pregnant woman is in a state of *becoming*—a state of transition between being just herself and being the mother of a child, rather like a person who is dying, who is on the road between being a member of society and a member of the spirit world, or a young person who is passing puberty rites (a girl having just had her first period, perhaps) who is in the transitional state between being a child and a full adult member of society. And of course, the baby is also on the bridge of becoming, and the expectant father too.

For people on these bridges between one state of social identity and another, there are rituals regulating their behaviour. One of the most important is that of *avoidance*—and an obvious expression of this during pregnancy is a ban on intercourse.

It pays to respect these ideas. What if a woman feels that she shouldn’t have intercourse—but does -- and then has a miscarriage shortly thereafter? Will she ever forgive herself? One woman was desperately worried because she had lost her baby at about twelve weeks. She had remembered that they had made love just before it happened and wondered if that could have been the cause. Not only could this not happen, but if, as in this particular case, the woman is tense and anxious anyway, she may be more likely to hold on to her pregnancy if she can enjoy intercourse and learn how to relax in her partner’s arms.

But because it is easy to feel guilty, it is important that each woman should feel free to follow her feelings, and not be forced into a pattern of behaviour just because the books, or an expert, says so. If she has already had a miscarriage, it is reasonable to avoid having intercourse at the time when the first three periods would be due, for this is the time when she is most likely to miscarry again. So if you have had a miscarriage, find other ways of

making love for the first three months or so during the week when your period would have come. It does not mean that you cannot show your love at all. Just be a bit more inventive.

The penis is rarely so long that it touches the uterus during intercourse because, as the woman becomes sexually stimulated, not only do the accordion-like folds in the vagina open up to receive the partner, but the vagina also becomes longer. When she is very excited, it becomes tent-shaped. In this way, a woman with a small vagina can easily contain the erect penis, provided she is aroused.

The female orgasm involves rhythmic contractions of the uterus—usually between five and ten—which sometimes set off contractions which persist after the couple have finished love making. The fact that the uterus contracts is not so drastic as it sounds, because it does this throughout the childbearing woman's life as part of its normal pattern of working. But if for any reason she is ripe to give birth, these can initiate real labour contractions.

Semen is also rich in prostaglandins, which ripen and soften the cervix. One way of inducing labour is to introduce a prostaglandin gel up into the cervix to prepare it for labour, and if the baby is about due anyway, this will usually start off labour contractions after some hours. (An unripe cervix feels like the hard tip of your nose when you press it with your fingers. A ripe cervix feels like a soft, relaxed mouth.)

If you notice bleeding after lovemaking and are not within 3 weeks of your due date, there is a good case to be made for stopping complete sexual intercourse and enjoying “pleasuring,” stroking and cuddling, instead. If you are near term or past the date when your baby is due, intercourse is not only harmless but may do good.

From Early Pregnancy On

Avoiding something she enjoys may make a woman feel virtuous, but the discipline involved won't hold on to a baby. In fact, it may be more important for her to be relaxed, happy and casual about lovemaking, and life generally. This will help her embark on her pregnancy in the placid, contented and luxuriously self-satisfied mood, which seems to provide the best emotional basis for motherhood. It is important that she has ways of unwinding even before tension becomes obvious. If she walks around bearing her pregnancy, her tiny miracle of life, like a precious crystal vase she is carrying over the slippery kitchen floor, she is bound to be strained—and this is the last thing that will help her to carry her baby to term. So it is up to her partner to coax her into a more relaxed attitude, and spontaneous, easy lovemaking plays a natural part in this.

It is better to go to bed after lunch on Sunday and have intercourse in the afternoon, for instance, with the passionate tenderness that comes from being able to make love whenever you want to and with all the time in the world, than to hold off until he (or she) can't stand it any longer. That can mean that you get caught up in frustrated and aggressive sex that turns the bed into a battlefield. (It is a most pleasurable battlefield when one is not pregnant, but this sort of lovemaking is not the best kind for either the first or last three months of pregnancy.)

So spontaneous, affectionate and gentle lovemaking plays its part in helping a woman to relax—and to know what release is like. Women starting a training course for childbirth often wonder if they can relax, and think there must be a special sort of athletic neuromuscular control—different from anything else—which they have to achieve in labour. In fact, if one is really relaxed in childbirth, it can be very much like the complete release from tensions and the luxurious warmth and peace after happily making love. The expression a man sees on a woman's face after a satisfying orgasm is in fact similar to that on the face of one who is enjoying her labour—glowing skin, flushed cheeks and shining eyes, damp and untidy hair, and a sense of deep contentment. Coitus and childbirth create their own sanctuaries from the cares and horrors of the surrounding world.

If You Don't Want Sex

But what if you cannot stand the idea of sex or don't get excited or, if you do, discover yourself unable to reach orgasm? At different phases of pregnancy, women can enter periods of being anorgasmic or uninterested in sex. The important thing to remember is that there are many ways of expressing love, and if you don't want intercourse, find some other means of showing your partner how much you care. (Pregnancy is the perfect time to invent minor “perversions.”) Some men feel shut out of their partners' pregnancies. Some are a little jealous of the coming baby who is interfering with their lives. Others are even jealous of their partner's reproductive powers and the ability to carry developing life in their bodies. Freudian psychoanalysis has put a good deal of emphasis on so called “penis envy”, but man also suffers a deprivation; he is unable to give birth. Many men need reassurance—a ready ear to listen to *their* problems with sympathy, comforting food, laughter, cuddling, stroking, passionate seduction—a combination of any or all of these.

When a woman is wrapped up in her difficulties, the horrible time she had at the clinic, her own tiredness or mental wooliness, or mother-in-law problems, she is slow to realize her partner's need, and exclaims indignantly—“But *of course* I love you! Why do you think I have been slaving all day in the house/toiling around the supermarket/putting up with your mother for three solid hours?” or whatever. It is not enough to love; we have to learn how to *show* love. And this is sometimes as difficult as learning a new language, the grammar of which has never been written.

In the first three months of pregnancy, terrific emotional and physiological adjustments have to be made by the pregnant woman. She is becoming a different sort of person, both in terms of her physical stuff (she may be tired, suffering from nausea and bouts of vomiting) and in terms of her feelings about herself and her body. She may

not want intercourse and may view it with distaste. Fortunately, sometimes the opposite happens and she enjoys making love more than ever before, and in as many different ways as she and her partner can discover together. In the last three months, she can be weary with the weight of her burden, unable to get long periods of sleep because of what feels like the drumming of football shoes inside, or because of heartburn, and she is impatient for the birth. Every day she goes past her due date feels like a week, and if people keep on coming up to say, "What, haven't you had it yet?" she is quickly reduced to tears. If the baby is late, intercourse is one way which sometimes helps labour start, and a much more pleasant way than an intravenous drip to induce labour.

She may not be on good terms either with herself or her body—not liking this vastly pregnant woman into which she has grown. There may be another period of time when she is unable to concentrate on lovemaking, or enjoys it only to a point and then no more, or fails to participate in the recurring, mounting waves of desire which culminate in physical and emotional release.

When this occurs—if it does—at the beginning or end of pregnancy, she should be honest about her feelings. Her partner may need to learn that orgasm is not necessarily what she seeks, and that she can feel satisfied sometimes without it (just as she can have an orgasm sometimes without feeling emotionally satisfied, something which can be difficult for a man to understand). She may have to put this into words, and to explain that she is deeply happy and peaceful without having an orgasm every time—no matter what the books say. Because manuals of sex technique invariably emphasize the importance of orgasm for a woman, a man can feel a dismal failure, and deprived of his virility, if he is unable to give her one. Sometimes she passes through the whole nine months guarding the fetus from him as if he were attacking or contaminating it. This may be related to feelings that sex is dirty or humiliating, or to hunger for a child, who makes her want to keep it securely locked inside her as her exclusive property, while denying her partner access either to her body or to her love. Either way, this is a problem for the relationship—and one that is more long-term than the pregnancy. A couple facing this sort of difficulty needs marriage guidance during pregnancy.

Experimenting

It is unlikely that a woman will pass through the whole of her pregnancy without wishing to vary her usual coital positions. It can get uncomfortable lying on her back, and when the baby's head is low, still more so on the back with her legs raised, since it is in this position that penetration is deepest. If the woman gets indigestion or heartburn when she lies flat, she will prefer to have her head and shoulders well raised with pillows. The first prescription for intercourse during pregnancy is to go out and buy some pillows—more than you think you will need. They will also come in very useful afterwards when feeding the baby.

The position in which the man lies on top of his partner is unsuitable in pregnancy, anyway, and he should avoid weight on her abdomen and breasts, not because he could harm the baby, but because it is uncomfortable. Her breasts are not only extra sensitive—especially responsive to his touch and oral caresses (and this is the most natural and pleasant way of preparing the nipples for breastfeeding) -- but also full and tender.

A side-by-side or sitting position is preferable. When the baby has engaged in the pelvis, it feels about to drop out and there seems to be little spare room. Then the woman can try lying, crouching or kneeling with her back to her partner so that he enters her from behind. Thus the uterus, which lies almost at right angles to the vagina, is free from pressure, and she can not only use her buttock muscles to grip him, thereby controlling the extent of penetration, but also give him pleasure by contraction of these muscles. In this way a couple, if they wish, can enjoy intercourse right up to the time when she goes into labour.

Most men recognize the importance of clitoral stimulation and know that they cannot expect to simply "trigger" a woman off without previous wooing. But it is not the clitoris alone which is responsive to touch; it is important also to remember the need for excitation of the mouth, breasts, small of the back, thighs and other erogenous zones, which vary with each person.

But not all men know that over-stimulation of the clitoris is possible, and this can result in irritation, boredom and a desperate feeling of "Oh, will he never get on with it?" Once the clitoris is firm and swollen, it is time for gentle penetration. If pregnancy is advanced, it may also be better for the man to ejaculate just *before* the woman enters the phase of accelerated rhythmic movements that result in orgasm. This may seem odd advice when books stress that the man must wait, but she may be unable to embark on free movement of her pelvis and the pelvic floor muscles when the penis is still erect and rigid inside her. Thus hampered in her movements, the chances of her reaching orgasm are reduced. So it may be best for the man to ejaculate first and then, with caresses, lead his partner onwards to her own orgasm.

Pregnancy is an ideal time for a couple to embark on a journey of discovery into the mystery of each other's bodies and the patterns of response in which each take delight. It brings the opportunity for a new tenderness and passion in their relationship

THE SUPER KEGEL

By Penny Simpkin

I used to feel hypocritical when I taught the Kegel exercised. After an elaborate description of pelvic floor anatomy, the benefits of good pelvic floor muscle tone, and the problems with poor tome, I taught my students that they should do 50 to 100 Kegels per day. Even as I taught it I was fully aware that I have probably never, even once in my life, done 50 to 100 Kegels in a day. Very few of my students do it either.

The dilemma is that the exercise is so tedious, people won't do it; yet, the problems it is designed to prevent or improve - pelvic floor relaxation, urinary incontinence, uterine prolapse, rectocele, and cystocele - are all extremely common among women. In fact, the prevalence of urinary stress incontinence ranges between 40 and 50 percent in the many studies of this problem that I have read.

The Super Kegel - a 10 second sustained contraction of the pelvic floor - may be our solution. Recent studies of pelvic floor muscle tone have incorporated the use of a computerized biofeedback device, consisting of a vaginal myograph (a tampon-sized sensor) connected to a computer and video screen. The woman performs Kegels and gets immediate feedback in graphic form. She can "watch" as her pelvic floor fatigues and muscle tone diminishes, even while she attempts to sustain the contraction. She quickly learns to feel her muscle losing tone and to renew the contraction by bringing in "fresh" muscle fibres to replace the fatigued fibres.

Try it. Most people can feel the tone fade and renew it without the use of biofeedback. If not, a referral to a urodynamics clinic may be appropriate.

How do I teach the Kegel in childbirth class? I have backed away from the 50 to 100 quick Kegels per day, and from the "elevator" exercise. I now suggest 5 to 10 Super Kegels per day, one during each bathroom stop. This is how I do it:

Using my upturned palm as a symbol for the pelvic floor, I slightly flex my fingers and lift my hand to signify a contraction. "Tighten your pelvic floor only, as if you are trying to hold back the flow of urine. Hold it, hold it. If you feel it starting to fade, even though you're not letting go, (illustrate with my hand relaxing and lowering), RENEW it, without letting go. And RENEW it...again...and again (for 10 seconds). And now let go!" I suggest that anyone who feels she cannot do it should

see me after class. I will then review the exercise with her individually, and if necessary, refer her to a physical therapist who specialized in pelvic floor re education.

Screening tests in Late Pregnancy

Gestational Diabetes (GDM)

What is it?

Gestational diabetes (GDM) is high blood sugar first diagnosed during pregnancy and subsequently goes away after the baby is born. It is not to be confused with regular diabetes. It can otherwise be termed as 'carbohydrate intolerance' of pregnancy. It occurs because the placenta produces hormones that interfere with the body's ability to use insulin effectively. Insulin is like a key that unlocks the door of cells, letting them access blood glucose in the blood for energy. Insulin resistance reduces the amount of glucose that can get into the cell, letting cells starve while the blood outside contains an excess of sugar.

All pregnant women encounter some insulin resistance, but most women are able to produce enough insulin to overcome interference of the placental hormones. In order to get gestational diabetes one must have a genetic predisposition to it however, lifestyle does have an impact. Gestational diabetes is said to occur when a woman's pancreas cannot produce enough insulin to compensate for the increased resistance during pregnancy. This usually occurs around the 26th – 28th week of pregnancy so is usually tested for at this time.

Is GDM dangerous for me or my baby?

The mother usually feels perfectly well and healthy. The importance of recognizing this condition in pregnancy and the actual impact on the mother and child is unknown. The following points show just how much debate still surrounds this issue.

Arguments IN FAVOUR of routine testing & treatment

1. GD testing may provide an opportunity to reduce birth size, thereby reduce the risk of birth trauma and the higher c/s rate associated with bigger babies (up to 30% of mothers with a positive GTT have babies weighing more than 8lb 12oz / 4000g). It is hoped that treatment of those identified as having GDM may also reduce the very small increased risk of death of the baby associated with a positive result.
2. GD testing hopes to lessen problems in the newborn such as the incidence of hypoglycaemia and jaundice hopefully providing the child with a better chance later in life at avoiding obesity, high blood pressure, diabetes and other health problems.
3. GD testing benefits women by identifying those at high risk of diabetes later in life.

Arguments AGAINST routine testing & treatment

1. Aggressive treatment is being used for a condition without adequate proof of effectiveness. 70% of women who test positive will have babies weighing less than 8lb 12oz / 4000g even if given no treatment and most 'larger than average' babies are born to mothers with a normal glucose test result. Treatment so far with diets, insulin and early induction, has not been shown to significantly reduce the size of larger babies (which itself is of dubious significance), shoulder dystocia, birth trauma or cesarean rates.
2. Intervention in mild cases of GD may actually cause more harm than it avoids as mild degrees of glucose intolerance is of dubious significance.
3. The available evidence supports the notion that the relationship between glucose intolerance in pregnancy and poor outcomes for the baby is a continuous one, and no single cut-off can separate pregnant women into those at high risk and those with no risk at all. When insulin is truly needed and what levels of average blood glucose level are best remain controversial.
4. There is little agreement on treatment and so treatment protocols vary widely
5. The rates of intervention for the mother are fairly high. Just by giving the diagnosis of GD to a mother places her at high risk of induction and caesarean section
6. The test used to diagnose the condition is not reliable. About 15% of women who are given the initial screening test will screen 'positive', and of those, about 15% will be diagnosed with GDM. In 1999, obstetricians Barrett and Pitman stated that between 50 and 70% of the women if retested, would have a negative result. Others have since made this claim.
7. Many of the delivery practices commonly used with GD patients (early induction, high rate of c-section, routine supplementation of the baby, admittance to the nursery for observation, delayed contact with mother for nursing etc) interfere with the establishment of breastfeeding which is of huge public health significance.

What does the SOGC & BC reproductive care program recommend?

Due to the lack of convincing evidence in relation to GDM, the SOGC consider the option of not screening acceptable but also (along with the BCRCP) continue to support a routine screening program. This means you would be recommended to have the test if any of the following apply:

- Maternal age > 25 years
- Member of Hispanic, African, native American, south or east asian, hindu, pacific islands or indigenous Australian ancestry
- Pregnant body mass index (BMI) > 27
- Previous history of GDM or glucose intolerance
- Family history of diabetes in first degree relative
- Previous infant over 4000g or previously unexplained stillbirth
- Repeated glycosuria, polyhydramnios or suspected macrosomia in this pregnancy

Testing for Gestational Diabetes?

A variety of tests are available. Usually, a blood test is done first when the mother has had nothing to eat (this is called a fasting blood sugar). A 'screening' test is then given such as a drink containing 50g (1.75 oz) of sugar, and the blood sugar is tested 1 hour later. If the result is 7.8 mm/L or higher, the screen is considered positive. If a woman has a positive screen, a more formal test – called a glucose tolerance test is performed. This can involve drinking 100g (3.5oz) of sugar and having the blood sugar tested after 1, 2 and 3 hours. Upper limits of normal are 10.5 mm/L after 1 hour, 9 mm/L after 2 hours and 8 mm/L after 3 hours. If the woman's results meet or are higher than any 2 of these 3 limits, the diagnosis of gestational diabetes is made (Barrett & Pitman 1999). Alternatively, women can undergo a less stressful test - a fasting blood sugar, then breakfast followed by a blood sugar test 2 hours later.

What happens to me if I screen positive?

With a positive diagnosis you are referred to the Diabetes Education Centre at VGH. This involves having your diet reviewed and you are taught how to test and record your blood sugar every day. You are reviewed at the centre regularly until they are happy that your blood sugar levels are considered 'normal'. If diet does not work alone then insulin treatment may be started. At this point an obstetrician will be involved in your care. Whatever your treatment plan, it will be continued through your labour and into the immediate postnatal period as well as involving testing of your baby's blood sugars after the birth. This is in line with hospital protocol at VGH.

What is the community standard in Victoria?

Routine screening is still common practice, regardless of a woman's level of risk.

Statement from WestCoast Midwives

To support this test for **ALL** women 4 conditions would need to be met;

1. GDM would have to pose a certain health risk
2. Diagnosis should accurately distinguish between those who need treatment and those who do not
3. Treatment should be effective
4. The benefits of diagnosis and treatment should outweigh the risks

Routine diagnosis and treatment of GDM does not fulfill any of the above criteria. The best way of identifying and treating women with abnormal blood glucose tests in pregnancy is not known. More research is needed. As a result of this lack of evidence showing benefit for performing the test, we do not recommend routine screening. We believe that *routine* screening places women at risk for poorer outcomes. However, we acknowledge that poorly controlled, more severe GD may have real risks. Hence, we offer highly selective screening based upon individual risk factors in the hope of identifying those at most risk. We strongly encourage a healthy lifestyle including a balanced diet (see page 21) and regular exercise for all pregnant women as a means of ensuring the short and long term health of both mother and baby.

The choice is yours! Please do not hesitate to bring any questions or concerns you may have about this issue.

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Group B Streptococcus (GBS) and Pregnancy

What is GBS?

This is a bacteria that is one of the most frequent causes of infection in newborns. It is not a sexually transmitted infection. For most of the time, it lives as a normal part of our body's bacterial flora.

GBS & Pregnancy

10 to 35% of the general population carry GBS in the intestine & lower genital tract. It can be transient, intermittent or have a long term presence within our bodies. Occasionally, the bacteria may cause a urinary tract infection during the pregnancy. It has also been associated with miscarriage, premature rupture of membranes, premature birth and/or stillbirth. Very rarely, this bacteria can cause urinary tract infections, an infection of the placenta or uterus causing preterm rupture of membranes, preterm labour, stillbirth and/or postnatal wound infections. However, it is much more likely that GBS will not cause any problems during pregnancy. The main reason health professionals are concerned about this bacteria is because it can make newborn babies very ill.

How your baby can get GBS?

This is rare (approximately 2 babies per 1000 babies in Canada) but a serious infection for newborn babies. It is possible for a baby to become infected before the waters break or labour starts. However, it is more likely that the bacteria may be transferred to the baby once your waters have ruptured, during labour and/ or as your baby passes through the birth canal. At birth 50% of babies born to mothers who have GBS will become colonized. Of those that become colonized, 98-99% will not have any problems. However, 1-2% will develop a serious infection (called GBS 'disease'). The reason why this happens is not clear and therefore cannot be predicted. Babies who develop GBS infection or disease from the birth process are said to have 'early onset' GBS.

Early onset GBS

Of the very few babies who get sick, most do so within the first few hours of birth. Symptoms are

- Respiratory distress
- Cyanosis (blue lips, face, hands and feet)
- Shock
- Sepsis

Such babies must be treated promptly with IV antibiotics. If treated early many babies will recover. However, some babies (10 - 50%) will suffer permanent damage (such as blindness, deafness, mental retardation or learning disabilities) and/ or will die (approx 9% of those affected). Remember this is rare, affecting approximately 2 babies per 1000 live births.

Late onset GBS

Very rarely babies may become sick with GBS infection between 7 days and 3 months of age following the birth. This is called 'late onset' GBS disease. In this case, infection is most likely picked up from handling or nasal sources. This can be prevented by practicing good hygiene and careful hand washing when caring for your baby.

How is screening performed?

A cotton tipped swab is gently inserted about a ½ inch into the vagina and anal sphincter. This is then sent to the laboratory for analysis. This is done between 35 & 37 weeks of pregnancy. This provides an indication as to whether a woman is likely to be either GBS+ or – at delivery.

What are my Options?

1. Screen for GBS at 35 – 37 weeks pregnancy & treat in labour if GBS+

** This is the recommendation of the SOGC*

If the swab result shows you are GBS negative then no treatment is necessary unless you go on to develop signs of infection during labour. If the swab result returns showing you are GBS positive then treatment with antibiotics in labour is recommended. This is highly effective in reducing transfer of infection to the baby, thereby reducing the rate of early onset GBS disease in newborns. Antibiotics (usually Penicillin G) are given intravenously as soon as active labour is established and continued every 4 - 6 hours until the baby is born. For treatment to be effective, you must receive at least one dose at least 4 hours before your baby is born.

Treatment as determined by screening at 35-37 weeks is thought to be over 50% more effective than choosing to treat by risk factors alone (option # 2 and 3 below)

2. Screen for GBS at 35 – 37 weeks pregnancy & treat GBS+ women ONLY if risk factors present

Risk factors;

- Previous infant with Early Onset GBS disease
- GBS bacteriuria (urinary tract infection) this pregnancy (this indicates a more heavy colonization of GBS, increasing the risk of Early Onset GBS for the baby)
- Spontaneous onset of labour or rupture of membranes prior to 37 weeks
- Rupture of membranes for 18 or more hours
- Fever of 38 C or more

3. NO SCREENING for GBS at 35 – 37 weeks pregnancy. Treat ONLY if risk factors present

Risk factors as outlined above

However;

- 25 – 30% of infants who develop early onset GBS disease are born to mothers without any maternal risk factors
- Choosing treatment based on risk factors alone is thought to be 50% less effective in preventing early onset GBS disease in infants, than screening at 35 – 37 weeks of pregnancy & treating with antibiotics in labour if GBS + (option # 1)

Those who have the following risk factors are considered to be most at risk of having a baby with Early Onset GBS disease and are advised to automatically proceed to treatment with antibiotics in labour

- Previous infant with Early Onset GBS disease
- GBS bacteriuria this pregnancy (this indicates a more heavy colonization of GBS, increasing the risk of Early Onset GBS for the newborn)

Probable Risk of Early Onset GBS Disease In the ABSENCE of Antibiotic Prophylaxis

	Risk factors present	Risk factors absent
GBS positive (+)	1:25	1:200 - 700*
GBS negative (-)	1:1100	1:3200

*This varies with the literature

Giving antibiotics during labour to GBS + mothers (treatment option # 1 above) is approximately 80 – 86% effective in preventing Early Onset GBS infection in the newborn

Advantages to Treatment (ie; receiving antibiotics in labour)

- More likely prevention of GBS disease in the baby

Limitations to Treatment (ie: receiving antibiotics in labour)

- Any treatment to reduce the number of infected babies will mean giving antibiotics to large numbers of mothers and babies who don't need them, and will miss some babies who really do need treatment
- Screening will not pick up all GBS positive carriers, some will be missed
- Treatment with antibiotics is approximately 80 – 86% effective in preventing Early Onset GBS infection in the newborn and will not always prevent death. For example, this could happen if the infection was severe or present before labour started
- Treatment does not prevent late onset GBS infection
- The risk of severe allergic reaction to the antibiotics is approximately 1 in 10 000
- The potential negative consequences of antibiotic use in labour on the newborn are unknown. The effect on a baby's long term immunity and whether this affects allergy development is not known.
- Widespread antibiotic use does eventually contribute to the development of antibiotic resistant bacteria. This is a serious concern for our society as a whole

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NEWBORN PROCEDURES – You decide!

Occasionally a newborn baby can be susceptible to a number of congenital or genetically transmitted diseases. Some procedures are routinely performed on newborns in relation to these conditions. The following information is provided for your perusal and to facilitate discussion. If you have questions concerning these procedures, please discuss them with your midwife.

Prevention of eye infections from Gonorrhoea & Chlamydia

Gonorrhoea and Chlamydia are two sexually transmitted diseases that can be harmful to newborns. The diseases may be asymptomatic in the mother and the baby. If present in the mother's vagina at birth and passed on to the baby, these organisms can lead to infection. If undiagnosed and untreated the infection may cause blindness or more rarely, lead to systemic symptoms.

Treatment

Currently, the law in British Columbia requires that all babies be treated with an antibiotic ointment, unless both parents sign a refusal form. Erythromycin is placed in the baby's eyes as a protective measure against the above 2 infections. If infection is unsuspected but you wish to comply with the law, treatment will be administered within the first hours after birth. Consideration of your swab results, sexual history and lifestyle should be factors in the decision of whether to treat your baby or not. If infection is unsuspected and you do not wish to treat your baby, watch the baby's eyes for redness, discharge and swelling. If symptoms occur, rule out yeast or other vaginal infections. A culture may be done to test for gonorrhoea or chlamydia.

Prevention of Hemorrhagic Disease of the Newborn

Vitamin K is needed to help blood clot and vitamin K deficiency can cause bleeding in a condition called 'Hemorrhagic Disease of the Newborn'. The disease can involve serious bleeding such as intracranial haemorrhage. It is more likely in cases of prematurity or in babies born to mothers taking anticonvulsant medications. The incidence of hemorrhagic disease in infants *without* Vitamin K supplementation is approximately 1 in 1,200 live births for breastfed babies and 1 in 20,000 for formula fed babies.

All babies body stores of vitamin K at birth are limited and soon become depleted if milk does not arrive quickly once placental supplies are interrupted. Bottle fed babies are at less risk because formula is supplemented with vitamin K (approximately 4 times as much as breast milk). Babies go on to produce their own Vitamin K after 1 week of age, completing the process at 6 months.

Although, nature's blueprint is not flawed, the margin of safety is narrow. Babies who do not feed soon, well and regularly are at measurable risk of bleeding once their limited reserves of vitamin K are exhausted. Universal prevention with a 1mg injection of vitamin K to all breastfed babies is easy to give and provides virtually complete protection from early and late vitamin deficiency bleeding. Although there are no known links between vitamin K administration and resulting complications, it is almost impossible to prove that it is totally safe.

Treatment

Vitamin K can be given to the baby via intramuscular injection. This is the community standard in Victoria. The baby is given a single injection of Vitamin K into the thigh muscle within the first few hours after birth.

NEWBORN SCREENING

Ministry of Health, Health Files

Testing for Rare Disorders

Certain diseases can be present at birth. However, early detection and treatment can help prevent potentially permanent mental retardation from rare disorders. Babies with certain disorders **look** normal at birth. That is why the blood test is so important, as well as a careful examination by a doctor or midwife. This early detection process is called newborn screening.

How will my baby be tested?

In their first week of life, all babies in B.C. are offered a simple blood test. Just before the baby is discharged from hospital, a small blood sample is taken by a simple heel prick. Alternatively, a blood sample may be collected by your midwife at home. It will only cause a moment of discomfort. This sample is sent to the newborn screening lab for analysis.

What is my baby tested for?

The four disorders that newborns are tested for are:

- Phenylketonuria (PKU)
- Congenital Hypothyroidism (CH)
- Galactosaemia (GS)
- Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCAD)

About 50,000 babies are tested for these disorders every year in B.C.

Phenylketonuria (PKU)

PKU is a rare condition. It is found in about one out of every 18,000 new babies. A baby with PKU doesn't have enough of a special enzyme that breaks down *phenylalanine* in the body.

Phenylalanine is an amino acid - one of the building blocks of proteins. It is found in foods such as meat, eggs, fish and milk, including breast milk.

A shortage of this enzyme leads to high levels of phenylalanine in the blood. High levels of phenylalanine cause damage to the baby's brain. This usually leads to severe and irreversible mental retardation.

Those very few babies found to have PKU are put on a special diet low in phenylalanine. This prevents brain damage. Children with PKU, when treated early, function within the broad normal range of ability.

Congenital Hypothyroidism (CH)

CH is more common than PKU - about one in 3,000 to 4,000 new babies are affected. Like PKU, CH is easily detected by the blood screening test.

Congenital means the baby was born with the condition. Hypothyroidism means that the thyroid gland (found behind the "Adams apple" in the neck) is not working properly and not producing enough thyroxine. This is a hormone that is needed for normal growth and development. If CH is not detected and treated early in life, severe mental retardation will occur. The treatment for CH is simple and effective. Babies are given thyroxine to replace the missing thyroid hormone, helping them to grow and develop normally.

Galactosaemia (GS)

GS is a rare condition found in only one out of every 30,000 babies born in B.C. A baby not having the special enzyme that breaks down galactose causes the condition. Galactose is found in milk, including breast milk, and in most infant formulas. If the baby doesn't have this enzyme to break down galactose, it starts to build up in the body.

Symptoms of this disorder include a general failure to thrive, liver problems (jaundice), cataracts, mental retardation and possibly even infection that can cause death. Early detection is critical. A baby is treated with a galactose-free diet.

Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCAD)

MCAD is a rare condition. One baby in 20,000 is born with MCAD deficiency. A baby with this condition may have problems using fats stored in their body as an energy source. These babies do fine when they are eating well, but when they get colds and flus, they may not be able to use stored fats for energy. There is a risk of sudden unexpected death, which can be prevented by using a special diet and avoiding fasting.

When is the best time for testing?

The newborn screening test should be done between 24 and 48 hours after birth. The test is usually done before the baby leaves the hospital. The screening tests for Congenital Hypothyroidism (CH) and Galactosaemia (GS) are reliable any time after birth. However, tests for Phenylketonuria (PKU) and Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCAD) are not as reliable when done less than 24 hours after birth. Therefore, babies who are born in a hospital and stay longer than one day will be offered the test before discharge.

Babies born in hospital but discharged within a few hours of a delivery will either return to hospital for testing or have the test done during a home visit within the first week. Babies born outside a hospital setting (e.g. at home) under the care of a midwife will be offered the test during a home visit.

You should discuss these options with your physician, midwife or public health nurse to ensure that the test is done.

When will the results be ready?

The results are usually ready in a few days. You will not be contacted if the results are normal (negative). If one of the screening test results is positive, your family doctor or midwife will contact you and additional testing will be arranged. The results of follow-up tests will either be normal (ruling out the possibility of one of these disorders) or will confirm the diagnosis.

What if the result is positive for one of these rare disorders?

Almost all test results are negative.

However, if your baby is one of the very few found to have one of these conditions, the early detection of the disorder will help your baby get effective treatment as soon as possible. The earlier these treatable disorders are found, the better the outcome will be for your baby.

You will be referred to a doctor who is experienced in treating these disorders.

For more information on newborn screening, please contact your family doctor, registered midwife, or local public health unit.

Cutting Kids

Why the pain of circumcision lasts far longer than the procedure

By Karen Burka

Mothering Magazine, Issue 132, September/October 2005

Routine infant circumcision continues to be the most commonly performed surgery on children in the US, with about 1.2 million newborn boys circumcised each year.¹ The US also continues to be the only industrialized nation that circumcises the majority of its newborn baby boys for nonreligious reasons. The health-based reasons have been criticized and are controversial.²

Despite these facts, the rates of routine infant circumcision (RIC) in the US have steadily declined for more than a decade, and dropped more than 11 percent in just two years (2001–2003), according to the National Center for Health Statistics. Nationally, the average RIC rate fell to 55.9 percent in 2003, the latest year for which statistics are available. The largest decline was in western states, where the rate dropped 23 percent and seven out of ten boys remained genitally intact.³

Several factors are driving this decline, including parents-to-be who are better informed, more doctors and childbirth educators willing to speak out against circumcision, and an influx of immigrants from Asia, South America, and Europe—where RIC is anything but routine—who are not circumcising their newborn sons.

Perhaps most important, grassroots efforts to expose the medical myths and highlight the ethical concerns surrounding circumcision are becoming more widespread and mainstream. Here's what you need to know about circumcision to make an informed decision that can enhance your son's self-esteem and sexual health for the rest of his life.

What is circumcision?

Circumcision is the cutting off of the fold of skin that normally covers the glans, or head, of the penis. This double layer of skin, the prepuce, is commonly known as the foreskin. In a circumcision, a baby boy is spread-eagled on his back on a board or table; his arms and legs are strapped down so that he can't move. The baby's genitals are scrubbed and covered with antiseptic. The foreskin is torn from the glans and slit lengthwise so that the circumcision instrument can be inserted. The foreskin is then cut off.⁴ Years ago, doctors believed—and told new parents—that babies didn't feel pain, and that therefore circumcision didn't hurt and would be forgotten as the child matured. Today, experts both within and outside the medical community agree that babies do feel pain, and that circumcision is extremely painful for them. Many circumcisions are performed without anesthesia. Most doctors and childbirth educators agree that the administering of the available painkillers—including the most effective, the ring block, which requires four injections—can itself be extremely painful for an infant. And even when anesthesia is administered, it does not completely eliminate the pain.

Increasingly, the trauma experienced by the infant during circumcision is being linked to later childhood intolerance of pain. According to an article by British researchers Dr. Maria Fitzgerald and Dr. Suellen Walker, "One important study shows that boys who have been circumcised at birth show increased pain responses to vaccinations at four to six months compared to those who have not. . . . In a follow-up, prospective study of 87 infant boys, uncircumcised infants were found to have the lowest pain scores at vaccination four to six months later, followed by those circumcised after treatment with lidocaine-prilocaine cream (EMLA), while those circumcised after placebo cream showed the greatest responses."⁵

Real risks

As with any surgery, circumcision comes with serious risks, such as excessive bleeding, infection, complications from anesthetics, and even death. One-month-old Ryleigh Roman Bryan McWillis died in August 2002 after suffering severe hemorrhage from his circumcision.⁶ The Canadian-born baby had a normal-term birth, with no complications or problems. In August 2003, a four-week-old Irish infant named Callis Osaghae died of severe blood loss just hours after a routine circumcision.⁷ Complications from the circumcision of three-week-old Dustin Evans of Cleveland, Ohio, led his doctors to perform additional surgery to unblock the baby's urethra. Unfortunately, he never made it to the actual surgery, instead dying as anesthesia was administered.⁸ The sad conclusion of one story that made international headlines came in May 2004, when David Reimer, whose penis had been destroyed during a nontherapeutic infant circumcision, committed suicide at age 38. After the circumcision, Reimer's doctors had castrated him and convinced his parents to raise their son as a girl. He was renamed Brenda, and at puberty given feminizing hormones to promote breast development while he waited for

sex-reassignment surgery. Reimer was confused and depressed; his suicide attempts began in his teens, when he was told the truth about his sexual identity and surgery. He later renamed himself David and had a double mastectomy and reconstructive penile surgery. A book about his tragic experience, *As Nature Made Him: The Boy Who Was Raised as a Girl*, was written by John Colapinto.

The value of the foreskin

The foreskin itself is gaining the respect it deserves as an incredibly rich and useful sexual and sensory organ. A large, double-sided tube of skin, nerves, blood vessels, and muscle, the foreskin comprises 80 percent or more of the penile skin covering,⁹ or at least 25 percent of the flaccid penis's length.¹⁰ According to Dr. John R. Taylor, coauthor of two anatomical studies of the prepuce, the foreskin's location and structure indicate that it is the most important sensory tissue of the penis.¹¹

The key to the foreskin's sexual function is the ridged band, a zone of corrugated tissue just inside its tip. First described by Dr. Taylor in the *British Journal of Urology*, the ridged band contains thousands of specialized, highly erogenous nerve endings that enhance sexual pleasure.¹² Because circumcision removes almost all of these nerve endings, circumcised men never feel the sensations those nerves can provide.

The foreskin also serves as a vital defense against infection. Just as the eyelids protect the eyes, the foreskin covers and protects the urinary opening, helping to maintain the sterility of the urinary tract. It also keeps the surface of the glans soft, moist, and sensitive. Thus it maintains optimal warmth, pH balance, and cleanliness.¹³ Between the foreskin and glans, an antiviral, antibacterial substance called smegma accumulates. Smegma contains several protective substances, including an immunoprotective enzyme, lysozyme, which is also found in tears, breastmilk, and other body fluids. When the foreskin is removed during circumcision, smegma no longer accumulates between the foreskin and glans, and smegma's immunoprotective properties are lost.¹⁴

Circumcised men are becoming more aware of what they have lost through circumcision, and a growing number are attempting to restore their foreskins with devices that help stretch the skin of the penis and restore sensitivity to the glans. One of these devices, the Foreball, was developed by Dr. Wayne Griffiths, cofounder of the National Organization of Restoring Men.

Ironically, the value of the male foreskin is not lost on the cosmetics and medical research industries. Organogenesis is among several companies that use cells from foreskins amputated from male infants to produce artificial skin. Organogenesis received FDA approval for Apligraf, an artificial skin made from a combination of foreskin and bovine collagen. Cosmetics companies such as SkinMedica sell wrinkle creams and moisturizers made from infant foreskins. SkinMedica's TNS (Tissue Nutrient Solution) Recovery Complex, which retails for about \$125 per half-ounce, is said to reduce facial lines and wrinkles.¹⁵ According to the product's box, it is made from "human fibroblast conditioned media"—in other words, human foreskin. *medical myths vs. reality*

The medical value of circumcision is very much in dispute. Throughout its history, circumcision has been claimed by the medical community to cure a wide range of ailments, from epilepsy to tuberculosis. More recently, some claim it prevents penile and cervical cancers and other sexually transmitted diseases (STDs). However, all these claims either remain unproved or have been disproved.

According to the American Academy of Family Physicians (AAFP), "The evidence indicates that neonatal circumcision prevents urinary tract infections (UTIs) in the first year of life with an absolute risk reduction of about one percent and prevents the development of penile cancer with an absolute risk reduction of less than 0.2 percent."¹⁶ In its position paper on neonatal circumcision, the AAFP goes on to state that "evidence suggests that circumcision reduces the rate of acquiring an STD, but careful sexual practices and hygiene may be as effective."

As far back as 1989, the American Academy of Pediatrics (AAP) stated that "factors other than circumcision are important in the etiology of penile cancer . . . human papillomavirus types 16 and 18 DNA sequences have been found in 31 of 53 cases of penile cancer, suggesting the importance of these viruses in the development of this condition."¹⁷ The AAP has continued to amend its position on circumcision and no longer recommends it as a routine newborn procedure.

The Centers for Disease Control and Prevention (CDC) in 1996 found that the incidence of gonorrhea in the US was 26 times greater than the rate in Germany and 50 times the rate in Sweden. The CDC also reported in 1996 that the total rate of syphilis in the US was 13 times higher than that in Germany and 33 times greater than in Sweden.¹⁸ But while the US's circumcision rate is still above 50 percent, the circumcision policy statements of

both the AAP and the Canadian Pediatric Society acknowledge that circumcision is uncommon in most of Europe, including Germany and Sweden.

A study by Edward Laumann, PhD, published in the Journal of the American Medical Association, showed a US rate of chlamydia infection of 25.1 per 1,000 circumcised men, and zero for intact men.¹⁹

Some doctors continue to believe that circumcision can prevent certain cancers, including penile cancer and, in women, cancer of the cervix. But the American Cancer Society (ACS) has stated that “circumcision is not of value in preventing cancer of the penis,”²⁰ though the ACS does not have an official policy on circumcision. According to the ACS, proven risk factors include unprotected sex with multiple partners and cigarette smoking. Penile cancer continues to be one of the rarest forms of cancer, accounting in the US for less than one-half a percent of cancers diagnosed among men and less than one-tenth of a percent of cancer deaths among men.²¹

As far back as 1996, ACS members discouraged the AAP from promoting routine circumcision as a preventive measure for penile or cervical cancer. According to a letter from Drs. Hugh Shingleton and Clark W. Heath Jr. to the AAP’s Committee on Practice and Ambulatory Medicine, “Research suggesting a pattern in the circumcision status of partners of women with cervical cancer is methodologically flawed, outdated and has not been taken seriously in the medical community for decades. Likewise, research claiming a relationship between circumcision and penile cancer is inconclusive.”²²

Faced with this growing array of medical contradictions, the American Academy of Pediatrics in 1999 amended its position statement on neonatal circumcision to state: “Existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision.”²³

By stating this, the AAP joined the rest of the world’s medical associations in no longer recommending routine infant circumcision. The Canadian Pediatric Society does not recommend circumcision for newborn baby boys.²⁴ The more strongly worded position statement of the College of Physicians and Surgeons of British Columbia reads: “male circumcision is an unnecessary and irreversible procedure.”²⁵ And in the UK, the British Medical Association’s position on circumcision is: “The medical benefits previously claimed, however, have not been convincingly proven, and it is now widely accepted, including by the BMA, that this surgical procedure has medical and psychological risks.”²⁶

Ethical and legal concerns grow

US-based doctors, nurses, and childbirth services providers are increasingly counseling their patients and clients against circumcision and joining organizations such as Doctors Opposing Circumcision (Seattle, Washington) and Nurses for the Rights of the Child (Santa Fe, New Mexico). “As a nurse in the area of childbirth and newborn care, I refuse to participate in circumcisions and will not assist in getting the paperwork or consent signed,” says Tora Spigner, RN, MSN, of Berkeley, California. “I am an advocate for the family, and that includes the newborn. I have not even seen a circumcision since 1995 and care never to see one again.”²⁷

Broadly based ethical concerns have also arisen about a new mother’s ability to give informed consent to circumcise so shortly after birth, as well as the human rights and legal issues surrounding the infant’s own inability to consent to the permanent removal of healthy tissue (see article by Gussie Fauntleroy). People such as Matthew Hess, president of MGMbill.org, believe that the Federal Prohibition of Female Genital Mutilation (FGM) Act, which criminalizes circumcision of females under the age of 18 in the US, is unconstitutional because of its lack of equal protection for males. Hess’s group submitted a bill proposal to the US Congress to amend the law accordingly, and is looking for a sponsor to take up the bill. The Ashley Montagu Resolution to End the Genital Mutilation of Children Worldwide, named for Professor Ashley Montagu, a globally recognized scientist, scholar, humanist, and author, was drawn up in 1996. Its signatories include Dr. Jonas Salk and Nobel Prize recipient Dr. Francis Crick. Its goal is for governments worldwide to outlaw any kind of genital mutilation, including the circumcision of male and female infants and children.

The cost in dollars

Routine infant circumcision, acknowledged to be a medically unnecessary surgery, is proving to be a tremendous strain on the finances of medical insurance companies and government-sponsored services such as Medicaid. According to a 2004 cost-utility analysis by Dr. Robert S. Van Howe, neonatal circumcision increased incremental medical costs by \$828.42 per patient and resulted in an incremental 15.30 well-years lost per 1,000 males.²⁸ Dr. Van Howe’s study also found that “if neonatal circumcision was cost-free, pain-free and had no immediate complications, it was still more costly than not circumcising.”

A report published this year by the International Coalition for Genital Integrity found that US taxpayers pay for 28 percent of circumcisions, each state paying an average of \$754,478 for the surgery in 2003.²⁹ Faced with looming budget gaps, more state legislatures are looking to cut RIC funding through such programs as Medicaid. In fact, 14 states, including California, Florida, Oregon, Arizona, and Utah, have eliminated state funding for RIC. Other states are considering doing the same thing.³⁰ Circumcision is a highly personal decision. The most qualified person to make that decision is the one who will live with the lifelong consequences of body modification. The best thing you can do is to educate yourself about the medical, ethical, religious, or even monetary factors involved in circumcision before your son is born.

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Preparing for Labour & Birth

How a Doula can help you!

Doulas are trained professional women who provide emotional, educational and practical support to birthing women and their families. Doulas work collaboratively with clinical caregivers and are experienced in both hospital and homebirth settings. They are self-employed and are hired and paid for by the birthing couple. A doula performs no medical tasks.

The **labour doula** provides continuous support throughout labour and birth ensuring that the needs of both the mother and partner are met. Doulas provide guidance and comfort measures (such as breathing, relaxation, massage & positioning) during labour and are a continuous presence, often providing relief to the birth partner if needed. It is usual to meet with the family at least once before the birth.

Who needs a doula?

First time moms, those who have had a previous cesarean, moms wanting a natural birth... Who couldn't benefit from extra support during labour? Most moms I know could. Dad's can benefit too. We sometimes expect so much from our partners – but they haven't done this before either! A doula helps a partner to be involved (as much as he wants to be) in the labour and birth by offering ongoing support, guidance and reassurance.

BENEFITS OF PROFESSIONAL LABOUR SUPPORT

- 25% shorter labour
- 50% reduction in caesarean rate
- 60% reduction in epidural requests
- Doulas provide continuous and unconditional support of both the labouring mom and her partner
- Doulas help create a birth environment in which the woman feels safe and secure
- Doulas facilitate immediate postpartum bonding and breastfeeding support

Klaus, Kennell & Klaus (1993) Mothing the Mother: How a Doula Can Help You Have a Shorter, Easier, Healthier Birth

The **postpartum doula** is a woman who provides in-home care to the mother and family in the transitional time following birth. Her non-judgmental, nurturing care is focused primarily on the mother, looking after her physical and emotional needs and encouraging bonding, breastfeeding and rest for both mother and baby. The **postpartum doula** may also provide the following services: mother pampering and self-care support, cesarean recovery support, newborn guidance in bathing, massage, diapering, baby-wearing and soothing techniques, experienced breastfeeding counseling, sibling care, meal preparation, light household tasks and errands, specialized support for twins, multiples and special needs babies.

BENEFITS OF POSTPARTUM CARE

- Women breastfeed longer with woman to woman support
- The likelihood of postpartum depression is reduced through the doula's emotional support and maternal mentoring
- Increases confidence and positive parenting experiences
- Helps parents reconcile the realities of parenting and encourages them to trust their own parenting instincts
- Bonding between mother and baby and between father and baby is enhanced from the nurturing support, guidance and care of the doula

Avoiding Perineal Trauma

Here are some ideas that may help you avoid perineal trauma. Perineal trauma means either an episiotomy, tearing, bruising or swelling. The enjoyment of a comfortable perineum immediately postpartum will enhance your mothering and your general well being during these challenging days.

During Pregnancy:

- Good nutrition to promote healthy tissue
- Kegel or pelvic floor contraction exercise (see page)
- Pelvic floor relaxation and 'bulging' exercise
- Practicing various positions for the 2nd stage
- Perineal massage in the last month of pregnancy (see below)
- Education – what to expect during 2nd stage
- Treatment of vaginitis

During 2nd stage (pushing stage):

- Reassurance and encouragement
- Relaxation of the perineum
- Following your natural bearing down urges (don't rush)
- Selection of positions for comfort or to promote or slow progress

Gravity neutral positions for rapid descent

These positions will tend to slow down the descent and birth. They are useful if the 2nd stage is progressing rapidly

- Side lying
- Hands and knees

Gravity enhancing positions to promote progress

These positions will speed descent and birth as gravity aids the pushing

- Semi sitting or sitting
- Squatting
- Standing

Other ideas to enhance pushing, comfort and a gentle birth

- Use a mirror, touch the baby's head to encourage efficient bearing down efforts
- Hot compresses applied by the midwife
- Cessation of bearing down when stretching and burning are felt in the vagina. Pant or blow instead. Your midwife will assist you in this effort by informing you when to slow the pushing down

Perineal Massage

There are recent studies that support the practice of prenatal perineal massage to avoid episiotomies and perineal trauma. Perineal massage is believed to soften the tissue around the vagina and increase elasticity by taking advantage of the hormonal changes that loosen connective tissue in late pregnancy. More importantly, perineal massage seems to orientate women to their pelvic floor area simulating to some degree what she will feel during the 2nd stage and how her bottom should feel – relaxed!

Note: It is important to check with your midwife if you think you have vaginitis, herpes or other vaginal problems before you begin prenatal perineal massage.

Preparation

Either you or your partner can do the massage. Most women find it easier for their partner to do the massage. The first few times take a mirror and look at your perineum so you can see what you are doing. Be sure your fingernails are short. If you or your partner have rough skin, it might be more comfortable to wear disposable rubber gloves. Wash your hands before beginning.

Lean back comfortably on pillows, squat against a wall, sit on the toilet, or stand with one foot up on the edge of the tub or a chair.

Method:

Lubricate your fingers well with oil or water soluble jelly. Some people recommend wheat germ oil, available at health food stores, because of its high vitamin E content, but other vegetable oils or water based lubricants such as K – Y jelly can also be used. Do not use mineral oil or petroleum jelly put out a small dish and discard unused portion after massage. Do not replace in container.

If you are doing the massage yourself, it is probably easiest to use your thumb. Your partner can use their index fingers. Put the fingers or thumb well inside the vagina (up to the 2nd knuckle). Gently stretch the opening, pressing down on the perineal floor towards the rectum and to the sides (3 o'clock to 9 o'clock), until you feel slight tingling. At this point, stop, make sure your bottom is relaxed. Try doing a Kegel exercise, relax and then carry on maintaining the stretch and pressure for approximately 2 minutes. Then slowly and gently work the lubricant in using a sling-type motion, still maintaining the same pressure and stretch. Avoid the urethral area because of potential infection. Massage for 3-4 minutes, concentrating on any previous episiotomy scar tissue, which is especially non-elastic

In the beginning, you will feel tight, but with time and practice, there will be a noticeable increase in flexibility and stretchiness. Some women will find the motion of the fingers going in opposite directions to be more comfortable. Others will prefer the fingers to stretch the tissue in one direction at a time. You can also massage by rubbing the skin of the perineum between the thumb and forefinger (thumb on the inside, finger on the outside or vice versa).

Remember: practice both relaxing the perineal muscles completely and slow deep breathing while the massage is taking place.

Where will you have your baby – home or hospital?

Even early in your pregnancy you will be faced with a range of choices and asked to make decisions. In order to help you decide what is right for you and your baby, you need information about any potential advantages or disadvantages that there might be in the services available. The following information is designed to give you up-to-date information based on what is known to be effective, so that you can make the right choices for you and your baby. It will hopefully help you decide which place is best for you and your baby – hospital or home.

The general assumption is that women, especially women who are pregnant for the first time, will have their baby in hospital. However, you have a choice between giving birth at home or in a hospital environment. There are important factors that need to be thought through when you are making your decision. The main one is that of safety – for you and your baby. But alongside this is your own preference, where you will feel more comfortable, more relaxed and more in control.

Safety first

At the same time as hospital births became more common, fewer babies were dying. It's not surprising people linked the two and concluded that having babies in hospital was safer. Recent studies have not, however, shown any link, and it is probable that the number of babies dying would have fallen anyway due to the use of antibiotics, better education and improved living standards. Research is ongoing however, when pregnancy is straightforward or 'low risk', studies suggest that home birth is as safe as hospital births for women and their babies, so long as they are cared for by well trained carers. Therefore, even if this is your first baby, you can still book a home birth. There is no evidence to suggest it is unwise.

Midwives have to adhere to guidance given by the College of Midwives standard 'Indication for Discussion, Consultation and Transfer of care.' This guides midwives' decisions in practice so to help establish a woman's level of risk. There are some situations when your midwife will advise against home birth on the grounds of safety. Examples would include labour before 37 weeks, breech presentation or twins. Regular care and screening helps to detect most of these situations.

Home birth is safer when midwives have ready access to hospital back up in case of emergency. A safe time/ distance to the nearest hospital has never been determined but 30 minutes travel time to the nearest hospital is seen as acceptable.

Feeling comfortable

Being as relaxed as possible when you are in labour is more likely to help you and help your labour. If anything is making you anxious or upset, you will become tense and may feel more pain. Women who choose to give birth in their own homes are more likely to feel in control as they have familiar things around them and can wander around freely and do as they please. A home birth may be right for you if you have strong feelings about how you want your labour to be; for example if you:

- _ don't like hospitals;
- _ want more privacy.

But only you know the kinds of things that will help you feel relaxed. Other women may feel safer in hospital, and may feel reassured by having experts and a range of services on hand to help them if needed.

The choices

Hospital

Advantages

- _ You can choose any type of pain relief including an epidural.
- * Most hospitals provide expert emergency care including cesarean section
- _ Everything is to hand if there are problems – you don't have to move.

Disadvantages

- _ There are hospital policies and procedures that must be followed when birthing in hospital
- _ There may be a limit to the number of people allowed in the birth room
- _ Unfamiliar surroundings and caregivers can affect a woman's confidence and ability to labour. _ Women may feel restricted and/ or inhibited. This can make it more difficult to feel in control of your birth experience
- _ You are more likely to need pain relieving drugs during your labour, have an episiotomy (a cut in the opening of the vagina), to have your labour augmented, need a forceps or vacuum delivery or cesarean section
- _ Mother and baby must stay for a few hours after the birth before they can go home
- _ Separations between mum and baby for routine hospital procedures may occur
- _ Following the birth, mum and baby are moved to the postpartum ward, where rooms are often shared.

Home birth

Advantages

- _ You are less likely to need pain relieving drugs during your labour, have an episiotomy (a cut in the opening of the vagina), to have your labour augmented, need a forceps or vacuum delivery or cesarean section
- _ Studies have shown that women who have had both a home and hospital birth, say they much prefer a home birth.
- _ Security. Only the people you have invited to share in your experience will be present.
- _ The comfort of being in familiar surroundings is relaxing and helps to connect the experience of labour to normal life experience.
- _ You may feel more relaxed and in control when you're in your own home.
- _ Relaxing helps women to labour more effectively
- _ Women may be less inhibited and able to move and make sounds as they feel
- _ Mother and baby experience less separation and interruption which helps breastfeeding and bonding

Disadvantages

- _ You can't have an epidural or other pain relieving drugs at home
- _ You may have to transfer to hospital if there are any complications.
- _ It is the responsibility of the family to gather and purchase birth supplies
- _ The postpartum mother may have less support than that available in the hospital (for example; supervised nurseries and meals).

What we don't know

All of life involves some measure of risk and this applies to giving birth, wherever the birth takes place. When considering home birth, one must therefore accept that there is always the possibility, no matter how small, of a tragic complication which could have been more effectively dealt with in hospital.

However, this risk is small and midwives are trained to handle obstetric emergencies. Midwives update their skills regularly and they carry equipment and drugs that would be necessary in such an event. Midwives are also trained in infant resuscitation in the same way that doctors and nurses are.

Occasionally, women develop complications during pregnancy and/or labour where they need access to specific care that is usually only available within a hospital environment. Therefore even if you have chosen to have your baby at home, if complications arise, you may be advised to transfer to a hospital.

Transfer

A few women having their first baby have to be transferred from home to hospital during labour. Women who have already had a baby are much less likely to transfer. The most common reasons for transferring to hospital are worry about the baby's condition or when labour is not progressing. Even if your baby is born at home, there's a small chance you or the baby may need to go to hospital. Studies suggest that women who transfer with a continuous care giver (for example; a midwife) do not regret their original decision to have a home birth.

Your choice

Choosing where to give birth to your baby is an important decision. You have plenty of time to make your decision and you can change your mind at any time during your pregnancy. If you are advised not to give birth in the place you want, ask the midwife to explain the benefits and risks for you and your baby.

How to find out more

If you want to talk more about where to give birth, you can discuss this with your midwife.

Questions you may want to ask

After reading this leaflet there may be some things you are still not sure about. You can write down any questions you have and any things you would like to discuss further.

PREPARING FOR A HOMEBIRTH

Preparing for the birth of your baby requires physical, emotional and education preparation. There are also some practical preparations to help everything go as smoothly as possible before, during and after your baby's birth. Although this information is primarily designed with home births in mind, many of the suggestions will be useful to those planning a hospital birth.

SUPPLIES NEEDED:

Have everything collected and ready 3 weeks prior to your due date. Pharmasave Compounding Pharmacy carries all supplies needed for home births. Alternatively, supplies can be bought online at www.MamaGoddessBirthShop.com or at Mothering Touch on Fort Street (see contact details in the Resource List at the beginning of this book). Store supplies in a clean, dry, childproof container in your birthing room. Ensure that your partner knows where you have put everything!

Labour and Delivery:

- 2 packs of laparotomy sponges
- Large zip lock bag or yoghurt container for placenta
- 24 disposable under pads (approx. 18" x 24")
- 1 peri bottle (squirt bottle)
- Plastic sheet (or shower curtain) to cover mattress
- 2 garbage bags for trash and laundry
- 1 thermometer
- 1 hot water bottle or an electric heating pad (optional)
- 1 hand mirror (optional)
- 1 flashlight and extra batteries
- 1 large box of sanitary napkins (overnight, extra long or maternity)
- 1 or 2 pairs of disposable, net underwear (optional)
- 2 gel-type cold packs in the freezer or a good supply of crushed ice
- Traumeel tablets or homeopathic arnica 200 ch

Gatorade (to help maintain hydration and provide needed calories while you are in labour)

Alternatively, see recipe for '**Labour aide**' on page 56

If this is at least your 2nd baby:

Ibuprofen or Tylenol (acetaminophen, not aspirin) for after pains

1 box of newborn disposable diapers for the first few days (optional)

Refer to Postpartum Treatment sheet for more information

Linen

- 2 flat sheets
- 2 fitted sheets
- 2 hand towels
- 4-6 large towels
- 8 wash cloths
- 8 receiving blankets

Birth Packs

Wash all of the linen items in hot water and dry in a hot dryer until thoroughly dry. Wrap them in clean pillowcases or double bag in paper bags and label the contents on the outside. Store in a clean, dry area of your birthing room. Use old or dark coloured linens as some may be stained during the birth. Wherever you choose to give birth should be clean, draft free, dust free, easily heated and well lit. Some people prefer to use their living room or a spare room for birth, keeping their own bedroom clean and peaceful for after the birth. Wherever you choose to be, the following guidelines will help you get organized.

Bed

Must be firm (waterbeds are unsuitable)

Access to the bed from both sides is helpful

Make up the bed with a good sheet first (for after delivery), the plastic sheet on top of this, then the birth sheet over the plastic. If you will move to another bed after the birth, the bottom sheet is not necessary.

Tables

One by the bed for birth supplies (clean and clear of clutter)

One table/dresser top near the bed for setting up infant resuscitation equipment.

A good light source (eg. gooseneck lamp) is required here.

Lighting

Candlelight is fine for the birth (provide sturdy, safe candle holders in a safe place to prevent accidental upset)

Provision for instant adequate electric lighting if required.

Electrical Outlets

You need to have 2 or 3 free electrical outlets in the birthing room

Having an extension cord available is useful

Heating

The birth room's temperature may be controlled (kept cool) for the comfort of the mother during labour.

When the baby is born, it is very important for the room to be warm and draft free (an auxiliary space heater may be required)

Hygiene

Please provide a clean, uncluttered area close to the birth room for hand washing, with clean towels, soap and paper towels

Showers and tub baths are helpful for relaxation and/or pain relief during labour. (Check with your midwife before taking a tub bath during labour if your waters have broken).

Ensure that the tub/shower is very clean.

GENERAL PREPARATIONS

- Pre-register at the hospital approximately 4 weeks before your due date.
- Ensure that your house number is clearly visible from the road, lighted if possible.
- Post a phone list and directions to your house beside your phone
- Keep your vehicle in good working order, free of extra belongings, with sufficient gas in case transport to the hospital is required. (There should be at least enough room for the driver, labouring mother and the midwife)
- Food and drink for the labouring woman and helpers. Flexible straws or sports drinking bottle with a built-in-straw are good ideas.
- Frozen meals (soups, casseroles, breads, muffins, etc.) for at least one week
- Household help and childcare for at least 2 weeks so the new family can relax and enjoy the new baby.

*** Optional - birthday cake, champagne, balloons!

Recipe for Labour Aide

In a blender add;

1/3 c fresh lemon juice

1/3 c honey (to taste)

¼ tsp salt

2 cal/ mags, crushed (calcium/ magnesium tablet)

Add water to make one litre

Blend and freeze in ice cube trays

Three Variations of Labour

By Leslie Clough, Childbirth Educator, BC Women's Hospital

	What's happening?	How will it feel?	What helps? (Mother)	Partner
Slow to start	The cervix is thick, long and in a posterior position when contractions start. The baby's position may still be high in the mother's pelvis. The cervix is slow to dilate despite contractions	Contractions may or may not be very painful May be tiring, discouraging, draining Worried something is wrong with her or the baby	Alternate between restful, distracting, and labour stimulating activities. Discuss labour stimulating activities with your caregiver <u>Restful</u> Baths/ showers Massage Warm drink Napping <u>Labour stimulating</u> Walks Love making Nipple stimulation Bowel stimulation <u>Distracting</u> Walks Baking Videos Games Drink & eat to thirst & hunger. Fluids are very important Use breathing techniques Try not to worry	Maintain her morale Keep patient & confident Focus on restful, distracting, labour stimulating activities, not on contractions Call people / caregivers who are encouraging (ie doula) Help her alternate activities
Rapid Labour	The cervix is very soft (ripe) & thin (effaced) and may be partially dilated before labour begins. Labour starts with hard frequent contractions. The cervix quickly dilates, and there is little pushing time	Labour starts with hard frequent contractions No noticed early labour Anxiety, provoking, hectic Shocked, not believing this is labour Panic and loss of confidence if she thinks these are the easy early labour contractions	Keep list of phone numbers by phone - Midwife, partner, alternate partner Call for help immediately Trust what you are feeling Go into and stay in gravity neutral position (eg side lying) Use the type of breathing that most helps Once help arrives focus on contractions Go to hospital by ambulance if you feel the baby is coming or you want to push	Believe what you see Move into a leadership role to help her cope. Help her maintain a gravity neutral position Don't lose faith in her Call midwife Drive carefully but don't waste time Go by ambulance if she is pushing or feels the baby is coming
Back labour	The baby's back is facing the mothers back. The baby's head is pressing against the mother's sacral area. Contractions help to turn the baby	Pain is centred in the small of the back The length of active labour may be increased Back pain may become worse in active labour & more painful than contractions until the baby turns	Choose positions that encourage the baby to turn; Hands and knees (head down) Stand/ walk/ up and down stairs Pelvic tilt/ rocking Change positions frequently Go into the shower and direct on lower back, combine position and water therapy Stroke your tummy (or partner can) in direction you want the baby to turn. Start at her back and move your hand to the front	Help her to change positions Apply counter pressure Massage Apply cold/ heat to lower back

Labour & Birth: Questions & Answers

	What's happening?	What does it feel like?	What the partner can do?
Prelabour On & off constant for hours or days	Cervix softens, thins	Mother has some possible very early signs of labour (<i>vague nagging backache, several soft bowel movements, intermittent or continuous cramps possibly extending into the thighs, unusual burst of energy, increased vaginal discharge, 'show', continuing, non progressing contractions that do not become longer, stronger and closer together over a period of time</i>) Mother may become anxious or tired if it lasts a long time	Encourage normal activities in the daytime, as long as they are not strenuous. If the contractions start in the evening or during night, take a shower and go to bed – it is ok to take Graval 100mg Distracting activities are appropriate Mother should eat whenever she feels like it Be patient; do not get over excited or preoccupied with contractions Mother can bathe or shower* to relax *(Do not have a bath if your waters have gone)
Early labour (1st stage) Lasts a few to 20 hours	Cervix thins & dilates to 3 or 4 cms Contraction every 5-20 mins, last 30-40 sec, may be mildly painful Cervix may also need to soften and move forward Longest part of labour May have 'show' Membranes may rupture	May feel a heaviness in lower and abdomen like the beginning of a period Contractions start in the back and move to the front Restless Excited, anxious May feel nauseated & vomit	Continue as in prelabour Go for a walk Frequent fluids (see Labour aide recipe below) Light meals, easily digested Empty bladder every 1-2 hrs Have baths/ shower Music Slow relaxation breathing when mother cannot walk or talk through contractions
Active labour (1st stage) Lasts ½ to 6 hours approx	Cervix thins completely Continues dilation to 8 cms Rhythmic contractions last about 60 sec's and occur every 3-5 mins Faster progress Baby moves down in the pelvis	- Contractions are longer, stronger and close together, They are much more intense - you cannot talk or walk during contractions - increasing pain keeps you focused on working with your body. You become quiet and focused on the labour - need to stay relaxed and keep breathing softly regardless of the pattern of breathing being used or the intensity of contractions	Now, its time to call the midwife! Continue as above <u>In addition:</u> She will require your total, undivided attention Match her quiet, serious, focused mood Use comfort measures. For backache use cold or heat, counter pressure, massage position changes Remember to offer fluids after every contraction Remind her to urinate every 1-2 hours
Hard labour or transition (1st stage)	Last stage of labour Dilation is completed Contractions every 1-2 mins lasting 60-90 secs Shortest stage Body working very hard & efficiently Baby may begin descent giving pressure on rectum	Most intense part of labour Completely focused, using all resources to work with contraction, nothing else matters Hearing acute Intensity may be overwhelming May express feelings of fear, panic, anger, despair May feel sick, vomit, tremble, belch, hiccup, hyperventilate, grunt, urge to push	Know this is the shortest & most intense part of labour Complete concentration with each contraction Support of these around you Focal point Remember the baby <u>Use comfort measures:</u> Change position between the contractions Shower/bath Use your voice (low & deep)
Birth (2nd stage) Lasts 15 mins to 3 hours	Contractions push the baby out of the uterus, down the vagina Uterus does 80% of the work Mother follows her natural urge to push using abdominal muscles Baby's head turns to find the best fit through the pelvis and under the pelvic bone Perineum stretches Contractions every 3-5 mins lasting approx 60 sec	Some women experience a rest period before pushing starts Urge to push builds in intensity until uncontrollable. May occur intermittently during a contraction Working very hard Feel very hot/flushed but feet cold May feel more motivated / energized More aware of surroundings More rectal pressure Crowning of baby's head causes a stretching, tingling & burning sensation Tremendous relief with birth of head	Help her to relax between contractions & encourage her to push when she feels the urge Cool cloth on face and neck Hair off the face and neck Warm socks on feet Help to change positions Remind her of the baby Don't rush – the midwife will remind her to stop pushing and breathe her baby out or pant to stop pushing Help her to tune in to midwife's instructions
Delivery of Placenta (3rd stage) Lasts 5 to 60 mins	The uterus contracts to release the placenta	Mother may feel shaky May feel the uterus contracting Relief as soft placenta is delivered Birth of the placenta is often hardly noticed	Enjoy baby You may want to cut the cord You may want to hold baby if mother is not ready or has pain still from contractions or needs stitches

Note: When the waters break – you do not need to call the midwife unless:

1. It is daytime
2. The midwife has instructed you to do so
3. The fluid is dark green in colour
4. Contractions intensify quickly
5. You are less than 37 weeks pregnant

After the baby is born!

KEEPING YOUR MIDWIFE INFORMED: If you have any problems, call a midwife immediately. You can expect to see a midwife at your home every day for the first 2-3 days and then gradually decreasing over the next month.

Your Emotions: Up to 80% of women get the 'blues' within the 1st 3 to 4 (sometimes up to 10) days after birth. You may be surprised by sudden periods of crying, anxiety, quick mood changes and irritability. The good news is that these feelings usually don't last long and you can do something about them;

- Have regular breaks during the day
- Talk to others about how you feel
- Rest as much as possible
- Take part in activities you enjoy
- Accept help from others
- Take time for relaxing exercise, even a simple walk
- Remember that household chores can wait while you get to know your new baby

IF YOU ARE STILL EXPERIENCING NEGATIVE FEELINGS after the first 2 weeks after childbirth, you could have postpartum depression or anxiety which occurs in about 20% of mothers (for more information see '*Babies Best Chance*' p86). You may need help. It is important to let your midwife know how you are feeling.

Rest: Get plenty of rest for the first two weeks. You will be able to care for yourself and the baby, but don't expect too much of yourself. You will need someone to substitute for you in general household duties (cooking, cleaning, laundry, shopping and caring for older children) for at least one week. Rest when the baby is sleeping and keep visitors to a few close friends or relatives who are willing to help. Remember that fatigue decreases your breast milk supply and your ability to cope with these new added responsibilities.

Baths & Showers: Sitting in a warm *sitz* bath for 10-15 minutes several times a day will aid in healing of stitches, keeping your perineum clean, and decreasing discomfort from haemorrhoids or stitches. Thoroughly clean and rinse the tub before using. Have a shower to cleanse your body, rather than washing yourself in the tub and then soaking in the same water. Showers are also useful to relieve breast discomfort associated with engorgement.

Vaginal Bleeding: Normal lochia (flow) lasts for 3 to 4 weeks though can continue until 6 weeks in some women. Generally, during the first 24 hours after birth, the bleeding should be like a heavy period. By the third or fourth day it will have thinned and become *reddish/ brown* in colour. By the tenth day it is often like a pale, pink, watery fluid, spotting enough to require a light pad. If after the third day the bleeding becomes bright red and heavy again, it is often a sign that you are overactive and need to slow down. *Sometimes a sudden but transient increase in bleeding may occur between day 7 to 14. This is sometimes related to the shedding of the old placental scar from the uterine wall and should stop within 1 to 2 hours.* If you should bleed heavily at any time (ie; soak through a pad in one hour or less); you must empty your bladder, lie down with an ice bag on your abdomen, and nurse the baby. Massage your uterus and ensure your uterus stays firm. If this does not stop the bleeding, call your midwife.

Activity & Exercise: Listen to your body and let it be your guide to activity and exercise. You should limit your stair climbing for the first week. You may go out for a ride or dinner when you begin to have "cabin fever" and drive your car in two weeks. Begin Kegel exercises within the first week and abdominal exercises when you feel ready after delivery. Start going for short walks 10-14 days after the birth. Remember that you have to get home again, so make the first walks very short, and then gradually increase the distance each day.

Sex: Again, listen to your body. Women vary greatly in when they feel like having intercourse again: some will start in 2 weeks, others not for 6 months depending on how the birth was, amount of trauma to the perineum, how much time is spent with the baby, how tired you are and what your relationship with your partner is like. Whatever you feel is right for you. Talk to the midwives as you feel the need. Breastfeeding can also reduce women's natural vaginal lubricant – a synthetic lubricant, such as 'astro glide' can be used.

Contraception: You CAN become pregnant again soon after childbirth even if you are breastfeed

*See pages 92 - 95 in '*Babies Best Chance*' for an outline of your options

Note:

- Combined oral contraceptives (oestrogen and progesterone) can suppress milk supply & is not recommended if breastfeeding. The Progesterone only pill is safe during breastfeeding however it is best delay starting this until breastfeeding is well established
- Natural family planning - methods which depend on predicting the time of ovulation by use of basal body temperature or assessment of cervical mucus cannot be used until regular menstrual cycles have resumed.

Common Postpartum Discomforts

Constipation: You will probably have your first bowel movement within three days after delivery.

- Drink plenty of fluids (6-8 large glasses each day), and eat a diet high in fibre; raw fruits and vegetables, bran and whole wheat products.
- Sometimes it may be necessary to use a gentle stool softener but you must be careful not to become dependant on this. Only use stool softeners if necessary and for no longer than a few days

Stitches & Haemorrhoids:

- Sit in a tub of warm water several times a day to soothe your perineum whether the discomfort is due to stitches, bruising from birth, or haemorrhoids.
- You may also apply ice packs or witch hazel compresses (Tucks) to the area

Difficulty passing urine:

- Try standing in a warm shower or sitting in a tub of warm water.
- Leave the water running in the tub or spray warm water over your perineum (front to back) with your squeeze bottle.

*If the above methods fail and you are still unable to void call a midwife

Breast Engorgement & tenderness: When your breasts begin to feel heavy, you may find comfort in a good supportive bra. The extreme fullness (due to engorgement of the tissues as the milk comes into the breasts) may be noticed on the second or third day. The discomfort usually lasts for 12-24 hours

- Place cool, washed cabbage leaves directly on and around the breasts and hold in place with a bra. Do not leave in place for longer than 2 hours.
- Nurse the baby frequently and apply heat in the form of a shower or warm towels prior to breastfeeding to aid the letdown reflex.
- Express a few drops of colostrum or breast milk after each feeding and let your nipples air dry for 20 minutes.
- Ensure that the baby is accurately positioned at the breast and change breastfeeding positions, as this will rotate the pressure area on the nipple. Nipple tenderness as the baby latches on and shapes the nipple is a normal sensation. The discomfort should be gone after the initial 8-10 seconds of breastfeeding.
- If the pain persists, check the baby's position carefully and correct as needed.

After Pains: There is usually little or no cramping pain after your first baby. With second or subsequent babies, the after pains may be severe for the first few hours after the birth. These contractions will diminish in intensity and are often easy to handle by 24 hours after the birth.

- Urinate frequently: every 1-2 hours even if you don't feel the need. This reduces tension on the uterus.
- Black Haw will significantly reduce the pain in the first few hours. Have the herb capped and ready before the birth or purchase in tincture format.
- Take 4 size 00 capsules as soon as the after pains gain your attention. The pain should diminish within 20 minutes. Take 4 more when the pain returns, up to 24 capsules during the first day. Reduce the dosages with each day as the pain severity decreases. Usually Black Haw is not needed by the third or fourth postpartum day.
- Many women prefer to use acetaminophen (Tylenol[®]) or ibuprofen (Advil[®]). Ibuprofen is particularly effective in reducing the discomfort of after pains. Take 400 mg every 4 hours as needed for the first few days after the baby is born.

Perineum Discomfort:

- COMFREY ROOT and GINGER ROOT: Put a handful of dried or fresh comfrey and 6 large slices of fresh ginger root into 1 1/2 litres of water and bring to the boil. Reduce the heat and simmer for 45 minutes. Add 6-10 leaves of fresh comfrey if available, during the last 5 minutes. Let the decoction cool until the water is just cool enough to touch with your hands. Dip a clean diaper or hand towel into the brew, wring it out, and apply as warm as tolerable to the perineum. Replace the poultice once it cools. Repeat this process for 1/2 an hour at least twice daily. Apply more frequently for severe swelling or soreness. Keep the brew in the pot and reheat as needed. Replace the decoction

after three days. You may also add this decoction to your bath water 1-2 times daily, keeping the level of the bath only a few inches deep to avoid diluting the decoction too much. A sitz bath is also excellent for this purpose.

- HONEY: Buy a small new jar of honey and put it close to your toilet. When you change your pad, swab honey onto the peri pad. The honey will soothe and heal the perineum. Its antibacterial qualities will help prevent infection.
- GREEN CLAY: This is healing clay, which can be applied directly to the perineum after bathing or liberally applied to your clean menstrual pads for the first 1-2 weeks. Green clay is also excellent for healing the caesarean scar. Apply liberally to the clean scar.

Stress: Stress causes your body to use calcium faster. Liquid calcium supplements are more readily absorbed.

- Drink 1-2 cups of CALCIUM TEA daily. If you use a pill form, ensure that it has a 1:1 ratio with magnesium to ensure absorption and usage. Calcium helps your muscles, nerves and mind to relax. It will calm you and help you to sleep, or to rest when the baby sleeps.

Sleeplessness:

- VALERIAN ROOT POWDER: Many mothers find that they are unable to sleep or “let go” in the first or second week after birth. If you find that you are unable to sleep when everyone else is sleeping, take 2 capsules of Valerian. To counteract the strong, unpleasant odour, take with food or drink.
- WARM MILK contains an amino acid called tryptophan, which aids in relaxation.
- Rest when the baby sleeps, even if it is mid-day and household duties remain undone. A relaxed and rested mother is more important than a clean house!

Breast Infection:

- POKE ROOT: Pokeroot tincture: 4-6 drops every 2 hrs for 6 hrs (4 times in total). Then, 4 drops every 6 hrs for the next 24-36 hrs.
Capsules: 2 capsules 3 times daily for 3 days
The homeopathic form of pokeroot is Phytolaca. It is also effective in treating breast infections.
- ECHINACEA: Combined with above tincture, 5-10 drops every 2 hours for 2 days, or until infection subsides.
- VITAMIN C: 1000 mg 3-4 times daily.
- HOT COMPRESSES: Use a towel soaked in hot water and wrap the breast or try soaking towel in the following brew:
- SLIPPERY ELM powder, COMFREY ROOT, and GINGER powder: Combine and simmer with water for 20 minutes. Soak a towel in the brew and apply to the breast. The brew can be used for several applications.
- A POULTICE of grated, raw POTATO, can draw out the heat of the inflammation, and unblock plugged ducts. Apply directly to the affected breast, cover with a clean cloth and change when dry.

GENERAL CARE IF YOU HAVE A BREAST INFECTION:

Check the baby's eyes and skin. If scaly, wash area, change bedding and wash hands.

Check the baby's mouth for thrush and your nipples for yeast. A yeast infection transferred between the mother and baby is a possible cause of breast infection. Contact the midwife for a diagnosis and treatment of yeast.

Drink lots of fluids and rest as much as possible. Stay cool and eat cooling foods such as watermelon. Avoid cheese, meat, greasy foods, coffee and alcohol. Fatigue can prolong a breast infection. If you have a fever or flu-like symptoms, acetaminophen (Tylenol ®) or ibuprofen (Advil ®) may be taken.

Encourage the baby to feed frequently on the affected breast. Pump the breast if the baby is not draining it well.

Change the baby's position when feeding to allow drainage of different milk ducts. Gentle massage of the affected area of the breast can also help to clear the plugged duct.

Summary points – when you need to call your midwife;

1. If bleeding becomes heavy (ie soaking through a maternity pad in less than an hour)
2. If you develop a temperature over 37.8 C or 100 F
3. If you cannot pass urine
4. If you develop flu like symptoms or think you have an infection
5. If you have persistent feelings of inadequacy, helplessness, anxiety or thoughts of harming yourself or your baby
6. If you have urgent concerns about your baby's well being

GENERAL POSTPARTUM RECOVERY:

- **BOB'S IRON FORMULA:** keep taking this to boost your iron levels. Available only at Pharmasave Compounding Pharmacy on Old Island Highway at Helmcken Rd.
- **ARNICA:** is a homeopathic remedy used for physical shock and trauma. It aids in healing and recovery. Take 3-4 pills of Arnica every few hours, starting immediately after the birth, for the first 12 hours. Arnica can be given to the baby if the birth was stressful. Give 1 pill on the baby's tongue every few hours for the first 12-24 hours to aid in recovery (up to 4 pills total).
- **WUCHI PAI FENG:** sometimes called "chicken eggs" is an ancient Chinese remedy used to tone the blood and energy, warm the uterus and nourish the mother in her postpartum. It is particularly useful if you feel nervous, tense or exhausted. 12% of this formula is made from chicken. Take 10 pills 2 times daily for 1-2 months. Do not take this remedy if there are any signs of infection anywhere in the body. Do not take if you have a fever, cold and flu, or if your breasts are tender and pink beyond normal tenderness of engorgement. Do not take if your lochia smells bad or if your uterus is painful to touch (other than normal after pains).
SHOU WU CHI: is the postpartum remedy for vegetarians.
- **FLORADIX:** is a useful tonic during the first few postpartum weeks if your haemoglobin is low due to blood loss during the birth.
- **HEMAPLEX 50** is another excellent supplement for low haemoglobin. It can be purchased at a health food store.
- **AN MIEN PIEN:** A Chinese remedy for sleeplessness in pregnancy or postpartum. Follow directions on the box and wash the outer red coating off the pill with cold water

Supporting Milk Production:

BLESSED THISTLE: brewed as a tea helps with milk production. Ensure that the baby is well positioned at the breast and nursing frequently. Exhaustion and lack of food or fluids will decrease your milk supply

NEWBORN GUIDELINES FOR PARENTS

KEEPING YOUR MIDWIFE INFORMED: If you have any concern about your baby, please do not hesitate to call.

Breathing pattern: Babies make all sorts of sounds with normal breathing. It is normally irregular with rapid (30 - 60 breaths per minute), shallow respirations alternating with deep, slow respirations. The most common breathing sounds come from small amounts of mucous in the nose and throat. Babies will also have periods of very quiet breathing. When babies cry vigorously, they become redder in the face and take deep, gasping breaths.

Colour: A small amount of bluish colour around the lips, hands and feet is normal for a newborn. There may also be some mottling on the chest and abdomen.

Temperature: Your baby's temperature may be unstable for the first few days. Take the baby's temperature under the arm. A normal temperature is between 36.5 - 37.5 ° C or 97- 99°F.

Feeding: Your baby should have a strong and vigorous suck. Note the strength of the suck. Nurse the baby whenever he/she appears to be hungry but do not let the baby go more than 4-5 hours without feeding in the first month. Breastfeeding is erratic in schedule for the first few months but usually there will be 10 - 12 feedings (minimum of 8) in a 24-hour period. Frequent feedings in the first few days encourages the baby's bowels to move, getting rid of the meconium and thereby lessening a problem with jaundice. Frequent sucking also brings your milk in sooner. Ensure that the baby is correctly positioned at your breast every time you feed.

Urine: Please note the time of the first urination. If the baby has not had it's first urination by 24 hours of life, please notify us. After your breast milk is in, expect the baby to have six or more saturated wet diapers per day, indicating that the baby is getting an adequate supply of breast milk.

Bowel movements: The first bowel movements are large, sticky, black/green stools called meconium. Note the time of the first bowel movement. It normally occurs within the first 24 hours. The transitional stool between meconium and the milk stools will range in colour from brown to green and be quite soft. The breast milk stools are mustard in colour and quite liquid in consistency. Notify us if the baby has not had its first meconium stool within 24 hours after delivery.

Movements: Most babies' movements are initially somewhat jerky. The startle reflex is normal in the first 3-4 months. Babies move both arms and legs at the same time.

Jaundice: Following birth, the newborn begins to break down excessive red blood cells which are no longer necessary. The liver is responsible for breaking down the red pigment matter (bilirubin) in the red blood cells. Sometimes because of immature functioning or a backlog of cells to breakdown, the liver does not keep pace with metabolizing of the bilirubin and the extra bilirubin circulating in the blood system gives the baby a yellow appearance to the skin and whites of the eyes. Blanch the baby's skin in the natural light of a window and look at the colour of the skin and the eyes.

Cord Care: Current research has shown that it is unnecessary to use alcohol to treat the umbilical stump to facilitate its drying and healing. Keep the diaper folded beneath the umbilicus to facilitate drying. There may be one or two drops of blood when the cord separates. The cord may fall off anywhere from 5 days to 14 days after birth.

Bathing: You may sponge bath or tub bath your baby. Generally babies need very little soap, just a good soaking in warm water. You may also have one parent get into the bathtub, then have the other parent hand the baby in and have a bath together.

For further information on Infant Care please see 'Babies Best Chance' p110- 138

Sleeping	110	Coughing and sneezing	118
Safety and Sleeping	111	Vaccinations	119
Sleeping Equipment	112	Tummy time	121
Diapering	113	Crying	121
Bathing	114	Shaken Baby Syndrome	123
Caring for Baby's skin	116	Anger Management	124
Caring for Baby's nails	116	Baby Medical Care	125 – 127
Jaundice	116	Baby Safety	128 – 131
Bowel movements	117	Special circumstances	133
Urination (peeing)	117	Baby Development	134 – 137

THE SECLUSION PERIOD

By Gabrielle Moore

Mothering, Spring 1982

Consider carefully your baby's first weeks in this world. Hopefully each parent will provide a peaceful, secure, loving, and centered home environment where the baby can integrate into the world without confusion, stress, tensions, overstimulation etc. The baby is a pure heart entering as a clean slate with no thoughts, fears, worries, expectations, and projections – just love. No time is more important for the child's developing being than the first few weeks following birth. This is when the infant absorbs all impressions brought before it. Therefore, the mother may wish to be discrete in choosing what impressions to expose her child to.

This is when the seclusion period comes in. It is best to have a close friend or relative live in or drop in to tend to the preparation of meals, the washing of clothes, and the other household duties, to free the mother to be with the baby. Seclusion allows the baby and mother a time to bond without interruptions. The mother may find she needs the seclusion period to adjust to her new role, to stay centered, and to rest and recuperate. Being alone with the baby provides a comfortable environment for the mother to learn how to be with her baby, how to nurse, how to comfort her baby, how to coo with her baby, without feeling self-conscious and nervous in front of others. It is important for the mother to *be* love herself, for no one impresses the infant more than the mother. One wants to reflect feelings of love and beauty, pure thoughts, and the awareness of seeing everything as God's perfection. Seclusion helps in preventing the energy drain that often results from visiting others. Pregnancy and birth are a greater stress on one's being than one realizes. A new mother needs to isolate herself from too many outside impressions too, for she needs peaceful rest for her body to deal with her baby lovingly.

Help your baby integrate into a secure, loving, peaceful home environment before he or she is overwhelmed meeting the rest of the world. There will be plenty of time to share your new blessing with your friends. (It may be more comfortable for you after a few weeks of getting to know your baby, of feeling more confident as a mother, and of strengthening your body and nerves). Your baby has the rest of its life to buzz around in cars in noisy traffic, to be exposed to the mass consciousness, to TV, and to fluorescent lights. Our children are our hope and future. Let them begin knowing love and security that they may grow up without confusion, fears, anxieties, insecurities, and sadness. Let's help them keep their higher attunement, which they bring with them at birth.

It is best to consider how you wish to handle this delicate period while you are pregnant. Make an understanding of this with all family members. It is wise to tell friends and relatives before the birth, how you feel and when you will be ready to receive their presence. This eliminates having to explain yourself at a time when you do not wish to use the energy to do so. Your friends will feel more comfortable knowing when it is all right to call or visit. Listen to your inner feelings and act upon them, not the pressures and feelings of others. You know what is right for your baby, for you and for your family. You are the one who has to deal with the restlessness, tensions, and fussiness if the wrong vibrations or too many good vibrations enter into your home. Friends may or may not understand, but they will respect your decision. Enjoy this special time.

Breastfeeding—Starting Out Right

Breastfeeding is the *natural, physiologic* way of feeding infants and young children, and human milk is the milk made specifically for human infants. Formulas made from cow's milk or soybeans (most formulas, even "designer formulas") are only superficially similar, and advertising which states otherwise is misleading. Breastfeeding *should* be easy and trouble free for most mothers. A good start helps to ensure breastfeeding is a happy experience for both mother and baby.

The vast majority of mothers are perfectly capable of breastfeeding their babies **exclusively** for about six months. In fact, most mothers produce **more than enough** milk. Unfortunately, outdated hospital routines based on bottle feeding **still** predominate in too many health care institutions and make breastfeeding difficult, even impossible, for too many mothers and babies. For breastfeeding to be well and properly established, a good start in the early few days can be crucial. Admittedly, even with a terrible start, many mothers and babies manage.

The trick to breastfeeding is getting the baby *to latch on well*. A baby who latches on well, gets milk well. A baby who latches on poorly has more difficulty getting milk, *especially* if the supply is low. A poor latch is similar to giving a baby a bottle with a nipple hole that is too small—the bottle is full of milk, but the baby will not get much. When a baby is latching on poorly, he may also cause the mother nipple pain. And if he does not get milk well, he will usually stay on the breast for long periods, thus aggravating the pain. Unfortunately *anyone* can say that the baby is latched on well, even if he isn't. Too many people *whoshould know better* just don't know what a good latch is. Here are a few ways breastfeeding can be made easy:

1. A proper latch is crucial to success. *This is the key to successful breastfeeding*. Unfortunately, too many mothers are being "helped" by people who don't know what a proper latch is. If you are being told your two day old's latch is good despite your having very sore nipples, be sceptical, and ask for help from someone else who knows. Before you leave the hospital, you should be shown that your baby is latched on properly, and that he is actually getting milk from the breast and that you know how to know he is getting milk from the breast (open mouth wide—*pause*—close mouth type of suck). See also the website www.thebirthden.com/Newman.html for videos on how to latch a baby on (as well as other videos). If you and the baby are leaving hospital **not** knowing this, get experienced help quickly (see handout *When Latching*). Some staff in the hospital will tell mothers that if the breastfeeding is painful, the latch is not good (usually true), so that the mother should take the baby off and latch him on again. This is not a good idea. The pain usually settles, and the latch should be fixed on the other side or at the next feeding. Taking the baby off the breast and latching him on again and again only multiplies the pain and the damage.

2. The baby should be at the breast immediately after birth. The vast majority of newborns can be at the breast within minutes of birth. Indeed, research has shown that, given the chance, many babies only minutes old will crawl up to the breast from the mother's abdomen, latch on and start breastfeeding all by themselves. This process may take up to an hour or longer, but the mother and baby should be given this time together to start learning about each other. Babies who "self-attach" run into far fewer breastfeeding problems. This process **does not take any effort** on the mother's part, and the excuse that it cannot be done because the mother is tired after labour is nonsense, pure and simple. Incidentally, studies have also shown that skin-to-skin contact between mothers and babies keeps the baby as warm as an incubator (see section on skin to skin contact). Incidentally, many babies do not latch on and breastfeeding during this time. Generally, this is not a problem, and there is no harm in waiting for the baby to start breastfeeding. The skin to skin contact is good for the baby and the mother even if the baby does not latch on.

3. The mother and baby should room in together. There is *absolutely no medical reason* for healthy mothers and babies to be separated from each other, even for short periods.

- Health facilities that have routine separations of mothers and babies after birth are years behind the times, and the reasons for the separation often have to do with letting parents know who is in control (the hospital) and who is not (the parents). Often, bogus reasons are given for separations. One example is that the baby passed meconium before birth. A baby who passes meconium and is fine a few minutes after birth will be fine and does not need to be in an incubator for several hours' "observation".
- There is no evidence that mothers who are separated from their babies are better rested. On the contrary, they are more rested and less stressed when they are with their babies. Mothers and babies learn how to sleep in the same rhythm. Thus, when the baby starts waking for a feed, the mother is also starting to wake up naturally. This is not as tiring for the mother as being awakened from deep sleep, as she often is if the baby is elsewhere when he wakes up. If the mother is shown how to feed the baby while both are lying down side by side, the mother is better rested.
- The baby shows long before he starts crying that he is ready to feed. His breathing may change, for example. Or he may start to stretch. The mother, being in light sleep, will awaken, her milk will start to flow and the calm baby will be content to nurse. A baby who has been crying for some time before being tried on the breast may refuse to take the breast even if he is ravenous. Mothers and babies should be encouraged to sleep side by side in hospital. This is a great way for mothers to rest while the baby nurses. Breastfeeding should be relaxing, *not* tiring.

4. Artificial nipples should not be given to the baby. There seems to be some controversy about whether "nipple confusion" exists. Babies will take whatever gives them a rapid flow of fluid and may refuse others that do not. Thus, in the

first few days, when the mother is normally producing only a little milk (as nature intended), and the baby gets a bottle (as nature intended?) from which he gets rapid flow, the baby will tend to prefer the rapid flow method. You don't have to be a rocket scientist to figure that one out, though many health professionals, who are supposed to be helping you, don't seem to be able to manage it. Note, *it is not the baby who is confused*. Nipple confusion includes a range of problems, including the baby not taking the breast as well as he could and thus not getting milk well and/or the mother getting sore nipples. Just because a baby will "take both" does not mean that the bottle is not having a negative effect. Since there are now alternatives available if the baby needs to be supplemented (see handout #5, *Using a Lactation Aid*, and handout #8 *Finger Feeding*) why use an artificial nipple?

5. No restriction on length or frequency of breastfeedings. A baby who drinks well will not be on the breast for hours at a time. Thus, if he is, it is usually because he is not latching on well and not getting the milk that is available. Get help to fix the baby's latch, and use compression to get the baby more milk (handout #15, *Breast Compression*). Compression works very well in the first few days to get the colostrum flowing well. This, **not** a pacifier, **not** a bottle, **not** taking the baby to the nursery, will help.

6. Supplements of water, sugar water, or formula are rarely needed. Most supplements could be avoided by getting the baby to take the breast properly and thus get the milk that is available. If you are being told you need to supplement without someone having observed you breastfeeding, ask for someone to help who knows what they are doing. There *are* rare indications for supplementation, but often supplements are suggested for the convenience of the hospital staff. If supplements are required, they should be given by lactation aid *at the breast* (see handout #5), not cup, finger feeding, syringe or bottle. The best supplement is your own colostrum. It can be mixed with 5% sugar water if you are not able to express much at first. Formula is hardly ever necessary in the first few days.

7. Free formula samples and formula company literature are not gifts. There is only one purpose for these "gifts" and that is to get you to use formula. It is very effective, and it is unethical marketing. If you get any from any health professional, you should be wondering about his/her knowledge of breastfeeding and his/her commitment to breastfeeding. "But I need formula because the baby is not getting enough!" Maybe, but, more likely, you weren't given good help and the baby is simply not getting the milk *that is available*. Even if you need formula, nobody should be suggesting a particular brand and giving you free samples. Get **good** help. Formula samples are not help.

Under some circumstances, it may be impossible to start breastfeeding early. However, most "medical reasons" (maternal medication, for example) are *not* true reasons for stopping or delaying breastfeeding, and you are getting **misinformation**. Get good help. Premature babies can start breastfeeding *much, much* earlier than they do in many health facilities. In fact, studies are now quite definite that it is *less stressful* for a premature baby to breastfeed than to bottle feed. Unfortunately, too many health professionals dealing with premature babies do not seem to be aware of this.

Questions? (416) 813-5757 (option 3) or drjacknewman@sympatico.ca or my book **Dr. Jack Newman's Guide to Breastfeeding** (called **The Ultimate Breastfeeding Book of Answers** in the USA)

Handout #1. *Breastfeeding—Starting Out Right*. Revised January 2005

Written by Jack Newman, MD, FRCPC. © 2005

When Latching

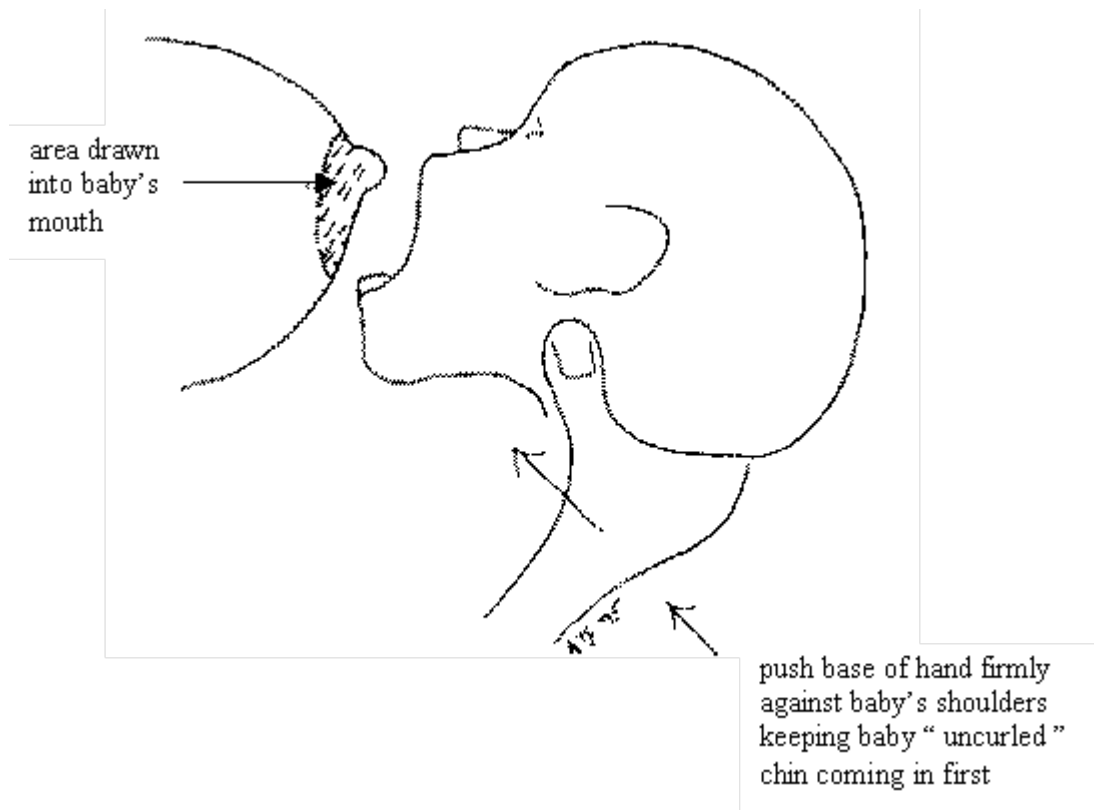
Push baby's bottom into your body with the side (the same side as where your baby finger is) of your forearm.

- This will bring him towards your breast with the nipple pointing to the roof of his mouth
- Mother's hand under the baby's face, palm up.
- Head supported but NOT pushed in against breast.
- Head tilted back slightly.
- Baby's body and legs wrapped in around mother.
- Use your whole arm to bring the baby onto the breast, when **mouth wide**.
- Chin and lower jaw touch breast first.

WATCH LOWER LIP, **aim it as far from base of nipple as possible**, so tongue draws **lots of breast** into mouth.

Move baby's body and head together – keep baby uncurled.

Once latched, top lip will be close to nipple, areola shows above lip. Keep chin close against breast.



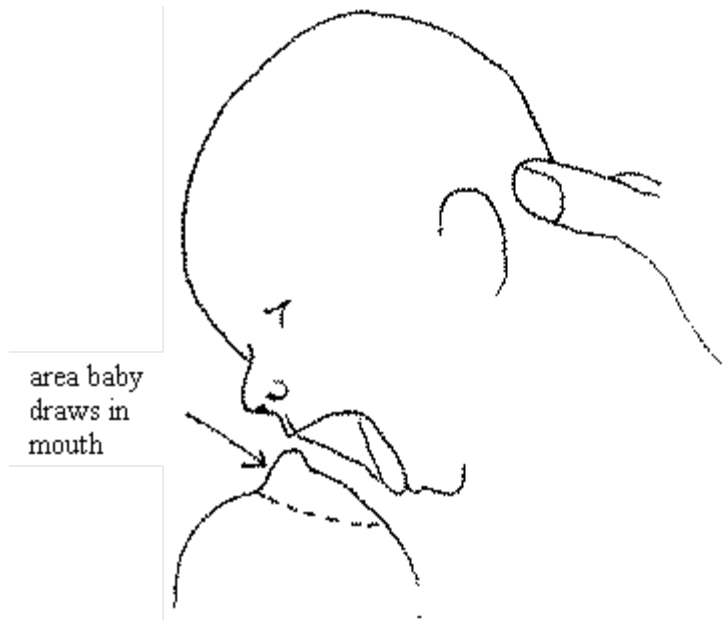
WIDE MOUTH / GAPE

Need **mouth wide before** baby moved onto breast. Teach baby to open wide/gape :

- move baby toward breast, touch top lip against nipple
- move mouth away SLIGHTLY
- touch top lip against nipple again, move away again

- **repeat until baby opens wide** and has tongue forward
- **Or**, better yet, run nipple along the baby's **upper** lip, from one corner to the other, lightly, until baby opens wide

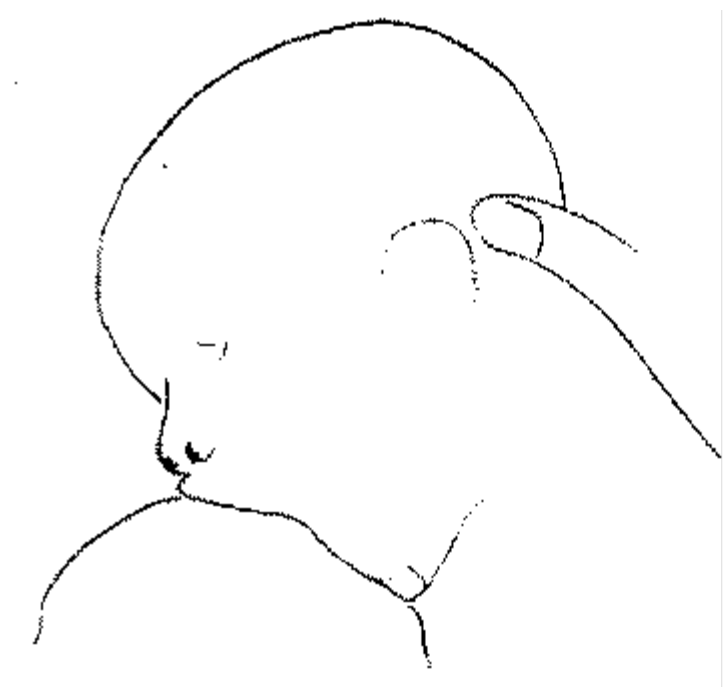
MOTHER'S VIEW WHILE LATCHING BABY



- baby's head tilted slightly back
- bring baby in quickly
- push with base of hand on shoulders
- chin touches first
- baby's body close against mother

Move baby not breast

MOTHER'S VIEW OF NURSING BABY



- head tilted slightly back
- chin well in against breast
- hold in firmly against shoulders keeping baby uncurled

RECOMMENDATIONS FOR THE MOTHER

Mother's posture

- Sit with straight, well-supported back
- Trunk facing forwards, lap flat

Baby's position before feed begins

- on pillow can be helpful,
- nipple points to the baby's upper lip or nostril

Baby's body

- placed not quite tummy to tummy, but so that baby comes up to breast from *below* and baby's eyes make contact with mother's

Support breast

- firm inner breast tissue by raising breast slightly with fingers placed flat on chest wall and thumb pointing up (if helpful, also use sling or tensor bandage around breast)

Move baby quickly on to breast

- head tilted back slightly, pushing in across shoulders so chin and lower jaw make first contact (not nose) while mouth still wide open, keep baby uncurling (means tongue nearer breast) lower lip is aimed as far from nipple as possible so baby's tongue draws in maximum amount of breast tissue

Cautions

Mother needs to AVOID

- pushing her breast across her body
- chasing the baby with her breast
- flapping the breast up and down
- holding breast with scissor grip
- not supporting breast
- twisting her body towards the baby instead of slightly away
- aiming nipple to centre of baby's mouth
- pulling baby's chin down to open mouth
- flexing baby's head when bringing to breast
- moving breast into baby's mouth instead of bringing baby to breast
- moving baby onto breast without a proper gape
- not moving baby onto breast quickly enough at height of gape
- having baby's nose touch breast first and not the chin
- holding breast away from baby's nose (not necessary if the baby is well latched on, as the nose will be away from the breast anyway)

See videos at www.thebirthden.com/Newman.html

Handout A, When Latching

Revised : January 2005

Original written and designed by Anne Barnes

Is My Baby Getting Enough Milk?

Breastfeeding mothers frequently ask how to know their babies are getting enough milk. The breast is not the bottle, and it is not possible to hold the breast up to the light to see how many ounces or millilitres of milk the baby drank. Our number obsessed society makes it difficult for some mothers to accept not seeing exactly how much milk the baby receives. However, there are ways of knowing that the baby is getting enough. In the long run, weight gain is the best indication whether the baby is getting enough, but rules about weight gain appropriate for bottle fed babies *may not be appropriate* for breastfed babies.

Ways of knowing

1. Baby's nursing is characteristic. A baby who is obtaining good amounts of milk at the breast sucks in a very characteristic way. When a baby is getting milk (he is not getting milk just because he has the breast in his mouth and is making sucking movements), you will see a pause at the point of his chin after he opens to the maximum and before he closes his mouth, so that one suck is (open mouth wide--> pause-->close mouth). If you wish to demonstrate this to yourself, put your index or other finger in your mouth and suck as if you were sucking on a straw. As you draw in, your chin drops and stays down as long as you are drawing in. When you stop drawing in, your chin comes back up. This same pause that is visible at the baby's chin represents a mouthful of milk when the baby does it at the breast. The *longer* the pause, the *more* the baby got. Once you know about the pause you can cut through so much of the nonsense breastfeeding mothers are being told—like feed the baby **twenty minutes on each side**. **A baby who does this type of sucking (with the pauses) for twenty minutes straight might not even take the second side. A baby who nibbles (doesn't drink) for 20 hours will come off the breast hungry.** The website www.thebirthden.com/Newman.html has videos that show this pause in the baby's chin.

2. Baby's bowel movements. For the first few days after delivery, the baby passes meconium, a dark green, almost black, substance. Meconium accumulates in the baby's gut during pregnancy. It is passed during the first few days, and by the third day, the bowel movements start becoming lighter, as more breastmilk is taken. Usually by the fifth day, the bowel movements have taken on the appearance of the normal breastmilk stool. The normal breastmilk stool is pasty to watery, mustard coloured, and usually has little odour. However, bowel movements may vary considerably from this description. They may be green or orange, may contain curds or mucus, or may resemble shaving cream in consistency (from air bubbles). The variations in colour do not mean something is wrong. A baby who is breastfeeding *only*, and is starting to have bowel movements that are becoming lighter by day 3 of life, is doing well.

Without becoming obsessive about it, monitoring the frequency and quantity of bowel motions is one of the best ways, next to observing the baby's drinking, (see above, and videos at www.thebirthden.com/Newman.html) of knowing if the baby is getting enough milk. After the first three to four days, the baby should have increasing bowel movements so that by the end of the first week he should be passing at least two to three *substantial* yellow stools each day. In addition, many infants have a stained diaper with almost each feeding. **A baby who is still passing meconium on the fourth or fifth day of life, should be seen at the clinic the same day.** A baby who is passing only brown bowel movements is probably not getting enough, but this is not very reliable.

Some breastfed babies, after the first three to four weeks of life, may suddenly change their stool pattern from many each day, to one every three days or even less. Some babies have gone as long as 15 days *or more* without a bowel movement. As long as the baby is otherwise well, and the stool is the usual pasty or soft, yellow movement, this is not constipation and is of no concern. **No treatment is necessary or desirable**, because no treatment is necessary or desirable for something that is normal.

Any baby between five and 21 days of age who does not pass at least one substantial bowel movement within a 24 hour period should be seen at the breastfeeding clinic the same day. Generally, small, infrequent bowel movements during this time period mean insufficient intake. There are definitely some exceptions and everything may be fine, but it is better to check.

3. Urination. With six **soaking wet** (not just wet) diapers in a 24 hours hour period, after about 4-5 days of life, you can be reasonably sure that the baby is getting a lot of milk (if he is breastfeeding *only*). Unfortunately, the new super dry "disposable" diapers often do indeed feel dry even when full of urine, but when soaked with urine they are heavy. It should be obvious that this indication of milk intake does not apply if you are giving the baby extra water (which, in any case, is unnecessary for breastfed babies, and if given by bottle, may interfere with breastfeeding). The baby's urine should be almost colourless after the first few days, though occasional darker urine is not of concern.

During the first two to three days of life, some babies pass pink or red urine. This is not a reason to panic and does not mean the baby is dehydrated. No one knows what it means, or even if it is abnormal. It is undoubtedly associated with the lesser intake of the breastfed baby compared with the bottle fed baby during this time, but the bottle feeding baby is **not** the standard on which to judge breastfeeding. However, the appearance of this colour urine should result in attention to getting the baby well latched on and making sure the baby is **drinking at the breast**. During the first few days of life, **only if the baby is well latched on can he get his mother's milk**. Giving water by bottle or cup or finger feeding at this point does not fix the problem. It only gets the baby out of hospital with urine that is not red. Fixing the latch and using compression will usually fix the problem (See Handout B: *Protocol to Increase Breastmilk Intake by the Baby*). If relatching

and breast compression do not result in better intake, there are ways of giving extra fluid without giving a bottle directly (handout #5 *Using a Lactation Aid*). Limiting the duration or frequency of feedings can also contribute to decreased intake of milk.

The following are NOT good ways of judging

Your breasts do not feel full. After the first few days or weeks, it is usual for most mothers not to feel full. Your body adjusts to your baby's requirements. This change may occur quite suddenly. Some mothers breastfeeding perfectly well never feel engorged or full.

- **The baby sleeps through the night.** Not necessarily. A baby who is sleeping through the night at 10 days of age, for example, may, in fact, not be getting enough milk. A baby who is too sleepy and has to be awakened for feeds or who is "too good" may not be getting enough milk. There are many exceptions, but get help quickly.
- **The baby cries after feeding.** Although the baby may cry after feeding because of hunger, there are also many other reasons for crying. See also handout #2 *Colic in the Breastfeeding Baby*. Do not limit feeding times. "Finish" the first side before offering the other.
- **The baby feeds often and/or for a long time.** For one mother feeding every three hours or so may be often; for another, three hours or so may be a long period between feeds. For one, a feeding that lasts for 30 minutes is a long feeding; for another, it is a short one. There are no rules how often or for how long a baby should nurse. It is *not true* that the baby gets 90% of the feed in the first 10 minutes. Let the baby determine his own feeding schedule and things usually come right, if the baby is suckling and **drinking** at the breast and having at least two to three substantial yellow bowel movements each day. Remember, a baby may be on the breast for two hours, but if he is actually *feeding* or *drinking* (open wide—*pause*—close mouth type of sucking) for only two minutes, he will come off the breast hungry. If the baby falls asleep quickly at the breast, **you can compress the breast to continue the flow of milk** (handout #15, *Breast Compression*). Contact the breastfeeding clinic with any concerns, but wait to start supplementing. If supplementation is truly necessary, there are ways of supplementing which do not use an artificial nipple (handout #5, *Using a Lactation Aid*).
- **"I can express only half an ounce of milk".** This means nothing and should not influence you. Therefore, you should not pump your breasts "just to know". Most mothers have plenty of milk. The problem usually is that the baby is not getting the milk that is available, either because he is latched on poorly, or the suckle is ineffective or both. These problems can *often* be fixed easily.
- **The baby will take a bottle after feeding.** This does not necessarily mean that the baby is still hungry. This is not a good test, as bottles may interfere with breastfeeding.
- **The five week old is suddenly pulling away from the breast but still seems hungry.** This does not mean your milk has "dried up" or decreased. During the first few weeks of life, babies often fall asleep at the breast when the flow of milk slows down even if they have not had their fill. When they are older (four to six weeks of age), they no longer are content to fall asleep, but rather start to pull away or get upset. The milk supply has not changed; the baby has. Compress the breast (handout #15, *Breast Compression*) to increase flow.

Notes on scales and weights

1. Scales are all different. We have documented significant differences from one scale to another. Weights have often been written down wrong. A soaked cloth diaper may weigh 250 grams (half a pound) or more, so babies should be weighed naked or with a brand new dry diaper.

2. Many rules about weight gain are taken from observations of growth of formula feeding babies. They do not necessarily apply to breastfeeding babies. **A slow start may be compensated for later, by fixing the breastfeeding.** Growth charts are guidelines only.

Questions? (416) 813-5757 (option 3) or driacknewman@sympatico.ca or my book **Dr. Jack Newman's Guide to Breastfeeding** (called **The Ultimate Breastfeeding Book of Answers** in the USA)

Handout #4. *Is My Baby Getting Enough?* Revised January 2005

Written by Jack Newman, MD, FRCPC. © 2005

Expressing Milk

Many women are under the impression that it is necessary to own or use a pump to breastfeed. This is not so. There are very few circumstances under which it is necessary to express your milk. But women are being encouraged to pump their milk and give it to baby via bottle for the most unnecessary reasons: Weddings, doctor's appointments, shopping...why not take the baby with you? How can babies not be welcome at weddings? Or, "so the father can feed the baby"! Partners were not meant to feed babies milk, and giving a bottle is not really helping. But they certainly can *help* feed the baby by helping mother with compressions, for example, (see Handout: #15 *Breast Compressions*) and they can help mothers in so many other ways as well. The pump should not replace the baby; you and your baby receive numerous benefits in addition to nutrition by breastfeeding. *No pump is as efficient as the natural pump that was made for your body, your baby!* A baby who breastfeeds well is the best pump, but, granted some babies don't breastfeed well. You do not need a breast pump to breastfeed; uninformed use of a breast pump can lead to premature weaning.

- **There is more to breastfeeding than just the breastmilk.**
- Obviously, if you can pump a lot, you are producing a lot, but if you cannot pump a lot, this does not mean your milk production is low. Do not pump to "find out how much you are producing".
- The most effective artificial pumps are high-powered, double, electric, and hospital-grade with adjustable pressure and speed. There are many pumps on the market that are just not very good.
- Improper use of a breast pump can lead to problems. Read all instructions thoroughly.
- It is important that milk be expressed and/or pumped **after** the feed as the breasts should be as full as possible for the baby's feeding. Babies respond to fast flow (see Handout #15, *Breast Compression*), and pumping before the feed will reduce the amount of milk in the breast.

Pumping method

Pump immediately after the feed--waiting an hour or so decreases the likelihood the breast will be full as possible for the next feed.

- Place nipple in the center of the flange (unlike nipple placement in baby's mouth, which should always be off-centre and pointed toward the roof of baby's mouth (see Handout: A: *When Latching*).
- Put the pump on the lowest setting that extracts milk, **not** the highest setting you can tolerate.
- Pump for 15 minutes each side. If breasts run "dry" before 15 minutes is up, pump until dry then add 2 minutes.
- Remember, **pumping should not hurt**. If it hurts:
 - Lower the suction setting
 - Ensure the nipple is centered in the flange
 - Pump for a shorter period of time

Cleaning the pump

All pumping equipment should be sterilized before first usage, thereafter it only requires washing with hot, soapy, water or by dishwasher.

- After each pumping: either place the pumping kit (not the tubes or motor) in the refrigerator until the next pumping, or if not pumping the same day, hot-water wash and hot-water rinse well, then air dry.
- Remember to take apart all pieces of the pump for cleaning---including the smallest pieces, and to ensure that no milk has clumped in the flange shaft.

Hand expression

Many women find that hand expression is an efficient way to pump when only occasional expression is required. In fact, when the milk production is not abundant (as in the first few days), it is often easier to get milk with hand expression than with a pump and many women find this the easiest way to express mature milk as well.

- Place thumb and index finger on either side of the nipple, about 3 to 5 cm (1-2 inches) back from the nipple.

- Press gently inward toward the rib cage.
- Roll fingers together in a slight downward motion.
- Repeat all around the nipple if desired.

Breastmilk storage

Unlike formula, breast milk is anti-infective, antibacterial, antifungal, and antiviral.

- Breastmilk will stay good:
 - At room temperature for at least 8-12 hours.
 - In the fridge for at least 8-11 days.
 - In the freezer, at the back, for many months.

Get used to the taste and smell of breast milk so you'll always know if it is good.

- Due to the high fat content of breastmilk, storage of any kind will produce a separation in the liquid. This is normal; a gentle mixing will give it a homogeneous look once more.
- Breastmilk may taste different after freezing; this is normal
- Never heat breastmilk in the microwave.
- Babies will often take cold milk, but if heating is desired, or if milk needs to be defrosted, place container or bag of milk in a cup of warm water for a minute or two.

Encouraging the M.E.R. (milk ejection reflex) or “let down”

If your baby is not present, you can encourage the “let down” reflex artificially, by having a picture of your baby to look at, or by having a piece of his clothing next to you.

- Apply a warm wet cloth to your breasts.
- Massage the breasts in small circular motions around the perimeter of the breast.
- Gently stroke your breasts with your fingernails in a downward motion toward the nipple
- Lean forward and gently shake the breasts.
- Gently roll the nipple between your finger and thumb.

You may feel the milk ejection reflex or notice your breasts leaking **or you may not**. You are likely to pump more milk faster if you pump both breasts at the same time. You do not need to feel or be aware of the milk ejection reflex in order to make milk. Some women may feel thirsty, sweaty, sleepy, or dizzy during a let down. However, many women do not feel this milk ejection response ever in their whole breastfeeding experience. Some women only become aware of it after the first few weeks. This has absolutely no bearing on milk supply. Breast compressions, while pumping, can be very effective at increasing the amount expressed, it may be a bit awkward at first, but it can be done (mothers have fixed the cups so that they sit inside the bra and then use compressions) or the partner can do it.

Questions? (416) 813-5757 (option 3) or drjacknewman@sympatico.ca or Edith Kernerman, breastfeeding@sympatico.ca or Jack's book, **Dr. Jack Newman's Guide to Breastfeeding** (called **The Ultimate Breastfeeding Book of Answers** in the USA), or our Video/ DVD: **Dr. Jack Newman's Visual Guide to Breastfeeding**.

Handout # 27. *Expressing Milk*. January 2005

Written by Edith Kernerman, IBCLC, RLC and Jack Newman, MD, FRCPC. © 2005

Appendix 1

Measure of attitude towards undergoing screening for Down Syndrome, spina bifida and Edward's syndrome

For each of the following questions, please circle a number from 1-7 on the scale that best describes how you feel at the moment.

1. For me, having the screening test for these 3 conditions when I am 15-16 weeks pregnant will be
A bad thing 1 2 3 4 5 6 7 Not a bad thing

2. For me, having the screening test for these 3 conditions when I am 15-16 weeks pregnant will be
Beneficial 1 2 3 4 5 6 7 Not beneficial

3. For me, having the screening test for these 3 conditions when I am 15-16 weeks pregnant will be
Harmful 1 2 3 4 5 6 7 Not harmful

4. For me, having the screening test for these 3 conditions when I am 15-16 weeks pregnant will be
A good thing 1 2 3 4 5 6 7 Not a good thing

5. For me, having the screening test for these 3 conditions when I am 15-16 weeks pregnant will be
Worthwhile 1 2 3 4 5 6 7 Not worthwhile

6. For me, having the screening test for these 3 conditions when I am 15-16 weeks pregnant will be
Important 1 2 3 4 5 6 7 Unimportant

Appendix 2

Measure of knowledge about Down syndrome

Which of these conditions do you think the MSS test screens for? (You may tick more than 1 box for this question)

- Spina bifida
- Anaemia
- Down syndrome
- Most abnormalities
- None of these
- Don't know

What kind of abilities can a child with Down syndrome expect? (Please tick just one box)

- Average ability to learn for his or her age
- Worse than average ability to learn
- Better than average ability to learn
- No ability to learn
- Don't know
- None of these

How long can a child with Down syndrome expect to live? (Please tick just 1 box)

- A life span of 10-20 years
- A life span of 20-40 years
- A life span of 40-60 years
- Normal life span
- Don't know
- None of these

What do you think a low risk result means? (Please tick just one box)

- The baby definitely does not have Down syndrome
- The baby probably does not have Down syndrome'
- The baby might have Down syndrome
- The baby probably does have Down syndrome
- The baby definitely does have Down syndrome
- None of these
- I don't know

If 100 women decided to have the screening test, about how many do you think would have a low risk result? (Please tick just one box)

- 100
- 50
- 95
- 5
- None
- Not sure

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What do you think a high-risk result means? (Please tick just one box)

- The baby definitely does not have Down syndrome
- The baby probably does not have Down syndrome'
- The baby might have Down syndrome
- The baby probably does have Down syndrome
- The baby definitely does have Down syndrome
- I don't know
- None of these

If 100 women decided to have the screening test, about how many do you think would have a high-risk result? (Please tick just one box)

- 100
- 95
- 50
- 5
- None
- Not sure

If 100 women had a high risk screening result, about how many do you think would have a baby with Down syndrome? (Please tick just one box)

- 100
- 50
- 25
- 2
- Not sure

Some women are offered further tests (amniocentesis or CVS, which involve inserting a fine needle into the womb). What are the possible risks of this test?

If further tests show that the baby definitely does have Down syndrome, what do you think a woman would be offered;

- Immediate treatment for the baby
- Another type of test
- A termination of pregnancy
- Extra vitamins
- None of these
- Not sure

Appendix 3

Bleeding During Pregnancy – An Overview

Many pregnant women experience one or more episodes of vaginal bleeding during their pregnancy. The cervix, the opening of the womb, is very blood rich, similar to your nose. Just like some people experience nosebleeds for no particular reason, some women experience bleeding from the cervix for no particular reason. Intercourse or a vaginal exam may cause a small, insignificant amount of bleeding or spotting. Most of the time, the cause is unknown.

However, you need to call your midwife if;

- You are healthy with no specific risk factors and have vaginal bleeding amounting to more than a “toonie” (4-5cm in diameter) size on your pad or underwear, the bleeding is not related to prior intercourse or vaginal exam or you are bleeding and have pain or cramping.
- Your midwife has informed you that you have individual risk factors (e.g. a diagnosed placenta previa) and you have noticed some bleeding on your pad or underwear.

First trimester bleeding

First trimester bleeding is any vaginal bleeding during the first 3 months of pregnancy. Vaginal bleeding may vary from light spotting to severe bleeding with clots. Vaginal bleeding is a relatively common occurrence in early pregnancy, affecting 20-30% of all pregnancies.

Second & Third trimester bleeding

Vaginal bleeding during the second and third trimesters of pregnancy (the last 6 months of a 9-month pregnancy) involves concerns different from bleeding in the first 3 months of your pregnancy. Bleeding during the second and third trimesters amounting to more than a slight amount of spotting following intercourse or vaginal exam is usually abnormal.

Bleeding after the 28th week of pregnancy

Bleeding from the vagina after the 28th week of pregnancy is a true emergency. The bleeding can range from very mild to extremely brisk and may or may not be accompanied by abdominal pain.

Causes

First trimester bleeding

Postcoital bleeding is vaginal bleeding after sexual intercourse. It may be normal during pregnancy.

Bleeding may also be caused by reasons unrelated to pregnancy. For example, trauma or tears to the vaginal wall may bleed, and some infections may cause bleeding.

Implantation bleeding: There can be a small amount of spotting associated with the normal implantation of the embryo into the uterine wall, called implantation bleeding. This is usually very minimal, but frequently occurs on or about the same day as your period was due. This can be very confusing if you mistake it for simply a mild period and don't realize you are pregnant. This is a normal part of pregnancy and no cause for concern.

Threatened miscarriage: You may be told you have a threatened miscarriage if you are having some bleeding or cramping. The foetus is definitely still inside the uterus (based usually on an exam using ultrasound), but the outcome of your pregnancy is still in question. This may occur if you have an infection, such as a urinary tract infection, get dehydrated, are involved in physical trauma, if the developing foetus is abnormal in some way, or most often, for no apparent reason at all. It is important for you to know that threatened miscarriages are almost never caused by things you do, such as heavy lifting or having sex, or by emotional stress. There is no effective treatment to stop or prevent a threatened miscarriage.

Completed miscarriage: You may have a completed miscarriage (also called a spontaneous abortion) if your bleeding and cramping have slowed down and the uterus appears to be empty based on ultrasound exam. This means you have lost the pregnancy. The causes of this are the same as those for a threatened miscarriage. This is the most common cause of first trimester bleeding. No treatment is needed other than a careful watch for signs of infection and treatment with appropriate antibiotics if an infection develops.

Incomplete miscarriage: You may have an incomplete miscarriage (or a Miscarriage in progress) if the pelvic exam shows your cervix is open and you are still passing blood, clots, or tissue. The cervix should not remain open for very long. If it does, it indicates the miscarriage is not completed. This may occur if the uterus begins to clamp down before all the tissue has passed, or if there is infection. Depending on the circumstances, you may choose to await spontaneous completion of the miscarriage or a medical or surgical completion. The first two options are only appropriate for women who are not experiencing excess bleeding or signs of infection and have appropriate support from their caregivers. A medical completion involves the use of oral or vaginal medication, which will assist your body to complete the miscarriage through initiation of uterine contractions to expel the uterine contents. Oral pain medication and /or preventative use of antibiotics may be offered, and the procedure can take place at home. Surgical completion of the miscarriage involves admission to hospital and a dilation and curettage of the uterus ("D&C") usually under general anaesthetic. This will be recommended for women experiencing excess bleeding or signs of infection.

Blighted ovum: You may have a blighted ovum (also called embryonic failure). An ultrasound would show evidence of an intrauterine pregnancy, but the embryo has failed to develop, as it should in the proper location. This may occur if the foetus were abnormal in some way and not due to anything you did or didn't do.

Intrauterine foetal demise: You may have an intrauterine foetal demise (also called IUFD, missed abortion, or embryonic demise) if the developing baby dies inside the uterus. This diagnosis would be based on ultrasound results and can occur at any time during pregnancy. This may occur for any of the same reasons a threatened miscarriage occurs during the early stages of pregnancy. It is very uncommon for this to occur during the second and third trimesters of pregnancy. If it does, the causes also include separation of the placenta from the uterine wall (called placental abruption) or because the placenta didn't get sufficient blood flow. Options for care will be determined in consultation with an obstetrician

Ectopic pregnancy: You may have an ectopic pregnancy (also called tubal pregnancy). This would be based on your medical history and ultrasound, and in some cases laboratory results. Bleeding from an ectopic pregnancy is the most dangerous cause of first trimester bleeding. An ectopic pregnancy occurs when the fertilized egg implants outside of the uterus, most often in the fallopian tube. As the fertilized egg grows, it can rupture the fallopian tube and cause life-threatening bleeding. Most cases of ectopic pregnancy are treated surgically and you will be referred to an obstetrician for care.

Symptoms of an ectopic pregnancy are often variable and may include pain, bleeding, or light-headedness. Most ectopic pregnancies will cause pain before the tenth week of pregnancy. The foetus is not going to develop and will die because of lack of supply of nutrients. This condition occurs in about 3% of all pregnancies.

There are risk factors for ectopic pregnancy. These include a history of prior ectopic pregnancy, history of pelvic inflammatory disease, history of fallopian tube surgery or ligation, history of infertility for more than 2 years, having an IUD (birth control device placed in the uterus) in place, smoking, or frequent (daily) douching. However, only about 50% of women who have an ectopic pregnancy have any risk factors.

Molar pregnancy: You may have a molar pregnancy (technically called gestational trophoblastic disease). Your ultrasound results may show the developing foetus is not actually a baby but is abnormal tissue. This is actually a type of cancer that occurs as a result of the hormones of pregnancy and is usually not life threatening to you.

However, in rare cases the abnormal tissue is cancerous. It can invade the uterine wall and spread throughout the body. The cause of this is generally unknown.

Late-pregnancy bleeding

The most common cause of late-pregnancy bleeding is problems with the placenta. Some bleeding can also be due to an abnormal cervix or vagina.

Placenta previa: The placenta, which is a structure that connects the baby to the wall of your womb, can partially or completely cover the opening of your womb. When you bleed because of this, it is called placenta previa. Late in pregnancy as the opening of your womb, called the cervix, thins and dilates (widens) in preparation for labour, some blood vessels of the placenta may stretch and painless bleeding can occur.

Placenta previa causes about 20% of third-trimester bleeding and happens in about 1 in 200 pregnancies.

About 50% of women with placenta previa will also have preterm labour. Painless

Vaginal bleeding can be the first sign that this is starting to happen.

Risk factors for placenta previa include:

Multiple pregnancies, prior placenta previa, prior Caesarean delivery

Placental abruption: This condition occurs when a normal placenta separates from the wall of the womb (uterus) prematurely and blood collects between the placenta and the uterus. Such separation occurs in 1 in 200 of all pregnancies. The cause is unknown.

Risk factors for placental abruption include:

High blood pressure (140/90 or greater)

Trauma (usually a car accident or physical assault)

Cocaine use

Tobacco use

Abruption in prior pregnancies (you have a 10% risk it will happen again)

Uterine rupture: This is an abnormal splitting open of the uterus, causing the baby to be partially or completely expelled into the abdomen. Uterine rupture is very rare but dangerous for both mother and baby.

About 40% of women who have uterine rupture have had prior surgery of their uterus, including Caesarean delivery. The rupture may occur before or during labour or at the time of delivery. For women with prior caesarean section the risk of uterine rupture in labour is about ½ percent (1 out of 200) most uterine ruptures in labour occur during induced labours.

Other risk factors for uterine rupture include:

Trauma

Excessive use of oxytocin (Pitocin), a medicine that helps strengthen contractions

A baby in any position other than head down

Having the baby's shoulder get caught on the pubic bone during labour

Certain types of forceps deliveries

Foetal vessel rupture: This very rare condition occurs in about 1 of every 1,000 pregnancies. The baby's blood vessels from the umbilical cord may attach to the membranes instead of the placenta. The baby's blood vessels pass over the entrance to the birth canal. This is called vasa previa and occurs in 1 in 5,000 pregnancies. Most Caregivers will never see a case of vasa previa in their entire career.

Less common causes of late-pregnancy bleeding include injuries or lesions of the cervix and vagina, including polyps, cancer, and varicose veins.

Inherited bleeding problems, such as haemophilia, are very rare, occurring in 1 in 10,000 women. If you have one of these conditions, such as von Willebrand disease, tell your midwife.

Appendix 4

Edinburgh Post Natal Depression Scale (EPDS)

(J.L. Cox, J.M. Holden, R. Sagovsky, Department of Psychiatry, University of Edinburgh)

Name: _____ EPDS Score: _____

Assessment Date: _____

As you have recently had a baby, we would like to know how you are feeling. Please underline the answer which comes closest to how you have felt in the past 7 days - Not just how you feel today.

Here is an example, already completed:

I have felt happy:

- Yes, all the time
- Yes, most of the time
- No, not very often
- No, not at all

This would mean "I have felt happy most of the time during the past week". Please answer the following 10 questions by placing a tick in the appropriate box. Thank You.

In the past 7 days:

1. I have been able to laugh and see the funny side of things -

- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

2. I have looked forward with enjoyment to things -

- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

3. I have blamed myself unnecessarily when things went wrong -

- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

4. I have been anxious or worried for no good reason -

- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

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5. I have felt scared or panicky for no good reason -

- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

6. Things have been getting on top of me -

- Yes, most of the time I haven't been able to cope at all
- Yes, sometimes I haven't been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping -

- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

8. I have felt sad or miserable -

- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

9. I have been so unhappy that I have been crying -

- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

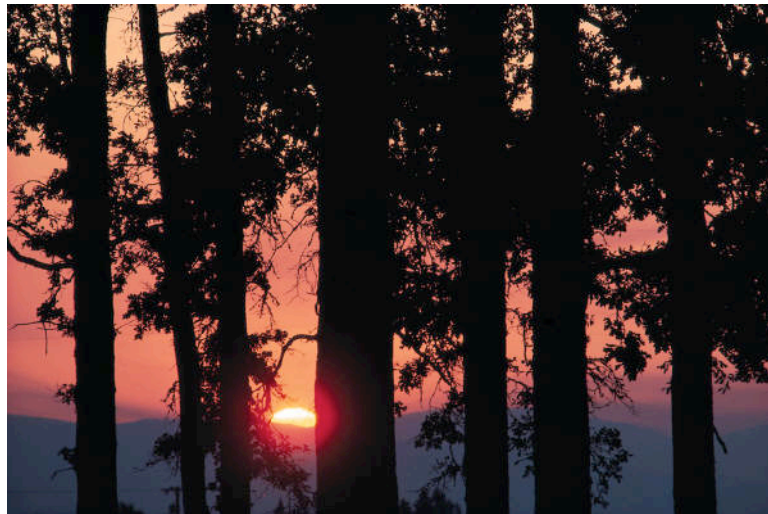
10. The thought of harming myself has occurred to me -

- Yes, quite often
- Sometimes
- Hardly ever
- Never

Appendix 5

After Pregnancy Loss

A Guide for Women and
Families Experiencing Early Pregnancy Loss



Prepared by:
Maggie Ramsey RM & Leah Gilley SN (UVIC)
March 2006
Adapted from B.C. Women's Hospital & Health Centre Society "After Pregnancy Loss"

Dear Grieving Family,

Pregnancy loss is a unique and often 'alone' event in a woman's life. Healing occurs more readily when physical and emotional changes are understood. We hope that this pamphlet will help you with your recovery and assist you to care for yourself following your miscarriage.

First... A few words you may hear...

Miscarriage – “Plain English” term for the loss of a pregnancy, usually refers to early pregnancy loss (up to +/- 20 weeks)

Spontaneous Abortion – Medical term for naturally occurring pregnancy loss. Often written on your chart as “SAB”.

There are 3 types of Miscarriage/SAB:

“**Complete**” – The fetus, placenta and other tissue have been passed and the uterus is empty.

“**Missed**” – The fetus has died, but the process of naturally emptying the uterus has not yet begun. The woman may no longer “feel pregnant” but does not yet have miscarriage symptoms such as bleeding or cramping.

“**Incomplete**” – the process of miscarriage is in progress, but not yet complete. The woman will be experiencing symptoms such as bleeding and cramping. Depending on the individual situation, in consultation with her caregiver, the woman may choose to

- (a) await spontaneous completion
- (b) use medication to assist completion
- (c) complete the SAB surgically (D&C)

A few Resources:

We have spent a lot of time searching the Internet for good information for parents experiencing pregnancy loss. These three websites stood out as useful, up to date and compassionate sources of information....

<http://www.griefwatch.com/> A website with a special section for pregnancy loss. Good information and resources for parents.

•**<http://www.aplacetoremember.com/>**• Support from other families who have experienced pregnancy loss

•**http://www.parentbooks.ca/Pregnancy_&_Infant_Loss.html**

Books for parents, children and professionals about pregnancy loss, grief and recovery

Taking Care of Yourself ...

Physical Changes Following a Complete Miscarriage

Over the next few days you will experience many physical changes as your body returns to a non-pregnant state. You may experience vaginal bleeding similar to a heavy menstrual period. This will taper off over the next week. In a couple of days you may notice some breast tenderness and some leaking of fluid from your breasts. This is an expected part of your recovery and will also subside in about a week's time. You may resume normal living and working activities as you feel up to it. Some changes in your body may require discussion with your caregiver.

Prevention of Infection

The entrance of the uterus (cervix) remains partially open for several days after pregnancy loss. During this time, bacteria can enter the uterus and cause an infection. It is important that you take the following precautions:

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- Use sanitary pads, rather than tampons, while you are bleeding
- Refrain from having sexual intercourse for at least one week. This is usually when bleeding has stopped and the cervix is closed. Using a condom is recommended if you are still having vaginal bleeding.
- Do not douche until after you have discussed this with your caregiver
- Refrain from using a Jacuzzi, jetted bath, or swimming until your flow has stopped

Call your caregiver if any of the following occur:

- Bleeding for more than two weeks
- Bleeding heavier than a normal period for more than 24 hours (you can expect a light to moderate flow for 3-4 days)
- Foul-smelling vaginal discharge
- Severe abdominal pain
- Nausea, breast tenderness, or bloating
- An elevated temperature (over 38 degrees or 100 F) or a feverish feeling, chills, or fainting

Incomplete Miscarriage ...

Your choices for care

If your miscarriage has not completed naturally and you have no signs of infection or heavy bleeding you and your caregiver may choose one of the following 3 options:

- (A) Wait for miscarriage to complete naturally
- (B) Use medication to complete the miscarriage
- (C) Schedule a “D&C” – a simple surgery to complete the miscarriage

Option A ... waiting

If you choose to wait for natural completion of your miscarriage, it is important that you and your caregiver have a clear plan regarding signs of concerns to report, how long you are both comfortable waiting, plans for follow up care or ultrasound, and at what point you might need to change your plans to either option B or C

Option B ... medical completion

Medical completion of a miscarriage for Missed or Incomplete SAB is becoming more common. Many women prefer this option as they can have some control over timing and prefer to miscarry in the privacy of their own home. The medications used to help your body to complete the miscarriage include: Misoprostol (cytotec) or Mifepristone (mifeprex)

It is important that you follow your caregiver’s instructions about the medication she has ordered to complete your miscarriage. The medication is meant to cause your uterus to cramp and expel the fetus, placenta and tissue. Bleeding may be quite heavy for a short period of time. Ask your caregiver for recommendations for oral pain medication, as it can be helpful to ease the pain of the procedure. Once you have passed all the contents of the uterus, the bleeding and pain will subside. Ask your caregiver for clear guidelines regarding what is normal to expect and what to do if there is excess pain or bleeding.

Option C ... schedule a Dilation and Curettage (D & C)

In previous years, a surgical procedure called a D& C (Dilation and Curettage) was frequently performed after a miscarriage. This is less common practice today, but a D&C may be recommended if the miscarriage is incomplete or if there is excess bleeding or signs of infection. Whether you need a D&C is a decision that you and your caregiver can make based on your individual situation. This surgery does not involve any cutting. The cervix is gently stretched open and the tissue lining of the uterus is removed with a spoon-like instrument (curette) or suction. A D&C is usually performed under general anesthetic or sedative medication. The medication may alter your mental and physical abilities for several hours. You may experience hoarseness, sore throat, or muscle aching in the first 24 hours after a general anesthetic. These symptoms usually disappear by themselves.

Post-Operative Recommendations:

The doctor who does your surgery will be responsible for your care and will give you specific instructions based on your individual situation. Here are a few general guidelines:

- You should be accompanied home by a responsible adult

WestCoast Midwives Client Handbook

- Rest at home the remainder of the day. Do not plan any other activities for 24 hours. Arrange for someone stay with you
- You should not drive an automobile or operate hazardous machinery for 24 hours following anesthesia.
- You may feel some dull cramping in your lower abdomen for a few hours. You may take pain relieving medication as recommended by your caregiver
- Do not drink alcohol for 24 hours since its effects will add to the effects of the anesthesia.

My Care plan

My name _____

Due date ___/___/___ Weeks pregnant _____

Care card number _____

My Care plan (check applicable)

I have had a: ___ Complete miscarriage (date) ___/___/___

___ Incomplete miscarriage (date) ___/___/___

I am planning to:

___ Wait for a spontaneous completion

___ Complete medically

___ Schedule a D&C

My follow up plans include:

Call _____ at # _____
if excess bleeding, pain or signs of infection occur

D&C scheduled ___/___/___ at _____ Hospital with Dr. _____ Tel # _____

Follow up office visit(s) to be scheduled with _____ Tel # _____ date ___/___/___

_____ Tel # _____ date ___/___/___]

___ Ultrasound booked for ___/___/___ at _____

___ Medication has been ordered by Dr. _____ For:

___ Pain

___ Prevention/treatment of infection

___ To complete the miscarriage

What to expect in the weeks following your miscarriage...

Menstruation

You should have a menstrual period in 4 to 6 weeks. If this does not occur, consult your caregiver

Birth Control

Birth control must be used when you resume sexual intercourse. It is possible to become pregnant **immediately** after a pregnancy loss, even before menstruation has started. Ask your caregiver or contact a Planned Parenthood Association for information

Future Pregnancy

It may be advisable to wait a few months before considering another pregnancy to allow the mind and body to recover fully. Discuss this with your partner and your caregiver.

Emotions

Physical recovery occurs quite quickly while emotional recovery may take a little longer. This may be influenced by other events happening at the same time, for example, holidays. Some women may experience little or no emotional upheaval while others may experience feelings of sadness, depression, anger or guilt. All of these are feelings of grief and can diminish over time, if you can “reach in” and allow your grief to surface. Working through feelings of grief can extend from a short time to many months. Support from family and friends may not always be present or appropriate. Coping mechanisms are founded in family structure, as well as cultural and religious beliefs. If you feel you need someone to talk to, there are skilled persons in your community. Discuss a referral with your caregiver, or select a resource located at the back of this pamphlet. If you are in hospital you can ask your caregiver or nurse about resources that are available to help you in hospital and in the community once you go home.

You may experience many feelings

These feelings may include numbness, shock, confusion, exhaustion, disbelief, anger, fear, isolation/aloneness, pining/yearning, responsibility/guilt feelings, sadness, mood disorders, impaired memory or concentration, appetite, sleep changes and even depression. The intensity of these feelings can range from mildly bothersome to quite overwhelming. Recent studies show that there is often no order or sequence to grief and that different feelings surface at different times throughout the bereavement period.

Children are unprepared for loss, and will require patience and love in helping them to understand. How much your children can understand depends on your child’s developmental readiness. Generally children deal best with loss if they are provided with “age - appropriate” information. There are booklets especially prepared for children. Some are listed at the back of this pamphlet

Family and Friends want to do the right thing but often are unsure how to help. Let them know what you are feeling and what you need at this time.

Your Partner also suffers the loss of this pregnancy and can experience many emotions and feelings. This can be a very difficult time for partners since it appears there is little they can do to help. Each partner has sustained a different loss and has a unique mourning experience. Partners may experience feelings of being left out since the focus of attention is with the woman who has experienced the loss in a physical way. Traditionally, a man is expected to remain outwardly strong to support his partner. He may hide feelings of sadness and loss as he tries to support his grieving partner. Same sex partners may feel left out as caregivers may not recognize that they are also a grieving parent.

A couple experiencing grief over a pregnancy loss often discover that their grief responses can be different from one another. No two people grieve alike or at the same time. This is normal. However, it can place a strain on your relationship if not recognized. Talking about differences with each other can be helpful. Partners may also play an important role in telling the other family members (including children) what has happened and what will happen in the immediate future. It is important to discuss with your partner how you will handle questions from children, family and friends.

Facing The Future

In the past, early pregnancy losses were not well understood or honoured. It is now recognized that miscarriage is a profoundly sad event in many family’s lives as they grieve the loss of their child. Making future family planning decisions are difficult at this time. It may be easier to face these future decisions when your grief is less intense. While grieving, you may feel physically and emotionally drained. Take time out. Make arrangements for private time and rest. It is important to grieve the loss of this pregnancy before planning another.