WELCOME TO WOMANCARE MIDWIVES

We hope that you will find this package helpful. It was prepared with your needs in mind and includes important information that is relevant for your care. If you are interested in other resources, please visit the Womancare library or talk to your coordinating midwife. It is not necessary to bring this booklet to appointments; however, keep it handy for reference throughout your pregnancy.

Handouts to be reviewed at your first appointment:
When to Call your Midwife
Contact Sheet/Information for your Coordinating Midwife

Handouts to be completed and returned to your coordinating midwife:
Questionnaire
Three Day Diet Summary (optional)

PHILOSOPHY OF MIDWIFERY CARE IN ONTARIO

Midwifery care is based on a respect for pregnancy as a state of health and childbirth as a normal, physiologic process. Midwifery care embraces the diversity of women’s needs. Midwifery also supports the variety of personal and cultural meanings attributed to the pregnancy, birth and early parenting experience by women, families and their communities.

The maintenance and promotion of health throughout the childbearing cycle are central to midwifery care. Midwives focus on preventative care and the appropriate use of technology.

Care is continuous, personalized and non-authoritarian. It responds to a woman’s social, emotional, cultural and physical needs. Midwives encourage the woman to actively participate in her care throughout pregnancy, birth and postpartum and to make choices about the manner in which her care is provided.

Midwives respect the woman’s right to choice of caregiver and place of birth in accordance with the Standards of Practice of the College of Midwives of Ontario. Midwives are willing to attend birth in a variety of settings – including birth at home.

Midwifery promotes decision-making as a shared responsibility between the woman, her family (as defined by the woman) and her caregivers. The woman is recognized as the primary decision-maker. Midwifery care includes education and counselling, enabling a woman to make informed choices.

Fundamental to midwifery care is the understanding that a woman’s caregivers respect and support her (and her decisions) so that she may give birth safely with power and dignity.
WOMANCARE MIDWIVES PRIVACY STATEMENT

The Midwifery Practice Group is bound by law and professional ethics to safeguard your privacy and the confidentiality of your personal information.

This includes:

Collecting only the information that may be necessary for your care
Keeping accurate and up-to-date records
Safeguarding the medical records in our possession
Sharing information with other health care providers and organizations on a “need-to-know” basis where required for your health care
Disclosing information to third parties only with your expressed consent, or as permitted or required by law
Retaining and/or destroying records in accordance with the law
Where required by the College of Midwives of Ontario standards, specific details of your care may be presented during peer review without divulging your name

You will be asked to sign a consent form that gives your consent for our collection, use and disclosure of your personal information for purposes related to your care.

You have the right to see and obtain copies of your records.

If you would like to discuss our privacy policy in more detail or have specific questions or complaints about how your information is handled, please speak to your midwife.

Womancare Midwives is also required to report certain statistics regarding your pregnancy, birth and postpartum to BORN – Ontario’s Better Outcomes Registry and Network. BORN was created in 2009 in order to help promote better care for mothers and babies through the collection of accurate and timely data in Ontario. For more information about BORN, please visit their website at www.bornontario.ca or speak with your coordinating midwife.
INFORMED CHOICE AGREEMENT

Responsibility for wellbeing rests with both those who offer health care and each individual seeking health care. Better health care is attained when individuals make informed decisions regarding their care. This information is being provided to assist you in your choice of care model.

THE ROLE OF A MIDWIFE:

The midwife sees pregnancy and childbirth as most often a normal state for the healthy woman. The midwife believes that unnecessary intervention is an interruption of a healthy process. The midwife is a skilled practitioner who provides primary care for the full duration of pregnancy, birth and postpartum care until six weeks postpartum for low risk women and their newborns. The midwife consults with and refers to specialists when necessary. The midwife will use emergency measures within the scope of her practice if the need arises.

Please see the wall of photos at our clinic on the main floor just past the entrance foyer for pictures of all the midwives at Womancare. A biography about each midwife can also be found on our Womancare website: http://www.midwives.on.ca/about.php. All midwives are registered with the College of Midwives of Ontario.

PHILOSOPHY OF CARE:

Womancare Midwives’ philosophy of care is based on respect for the birth process and for a woman’s ability to give birth. We are guided by the principles of continuity of care, non-authoritarian relationships, clients as the primary decision-makers, choice of birthplace, appropriate use of technology and informed choice.

CHOICE OF BIRTHPLACE:

The evidence is overwhelming that for low risk healthy women, a planned home birth with a midwife in attendance is a safe option. Homebirth outcomes are very similar to hospital birth outcomes except women who give birth at home see a significant reduction in interventions and less infection.

There are risks and benefits to any birth setting. Birth is essentially a normal process that can sometimes become a medical process. While birth is – for most women – uncomplicated, complications or emergencies can arise. Although approximately 80% of complications can be detected prenatally, some will arise spontaneously and unpredictably during labour and delivery. Should complications arise during a planned homebirth, most often transport to a hospital takes place in a straightforward manner (in either the client’s car or an ambulance). It is important to remember that there are rare and serious emergencies that can arise in any birth setting; in these rare situations, sometimes the technology available only in a hospital setting may be required and could make a difference to the well-being of the newborn or mother. It is also true that even with the assistance of technology, a good outcome cannot be guaranteed when these rare emergencies arise in any birth setting.
SERVICES:

During your pregnancy, you will be seen every four to six weeks until the twenty-eighth week, every two to three weeks until the thirty-sixth week and then weekly until the birth of your baby. We will be present during your active labour, birth and will stay with you for two to four hours postpartum. At a minimum we do five postpartum visits – more appointments can be arranged as needed. These appointments are usually on day one, day three, day five-seven and day ten-fourteen. The final visit is at approximately six weeks and is a follow-up visit for well woman/well baby care. Midwives are on-call twenty-four hours a day, seven days a week for urgent concerns and emergencies. Midwives are primary caregivers and are able to order laboratory work and tests (including ultrasounds) for safe care during normal pregnancy. Midwives consult and/or refer to appropriate medical specialists when risk factors arise during the pregnancy, labour, birth or the postpartum period.

As registered midwives, we follow the College of Midwives of Ontario protocols for Consultation and Transfer of Care – a copy of this document is included in this booklet. If your care should need to be transferred to an obstetrician, we would remain available to you in a supportive care role (for example, providing labour support, answering your questions or acting as an advocate on your behalf).

PARENTS' RESPONSIBILITIES:

You are expected to be responsible for your health. This includes eating a healthy diet, exercising and getting adequate rest. You will benefit from learning about the process of labour and birth.

We need to be informed of any relevant event or information that might affect your pregnancy or birth, including any pertinent medical information.

Active participation and decision-making together with your caregivers is expected throughout your care. We request that you refrain from the use of restricted substances. Please tell us about any substances that you may be taking including prescription, herbal, homeopathic, over-the-counter, illicit/recreational drugs; or cigarettes, caffeine or alcohol.

We ask that those planning a home birth have an adequately clean place for the birth. If complications or emergencies arise which necessitate transport to a hospital setting, we will be discussing this with you. You are asked to be responsible about accepting transport at such a time.

If you are planning sibling participation at your birth, you will need someone that you and your child (or children) trust to be present for them during your labour and birth. This person should also feel comfortable with being present at the birth and should not be attached to seeing the actual birth so that your child’s (or children’s) needs at the time may be met.

SECOND BIRTH ATTENDANTS

The College of Midwives of Ontario requires two midwives (or one midwife and one senior midwifery student) in attendance at your birth.

There are 2 exceptions:
If your care has been transferred to an obstetrician for the birth, your midwife may decide that having a second midwife at the birth is not necessary. OR Your midwife may decide to call upon the assistance of a Second Birth Attendant (instead of calling for a second midwife) to help provide care for you and your newborn at the birth.

A Second Birth Attendant is someone, other than a registered midwife; who is authorized by the College of Midwives of Ontario to assist at a midwife attended birth. The second attendant must meet competency requirements set out by the College of Midwives of Ontario.

The Second Birth Attendants at our practice are either registered nurses or graduates of the Midwifery Education Program whose registration is pending.

The Second Birth Attendant MAY be directed by your midwife to assist with the following:

- Provide you with labour support
- Listen to your baby’s heart rate during labour
- Take your blood pressure, pulse, and temperature
- Assess contractions by feeling your belly
- Draw blood samples from yourself or the baby’s cord
- Place an IV catheter
- Administer drugs
- Insert a urinary catheter
- Initiate CPR
- Check your baby’s heart rate, breathing, and temperature
- Initiate newborn resuscitation

The Second Birth Attendant MAY NOT:

- provide care in the absence of a registered midwife
- provide care outside of the birth and immediate postpartum period
- provide midwifery advice
- perform the newborn exam

TEACHING PRACTICE:

WomanCare Midwives is a preceptor site for student midwives. Students always work under the supervision of a midwife. You may be asked if a student can be involved in your care. You play an important role in teaching future midwives sensitive, woman-centered care. Your feedback to them, and to us, is an essential part of their experience.

CLINIC APPOINTMENTS:

We make every effort not to rearrange prescheduled appointments. However, at times, because the process of labour and birth is unpredictable (especially regarding when it happens), we may need to rearrange prescheduled clinic appointments. This will happen when a client goes into labour and needs us during clinic days. Should this be the case, we try to notify you as soon as possible. Thank you for your patience and understanding regarding this situation.
OTHER CONCERNS AND CONFLICT RESOLUTION:

If at any time you have concerns regarding your care, please share them with us. We want to provide midwifery care that is responsive to each individual. If further steps are needed, please contact Marie Hatherall at the office number.

INDICATIONS FOR MANDATORY DISCUSSION, CONSULTATION AND TRANSFER OF CARE

The midwife is responsible for writing orders and carrying them out or delegating them in accordance with the standards of the College of Midwives. The College has outlined conditions for which a midwife discusses care of a client, consults, or transfers primary care responsibility in The Indications for Mandatory Discussion, Consultation and Transfer of Care.

Category 1: Discuss with another midwife or with a physician
It is the midwife’s responsibility to initiate a discussion with or provide information to another midwife or physician.

Category 2: Consult with a physician
The midwife initiates a consultation that may involve the physician providing advice and information and/or providing therapy to the woman/newborn or prescribing therapy to the midwife for the woman/newborn. After consultation with a physician, primary care of the client and responsibility for decision-making together with the client either continues with the midwife or is transferred to a physician. The midwife must discuss the consultant’s recommendations with the client and ensure the client understands which health professional will have responsibility for primary care.

Category 3: Transfer to a physician for primary care
When primary care is transferred, permanently or temporarily, from the midwife to a physician, the physician, together with the client, assumes full responsibility for subsequent decision-making. When primary care is transferred to a physician, the midwife may provide supportive care within her scope of practice, in collaboration with the physician and the client.

INDICATIONS: Initial History and Physical Examination
Category 1: adverse socio-economic conditions
age less than 17 years or over 35 years
smoke cigarette
grand multipara (para 5)
history of infant over 4500 g
history of one late miscarriage (after 14 completed weeks) or preterm birth
history of one low birth weight infant
history of serious psychological problems
less than 12 months from last delivery to present due date
obesity
poor nutrition
previous antepartum hemorrhage
previous postpartum hemorrhage
one documented previous low segment caesarean section
history of essential or gestational hypertension
known uterine malformations or fibroids

Category 2: current medical conditions for example: cardiovascular disease, pulmonary disease, endocrine disorders, hepatic disease, neurologic disorders
family history of genetic disorders
family history of significant congenital anomalies
history of cervical cerclage
history of repeated spontaneous abortions
history of more than one late miscarriage or preterm birth
history of more than one low birth weight infant
history of gestational hypertension with proteinuria and adverse sequelae
history of significant medical illness
previous myomectomy, hysterectomy or caesarean section other than one documented previous low segment caesarean section
previous neonatal mortality or stillbirth
rubella during first trimester of pregnancy

Category 3: cardiac or renal disease with failure
insulin dependent diabetes
multiple pregnancy (other than twins)
gestational hypertension with proteinuria and/or adverse sequelae
symptomatic placental abruption
vaginal bleeding, continuing or repeated placenta Previa after 28 completed weeks

INDICATIONS: Prenatal Care
Category 1: presentation other than cephalic at 36 completed weeks
no prenatal care before 28 completed weeks
uncertain expected date of delivery
uncomplicated spontaneous abortion less than 12 completed weeks

Category 2: anemia (unresponsive to therapy)
documented post term pregnancy (42 completed weeks)
fetal anomaly
inappropriate uterine growth
medical conditions arising during prenatal care, for example: endocrine disorders, hypertension, renal disease, suspected significant infection, hyperemesis
placenta Previa without bleeding
polyhydramnios or oligohydramnios
gestational hypertension
isoimmunization
serious psychological problems
sexually transmitted disease
twins
vaginal bleeding other than transient spotting
presentation other than cephalic, unresponsive to therapy, at 38 completed weeks

**Category 3:**
cardiac or renal disease with failure
insulin dependent diabetes
multiple pregnancy (other than twins)
gestational hypertension with proteinuria and/or adverse sequelae
symptomatic placental abruption
vaginal bleeding, continuing or repeated
placenta Previa after 28 completed weeks

**INDICATIONS:** During Labour and Birth

**Category 1:**
no prenatal care
non-particulate meconium

**Category 2:**
breech presentation
preterm labour (34 - 37 completed weeks)
prolonged active phase
prolonged rupture of membranes
prolonged second stage
retained placenta
suspected placenta abruption and/or Previa
third or fourth degree tear
twins
unengaged head in active labour in primipara
preterm prelabour rupture of membranes (PPROM) between 34 and 37 completed weeks
particulate meconium
gestational hypertension

**Category 3:**
active genital herpes at time of labour
preterm labour (less than 34 completed weeks)
abnormal presentation (other than breech)
multiple pregnancy (other than twins)
gestational hypertension with proteinuria and/or adverse sequelae
prolapsed cord or cord presentation
placenta abruption and/or Previa
severe hypertension
confirmed non-reassuring fetal heart patterns, unresponsive to therapy
uterine rupture
uterine inversion
hemorrhage unresponsive to therapy
obstetric shock
vasa Previa

INDICATIONS: Post Partum (Maternal)
Category 2: suspected maternal infection e.g. breast, abdomen, wound, uterine, urinary tract, perineum
  temperature over 38°C (100.4°F) on more than one occasion
  persistent hypertension
  serious psychological problems

Category 3: hemorrhage unresponsive to therapy
  postpartum eclampsia
  thrombophlebitis or thromboembolism
  uterine prolapse

INDICATIONS: Post Partum (Infant)
Category 1: feeding problems
  failure to pass urine or meconium within 24 hours of birth

Category 2: 34 to 37 weeks gestational age
  infant less than 2,500 g
  less than 3 vessels in umbilical cord
  excessive moulding and cephalhematoma
  abnormal findings on physical exam
  excessive bruising, abrasions, unusual pigmentation and/or lesions
  birth injury requiring investigation
  congenital abnormalities, for example: cleft lip or palate, congenital dislocation of hip, ambiguous genitalia
  abnormal heart rate or pattern
  abnormal cry
  persistent abnormal respiratory rate and/or pattern
  persistent cyanosis or pallor
  jaundice in first 24 hours
  suspected pathological jaundice after 24 hours
  temperature less than 36°C, unresponsive to therapy
  temperature more than 37.4°C, axillary, unresponsive to non-pharmaceutical therapy
  vomiting or diarrhea
  infection of umbilical stump site
significant weight loss (more than 10% of body weight)
failure to regain birth weight in three weeks
failure to thrive
failure to pass urine or meconium within 36 hours of birth
suspected clinical dehydration

Category 3: APGAR lower than 7 at 5 minutes
suspected seizure activity
major congenital anomaly requiring immediate intervention, for example: omphalocele, myelomeningocele
temperature instability

THE FIRST TRIMESTER

EXERCISE:

We strongly encourage an active lifestyle and exercise during pregnancy. Being in good physical shape will help you meet the demands of pregnancy and labour. It is also an excellent way to reduce stress. Swimming, walking and bicycling are good exercise during pregnancy. Use your legs, not the car! Some worry about overexertion during pregnancy; if you are working out, you should be able to carry on a conversation (the “talk test”). We discourage you from lying flat on your back to do abdominal exercises after the first trimester, particularly if this makes you feel dizzy or light-headed. If you have more specific questions, talk to your midwife.

If you are interested in pursuing an active exercise program, UWO has an exercise and pregnancy lab (a gym) where you can exercise with other pregnant women. Parking is free. Access to the gym requires that you participate in studies that involve having blood drawn. This may not be a good option if you are fearful of needles. Please visit the UWO Exercise and Pregnancy website (http://www.uwo.ca/fhs/EPL/participation.html) for more information to see if you are eligible to enter into a study. Those women who are interested in entering a study are asked to contact Dr. Michelle Mottola at 519-661-2111 extension 88366.

NUTRITION:

Eating well when you are pregnant is crucial. We encourage you to eat when you are hungry. We suggest that you eat several small meals throughout the day to ensure that the baby receives a steady supply of nutrients. Pregnancy requires only 300 calories in addition to your non-pregnant diet – so you are not “eating for two.”

Trying to avoid refined sugars found in white bread, pasta, and sweets (including pop and juice) are recommended. Your baby will receive more nutrients from whole foods.

Plenty of fluids are essential for hydration. Limit the amount of coffee, tea or juice you drink and aim for 8 glasses of water a day. Do not exceed two measured cups of coffee per day.
A prenatal vitamin is not necessary for all women. However, pregnant women need adequate calcium, iron and protein. If you have concerns that your diet is lacking in any of these, talk to your midwife for more detailed information.

IRON:

Iron is the most common nutrient deficiency in pregnancy. Iron is necessary for increasing the quantity of red blood cells, which carry oxygen. The amount of needed iron doubles during pregnancy to meet the needs of your placenta and growing baby. Signs of iron deficiency include fatigue, shortness of breath, pale skin, increased susceptibility to infections, brittle nails, heart palpitations and dizziness.

Your midwife will check your iron levels in the first and third trimester. For some women, increasing their dietary iron is adequate to maintain their levels. Iron is available in meat and non-meat sources. Meat sources generally have the most iron and it is in a form that is easily absorbed. A supplement is likely more beneficial for women who eat minimal or no meat.

The best sources of iron (because they are most easily absorbed) are meat including beef, chicken, lamb, pork and veal. Other good sources include beans, eggs, tuna, lentils, pumpkin seeds, sunflower seeds, sesame seeds, nettle tea, quinoa grain, dried fruits, cooked oatmeal, pistachios, prune juice, cooked oysters, molasses, whole grain breads, leafy greens, iron-fortified cereals and bran muffins.

After reviewing your blood work, your midwife may recommend that you take an iron supplement, usually Ferrous Gluconate 300 mg taken one to three times per day or Ferrous Fumarate 300 mg (Eurofer or Palafer) taken once per day (either one capsule or five millilitres of oral suspension). Another option is HVP (Hydrolyzed Vegetable Protein) chelated iron 30 mg one to three times per day which is more easily absorbed than a non-chelated type. Ferrous Gluconate and Ferrous Fumarate can be purchased at most pharmacies. You may need to ask the pharmacist for it as it is typically kept behind the counter. The HVP chelated iron is found in health food and bulk food stores, which carry vitamins. Like all medications, they should be stored in a safe place as it is toxic if ingested in high doses, especially in young children.

Taking an iron supplement may cause nausea, bloating, constipation or diarrhea and may make your stools turn black. These side effects will often decrease as your body adjusts to the iron. Increasing your fluids and fibre and avoiding taking iron in the morning when your blood sugars are low should help minimize these side effects. Iron is best absorbed on an empty stomach; however, if this causes nausea, try taking it with a meal. For best absorption, iron should be taken with a source of Vitamin C, like orange juice or a Vitamin C supplement of 250 to 500 mg which will double the absorption. Tea, coffee or caffeinated sodas should be avoided a few hours before taking a supplement. If you take a thyroid medication, it should be taken at a different time as it will bind to the iron and inhibit absorption. Avoid taking calcium supplements, calcium-containing medications (such as antacids like Tums or Rolaids), or calcium-containing foods with your iron supplement as these will also inhibit iron absorption.

CALCIUM:

The other important mineral during pregnancy is calcium. Calcium is necessary for healthy bones, teeth and the development of your baby's skeletal system. Calcium also plays a role in regulating blood pressure. It may also decrease leg cramps; though excessive calcium may cause leg cramps. When women have insufficient intake per day, whether by diet or by supplement, calcium will be taken from
maternal bones. Fortunately, during pregnancy the body is twice as efficient as absorbing calcium as when you are not pregnant.

Pregnant women need 1000 to 1200 milligrams of calcium per day. If dairy is a normal part of your diet, three to four dairy servings per day will meet your needs. Dairy sources include milk, cheese (especially Swiss) and plain yogurt. Other non-dairy sources include tofu, soy milk, sesame seeds, sardines, canned salmon, evaporated milk, broccoli, oranges, legumes, almonds, kale, oysters and bok choy. In general, vegetable sources have less calcium and are not as well absorbed, especially when cooked. Where possible, try to eat vegetables raw.

For women with lactose sensitivity or those who do not regularly eat dairy, a supplement may be necessary. We recommend a Calcium citrate preparation with Vitamin D and Magnesium to increase absorption. This preparation also causes less constipation and bloating. If you are also taking a prenatal vitamin with iron or an iron supplement, avoid taking it within two hours of taking your calcium supplement to improve absorption of both minerals. Also avoid taking more than 500 milligrams of calcium at one time as absorption will also be decreased. Finally, like any supplement, too much is not good. High doses of calcium (i.e. more than 2500 mg) can increase the risk of urinary tract infections and kidney stones.

THE SECOND TRIMESTER

PRETERM LABOUR:

Definition of Preterm Labour

Preterm labour is labour that starts before 37 weeks of pregnancy. Preterm labour can happen to anyone. The reasons why are not well understood. You may be more at risk if you have had a preterm baby before, smoke, are underweight or are not getting enough healthy food, have lots of stress or have had several miscarriages.

Effect on Baby

Preterm babies may:
- have trouble breathing
- have trouble feeding
- have trouble keeping warm (temperature instability)
- have an increased risk of infection
- need special care in the hospital including prolonged hospitalization

Some preterm babies are very small and may not be strong enough to live.

Warning Signs
- cramps, contractions or pains that come at regular intervals (i.e. that are getting longer, stronger and closer together)
- lower back pain or dull aching
- pressure as if the baby is pushing down
- bleeding from the vagina
- a trickle or gush of fluid from the vagina
a feeling that something is not right

Page your midwife if you are less than 37 weeks and think that you may be having preterm labour.

GESTATIONAL HYPERTENSION:

Definition of Gestational Hypertension

Gestational hypertension (GH), also known as Pregnancy Induced Hypertension (PIH), is a serious condition that happens in 1 out of every 10 pregnancies. It is more common in first time mothers and women having a subsequent pregnancy, but with a new partner. It usually happens at the end of your pregnancy. Going to prenatal visits is important. We see you more frequently at the end of your pregnancy to check your blood pressure and to check if there is protein in your urine. Stress may play a role in hypertension. Know how to manage yours with exercise, support and a healthy diet.

Effect on Baby

Gestational hypertension may lead to preterm birth, stillbirth and growth restriction in the baby.

Warning Signs

Possible signs of gestational hypertension include:
- elevated blood pressure
- protein in your urine
- rapid weight gain (four or more pounds in a week)
- sudden, obvious swelling in your hands or face
- severe abdominal pain under your right breast (liver)
- severe headache (usually frontal) that doesn't resolve with the usual remedies
- blurry vision
- seeing spots before your eyes
- severe nausea and vomiting

If you develop these symptoms, please page your midwife.

THE THIRD TRIMESTER

FETAL MOVEMENT COUNTING:

Over time you will become an expert on your baby's movements. Often babies have predictable times when they are more active (i.e. after dinner). As you approach the end of pregnancy, the baby may change his/her movements as there becomes less room for big kicks. This change in the quality of movement is normal.

If you become concerned that your baby has not been as active as usual, we suggest that you do a fetal movement count as detailed below. Please note that this criterion applies after 32 weeks gestation.

Have a drink and then lie on your left side with your hands on your abdomen. If possible, try to avoid other distractions such as watching TV or reading a book. Count your baby's movements (i.e. kicks, jabs, punches, twists and turns). You should feel at least six movements in one hour. If you haven't gotten six movements
after one hour, continue counting for another hour. You should feel at least ten movements in two hours. Page your midwife if you felt no movement in one hour or if you counted less than ten movements in two hours.

NEWBORN MEDICATIONS:

In the first hours after birth, the following medications are routinely given to all newborns under medical care. Erythromycin is administered by law; however, some clients choose to decline erythromycin administration following an informed choice discussion. It is also your choice whether or not your baby will receive Vitamin K.

_Erythromycin_

This clear antibiotic ointment is administered into each eye. This ointment does not sting; it may cloud the baby’s vision for a brief period of time. Erythromycin effectively destroys gonorrhea and is somewhat effective against chlamydia. These are two bacteria that may be present in your baby’s eyes after passage through the birth canal. Both organisms may lead to blindness if symptoms of eye infection are ignored in the newborn period.

_Vitamin K_

In humans, Vitamin K is produced primarily by bacteria in the bowel. Babies are born naturally deficient in Vitamin K as only a small amount is transferred across the placenta in utero and the bowel is sterile at birth.

There are only small amounts of Vitamin K in breast milk. Cow’s milk is high in Vitamin K. Vitamin K is essential in blood clotting.

Vitamin K is administered by intramuscular injection (IM) to the thigh of newborns. It is effective in preventing a rare condition called Vitamin K deficiency bleeding (VKDB), formerly known as hemorrhagic disease of the newborn (HDN). The incidence of VKDB in breastfed babies who do not receive Vitamin K after birth is a difficult statistic to accurately determine from available studies; a fair estimate is 1 per 10,000 or 0.01%. The benefit of administering Vitamin K after birth is that the occurrence of VKDB is virtually eliminated.

Risks of Vitamin K IM injection include pain and bleeding at the injection site. Skin-to-skin and/or breastfeeding during Vitamin K administration may help to reduce the pain of the injection. Over thirty years of experience in administering IM Vitamin K in the early hours of life has not identified adverse effects related to this medication. However, only retrospective studies have been done and no prospective studies following a group of babies into adulthood have been, or are likely to be, conducted. Opponents to Vitamin K being administered after birth point out that there may be a natural advantage for babies to have less clottable blood in the early months of life. We do not know for sure if low levels of Vitamin K in the breastfed newborn is nature’s design, but it seems possible. However, it is also possible that in human history transfer of Vitamin K in utero and levels of Vitamin K in breast milk were higher and are low now because of environmental/social changes.
GBS INFORMATION HANDOUT

This handout is to provide you with information on Group B Streptococcus (GBS) infections in pregnancy and the relevance to your newborn. The information will help you decide if you would like to have a vaginal/rectal swab for GBS at thirty-five to thirty-seven weeks of pregnancy.

GBS is a type of bacteria that normally lives in the vagina, bladder and bowels in ten to thirty-five percent of pregnant women. In healthy adults, GBS does not typically cause infection.

If a pregnant woman has GBS and is not treated, it may be transmitted to the baby during the birth, as bacteria can travel upward from the mother’s vagina into the uterus. Fifty percent of infants born to mothers who are GBS positive will be positive for GBS themselves (i.e. will be colonized with GBS) if the mother is not treated. Fortunately, most babies who acquire GBS from their mothers do not get sick; however, one to two percent of babies who become colonized with GBS will go on to develop GBS infection/disease – in other words, approximately one in five hundred babies. GBS infection is treated with admission to the neonatal intensive care unit usually for seven to ten days (though it can be for longer) where babies are given antibiotics through an IV. For babies thirty-seven weeks gestation or older (term babies), the prognosis is very good, with approximately ninety percent of infected babies responding to treatment.

Do I Have GBS?

During your pregnancy, we will offer you a vaginal/rectal swab at thirty-five to thirty-seven weeks gestation to determine whether or not you carry GBS. It is your choice whether to have the swab or to decline it. Currently, family physicians, obstetricians and recent research from the Centre for Disease Control and the Society of Obstetricians and Gynecologists support routine swabbing of all pregnant women.

What happens if my Swab is Positive?

Women who swab positive for GBS are offered treatment with antibiotics through an IV during labour (usually penicillin, unless the woman is allergic). As previously stated, if a woman is GBS positive, the chances of her baby developing GBS infection is approximately one in five hundred. This risk decreases to approximately one baby in two thousand if the woman receives IV antibiotics at least four hours prior to delivery. Taking antibiotics by mouth during labour or before labour does not prevent GBS infection in the newborn.

It is recommended that newborns of GBS positive women who are untreated or partially-treated remain in the hospital for twenty-four hours after the birth to be monitored for signs of infection and/or so the baby can receive a blood test to rule out any infection. If you choose to go home before twenty-four hours, your midwife will educate you on signs and symptoms of infection.

If I am Positive for GBS, Do I Need to Have Antibiotics?

As midwives, we provide information and offer treatment options. It is your decision to accept or decline treatment.
If you have GBS and no antibiotic treatment, there is a one in five hundred chance that your baby will develop an infection. If you have GBS and antibiotic treatment, there is a one in two thousand chance that your baby will develop infection. The risk of GBS infection increases when other risk factors are present. These risk factors are:

- preterm delivery (delivery at less than thirty-seven weeks)
- fever during labour (greater than or equal to thirty-eight degrees Celsius)
- if your waters have been broken for eighteen hours or more before the birth
- having had a previous baby with GBS disease/infection
- having GBS bacteria found in your urine during the pregnancy

Possible Risks of Taking Antibiotics

Possible side effects of treating with antibiotics include:
- allergic reactions in the mother (i.e. anaphylaxis) – very rare
- yeast infections or thrush in mom and/or baby
- a potential for antibiotic resistance

What if I don’t Swab?

If we don’t know whether or not you have GBS, antibiotics would be recommended and offered in labour if you develop a risk factor as listed previously.

Waters Breaking and GBS

Once the amniotic sac is broken, bacteria can ascend up the vagina and to the baby.

If you are GBS positive, the community standard is to induce labour six hours after the waters are broken and to begin antibiotics at that time. However, other options are also possible – such as treating with antibiotics while waiting for labour to start on its own or declining antibiotics and waiting for labour to start on its own. Your midwife can discuss these options (and the associated risks and benefits) with you in more detail.

If you do not have GBS, you do not require antibiotics. You may choose to have labour induced or wait for labour to start on its own.

If your GBS status is unknown, the community standard is that you only receive antibiotics and be induced if a risk factor develops (i.e. if your waters have been broken for more than eighteen hours, if you develop a fever in labour or if you are preterm). However, other options are also available such as treating with antibiotics and/or undergoing induction of labour within six hours of your waters breaking (similar to if a woman were GBS positive).
PRE-LABOUR AND EARLY LABOUR

In the textbooks, labour is described in three stages. During the first stage of labour, the cervix is effacing (thinning) and dilating (opening). Second stage is the pushing stage and the third stage is the delivery of the placenta (afterbirth).

This information sheet is going to discuss the more specific details of pre-labour and early labour. As you can see from the chart below, labour can be described in terms of pre-labour (also known as false labour), early labour and active labour. This is all part of the first stage of labour.

**Pre-labour**

It is important to note that pre-labour is an important and valuable part of a woman’s labour. The term “false” labour is inappropriate. Pre-labour is preparing the uterus for labour. It is also important to know that while it is valuable, pre-labour usually does not bring about major changes to the cervix that active labour will.

During bouts of pre-labour (and there may be more than one bout), contractions are usually IRREGULAR or have NO PATTERN. Sometimes pre-labour contractions will be regular (i.e. every five minutes) but they DO NOT PROGRESS. That is to say, they do not get longer, stronger or closer together. They are uncomfortable enough to make you wonder if you are in labour, but not so uncomfortable that you have a lot of trouble coping with them.

It is really important to try to get these contractions to stop. While they are preparing your uterus, they are not changing your cervix and they may lead to exhaustion. There are a number of remedies to help alleviate pre-labour:

A hot bath – this is not just a warm and comforting thing to do; it has true physiological effects. The pre-labour contractions are due to a small amount of the hormone – oxytocin – in your blood stream. If you have a hot bath, the heat causes your blood vessels to increase in size and draw in more water or fluid. This fluid will dilute the concentration of the pre-labour oxytocin. This, in turn, will decrease these contractions and allow you to get the sleep you will need for true labour, when it happens.

Increase your fluid intake. You need to stay hydrated and the increased fluids will also assist in the dilution of oxytocin.

A gentle walk outside if weather permits, as ambulation may help slow pre-labour and it will help to distract you.

Sometimes pre-labour is working to get your baby lower in the pelvis or into a better position for labour. If the above suggestions don’t help, try position changes to aid your baby’s movement deeper into the pelvis. Often the most uncomfortable position is the one that works to shift the baby’s position.

**True Labour/Early Labour**

Early labour can take twenty-four hours or longer. Rest (sleep is even better) is essential to promote a normal process. Early labour may begin with menstrual-like cramps and increase in intensity slowly. Contractions may begin as irregular in length or frequency. For some women, their early labour begins as intense labour and becomes stronger from there. During early labour, the contractions cause your
cervix to get thinner (effacement) and to dilate to four centimetres. Early labour will continue at its own pace even if you attempt to speed it up. Walking often makes the contractions come more frequently, but they are often milder – so walk for comfort or pleasure, but don’t exhaust yourself trying to speed things up.

Early labour may be preceded or start with the passing of your mucous plug. It may be clear, or blood tinged. The mucous plug has been providing extra protection to your cervix, much like a seal. The mucous plug may be passed hours or days prior to the onset of labour.

As early labour can last many hours, it is very important to focus as much as possible on getting enough rest. Women who are unable to get enough sleep or rest in the days and nights preceding true labour risk being exhausted before active labour begins.

We recommend in early labour to live your life as normally as possible. This means that if it is three am, try and go back to sleep. If contractions wake you, try and have a warm bath. Remember that the better rested you are, the better you will cope and work with your labour once it becomes active.

If it is daytime, try to distract yourself. Go for a walk, watch some television or a movie, listen to music – anything that will help keep you feeling relaxed and positive. If you are tired, have a nap. Make sure to eat lightly and to drink adequate fluids. We suggest at least eight ounces of fluid (alternate between water and juice if you wish) each hour. If you want to time contractions, time a few every hour, but if they are more than five minutes apart and not lasting at least forty-five to sixty seconds consistently, then stop. This will only increase the focus on contractions and will drain you.

WHEN TO CALL YOUR MIDWIFE: When contractions are five minutes apart, lasting sixty seconds and this has gone on for more than an hour, you may wish to page your midwife. If you are coping well, it is not necessary to call your midwife. Five minute apart contractions can last for many hours and the contractions typically become closer together (i.e. three minutes apart, lasting a minute) and stronger when the labour is active. Be sure you are timing contractions correctly – they are timed from the beginning of one contraction to the beginning of the next one.

It is important to pay attention to the intensity of the contractions, as well as the timing.

IF THIS IS YOUR FIRST BABY: Contractions that are five minutes apart and are not getting closer, not getting stronger and not getting longer are likely early labour – especially if you are coping well (with slow deep breathing and focused attention). If you are coping well with five minute apart contractions, it is not necessary to page your midwife. You should page your midwife if you are having a hard time coping with contractions, regardless of the pattern.

IF YOU HAVE HAD A BABY BEFORE: You may cope well, even with very intense five minute apart contractions. You should page your midwife after an hour of regular, intense contractions that are five minutes apart and last forty-five to sixty seconds. Page right away if contractions are intense and less than five minutes apart. You should page your midwife if you are having a hard time coping with contractions, regardless of the pattern.
### Pre-labour, Early Labour and Active Labour:

<table>
<thead>
<tr>
<th>Findings</th>
<th>Pre-labour (or False Labour)</th>
<th>True/Early Labour</th>
<th>Active Labour</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotions</strong></td>
<td>Excited, eager</td>
<td>Apprehensive, may be anxious</td>
<td>Focused, very intense</td>
</tr>
</tbody>
</table>
| **Uterine Contractions** | Irregular, usually no pattern
If pattern is present, it does not progress (see notes below) | Regular PATTERN begins to develop
\(\uparrow\) frequency (every 5 – 60 min)
\(\uparrow\) duration (x 20 – 60 sec) AND
\(\uparrow\) intensity (mild then moderate) | Regular PATTERN
\(\uparrow\) frequency (every 3 – 5 min)
\(\uparrow\) duration (x 45 – 60 sec)
\(\uparrow\) intensity (strong) |
| **Bath/Sedation** | Both will usually stop or decrease the contractions | Will NOT stop the contractions, but may help relax you, allowing you to rest before active labour | - Your midwife will be in attendance and will give you suggestions
- Soaking in the tub or a shower can significantly increase your ability to cope with the pain
- Drink one cup (8 oz.) of fluid every hour
- Empty your bladder at least once every two hours
- Have something sweet to eat or drink every hour or so |
| **Suggestions** | - Time contractions only for ½ hour; if in early labour, stop timing contractions until you feel a significant change in pattern/strength
- Hot bath x 45 min
- Drink lots of water; keeping well hydrated may help as dehydration can increase symptoms and discomfort
- Not the time for pacing
- TRY to sleep or rest if it is nighttime, or you are tired (do not exhaust yourself) | - Time contractions only for ½ hour; if in early labour, it is time for REST & DISTRACTION
- Go about your normal activities (rest at night, usual events in day); Tylenol and Gravol can help you get much needed rest for the upcoming hard work of active labour
- Eat if you are hungry
- Drink lots of water; if not eating, have occasional sweet drinks or snacks
- Walking or position changes
- Start timing contractions again when you feel a significant change in pattern and/or strength
- See pre-labour and early labour narrative for information on when to call your midwife | - Early labour can be difficult to distinguish from pre-labour.
You will know it is early labour if it progresses: the contractions get longer, stronger and closer together.
Early labour can take 24 hours or longer, we cannot stress enough the IMPORTANCE OF GETTING REST |
| **Notes** | Some women have several bouts of pre-labour and contractions may be regular but they DO NOT PROGRESS (they do not get longer, stronger or closer together over time). In this situation, you may have some dilation and effacement which will mean there is less work to do when you are in early labour.
Pre-labour may promote descent or help baby get into a better position for labour. | Dilation from 4 cm to 10 cm can take approximately 12 hours if it is your first baby or 6 hours if you’ve had a baby before.
Some women have a very fast labour even with a first baby; typically, in these situations there is no early labour and contractions are frequent and very intense from the beginning. |
SUPPLIES FOR HOSPITAL BIRTH:

Regardless of where you plan to have your baby, it is a good idea to have a hospital bag packed. Your hospital bag should contain:

- Your envelope with your prenatal records
- Health card
- Money and small change for parking and vending machines
- Food and drink for yourself and your partner (during labour and postpartum)
- Extra pillow, slippers and pajamas
- Toiletries – toothbrush, toothpaste, shampoo, soap, body lotion, lip ointment or chap stick
- Clothes: an outfit for baby to come home in and one for you
- Infant car seat
- Optional – olive oil or coconut oil for baby’s skin

SUPPLIES FOR HOMEBIRTH:

Please have the following supplies gathered together in one place at thirty-seven weeks gestation. This ensures that if labour is active when we arrive, you will not have to spend time gathering supplies.

- Your envelope with your prenatal records
- In one clean plastic or paper bag, have freshly laundered baby’s first clothes to wear after the birth: undershirt, diaper, pajamas, socks, two hats (that you don’t mind getting soiled or stained) and two receiving blankets; in a second bag, have four towels (for first receiving baby) and at least four to five face cloths (for perineal compresses – you can make these by cutting up an old towel) which you do not mind soiling and staining
- Bowl for compresses
- Bowl for the placenta and a one litre disposable container for storage of the placenta
- Two cookie sheets (non-disposable): one for instruments, one for resuscitation
- Telephone in room where birth will take place (if possible)
- Two large receptacles (lined with garbage bags) where the birth will take place – one for laundry, one for garbage
- Clean towels for mom – especially if it is a water birth or if mom is labouring in the tub
- Large plastic sheet or fitted vinyl mattress cover
- Plastic shower curtain or other suitable floor covering
- Garbage bags for pillow protection (optional)
- Snacks and drinks available for nourishment during labour and after the birth

When labour starts, have the bed made up double sheeted with older sheets (that you don’t mind soiling) on top and a vinyl mattress protector/plastic sheet between the two sets of sheets, with the good sheets on the very bottom

Of note, prior to labour starting, you may want to clean the tub if needed.

POSTPARTUM SUPPLIES FOR HOME AND HOSPITAL BIRTH:

It may be useful to have the below supplies available prior to the birth to avoid having to go out to buy them in the early postpartum period:
• Empty clean squeeze bottle for perineal care (i.e. empty dish detergent bottle)
• Large sanitary pads – optional: you can make ice packs by soaking a few sanitary pads with one-quarter to one-half cup of water and placing them in the freezer (these can be used to reduce perineal swelling), alternatively you can make an ice pack by folding an adult washcloth in half and rolling it. Soak in water and cover it in Saran Wrap.
• Digital thermometer (an under-the-arm thermometer is preferred over an ear thermometer)
• Ibuprofen (Advil) and acetaminophen (Tylenol)
• Diaper cream, ointment or petroleum jelly
• Olive oil or coconut oil (for baby’s skin)
• Disposable diapers for the first few days will prevent cloth diapers from becoming stained with meconium
• Epsom Salts
• Tucks pads/Preparation H/Anusol or Witch Hazel for hemorrhoids

POSTPARTUM

MOTHER’S CARE FOR POSTPARTUM:

Postpartum Planning

DISCUSS RULES ABOUT VISITING PRENATALLY: Sometimes people assume that they are invited to visit immediately after you have the baby, either in the hospital or at home. Think about when you will want visitors, for what length of time, how many at a time, etcetera. Remember this is the most important time for you to get to know your baby, establish breastfeeding and heal from giving birth. We strongly suggest that you limit visitors during the first week.

PLAN FOR HELP: Whether it is family or friends, you will get more rest if you have help with household chores. People should be able to see what needs doing and do it without a lot of direction. Consider hiring a cleaning service or postpartum doula if you are able.

ORGANIZE MEALS: Make a list of things your family likes to eat and post it on the refrigerator for all to see. This provides a quick answer for those asking to bring a meal. If you have some last trimester energy, freeze meals ahead of time and stock up on non-perishables.

LISTEN TO YOUR BODY: If it says sleep, then sleep. The best way to take care of your baby is to take care of yourself. We will spend time talking about realistic expectations for new mothers and newborns.

CONSIDER SIBLINGS: They go through adjustment, too. Plan playtime for them at other homes. Wrap little goodies ahead of time for “I feel left out” moments. Consider taking ten minutes three times a day to read books or play games (i.e. have designated time for older children).

REST AND FLUIDS: Spend the first twenty-four to forty-eight hours after the birth in bed. Take as much help from others as they will give, but you take the baby. Keep visitors to a minimum in the first one to two weeks. Your partner can entertain while you and baby get rest. Consider wearing pajamas during visits to remind people that you are recovering from giving birth. Short visits work well. Baby is here for good, let friends and relatives get to know him/her when you are all well-rested.