NHS Grampian

Planning how you want to give Birth

Introduction

Our maternity services are proud to support you and your family to plan care that is individual to you and takes account of what is most important to you.

Many women wish to make a choice about how they aim to give birth. The following information is designed to help you plan for either vaginal birth or scheduled caesarean birth.

All births can be positive experiences but may also bring risks and consequences that affect women and their families in different ways.

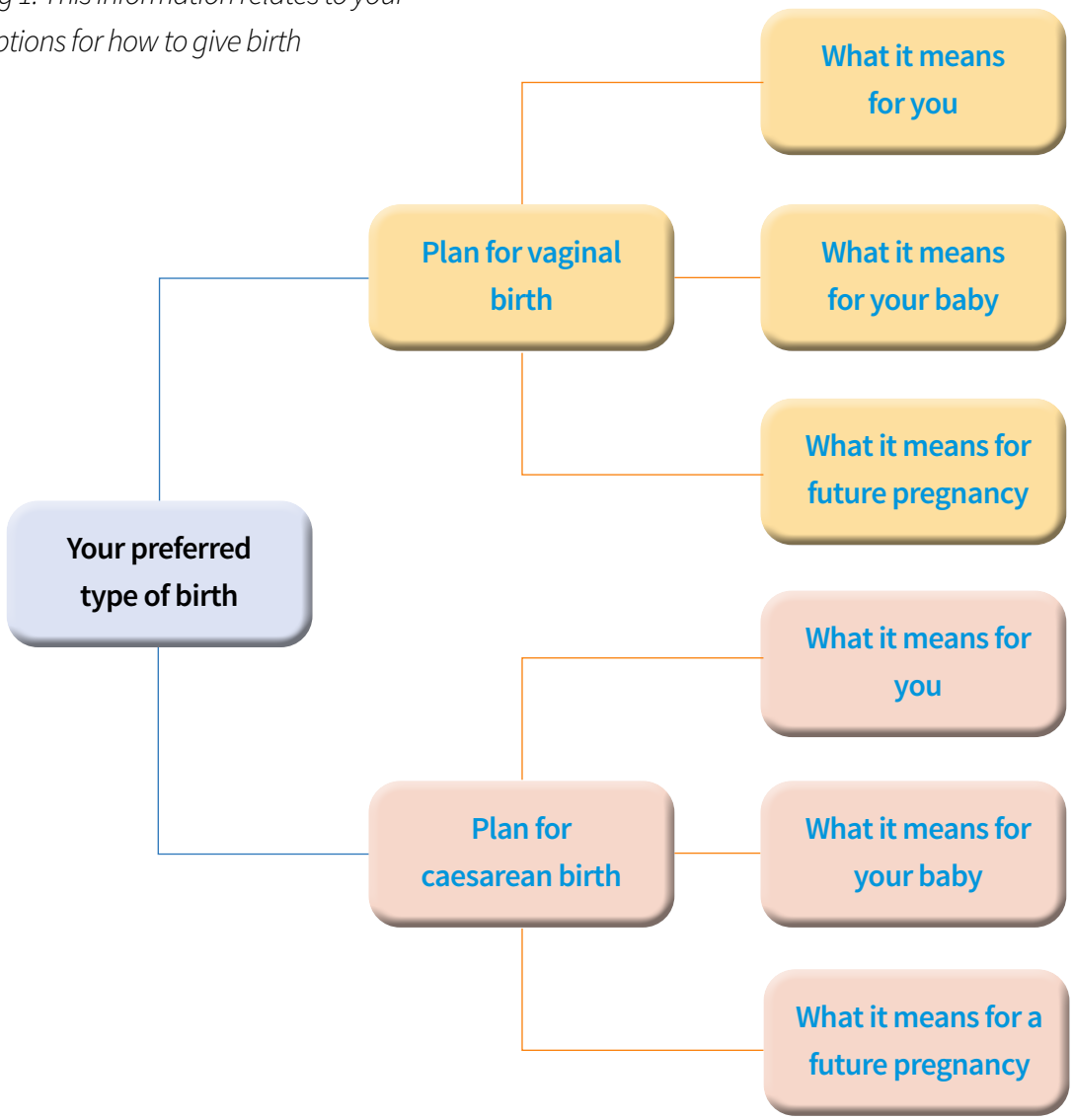
This information aims to help you to prepare for birth and to understand some of the events that can take place, sometimes unexpectedly.

If you have a twin pregnancy, a baby in the breech position, placenta praevia or a medical condition affecting how you may choose to give birth or you have had a previous caesarean birth, you will receive tailored advice, extra support and information from your care team.

Once you have read this information, you may want to decide how you wish to give birth, you may want to discuss it with your partner or family, and/or you may have questions for your midwife or obstetrician. You will be given the opportunity to discuss your birth plan during your antenatal appointments, but you can also start the conversation yourself at any time. As circumstances often change during pregnancy, your plans can be revisited at any time.

Blue bold text can be clicked to access further information or the original information source.

Fig 1. This information relates to your options for how to give birth



Contents

Aiming for vaginal birth

Most women aim to give birth vaginally.

Benefits of aiming for vaginal birth

There are many benefits of aiming for vaginal birth when the birth goes to plan.

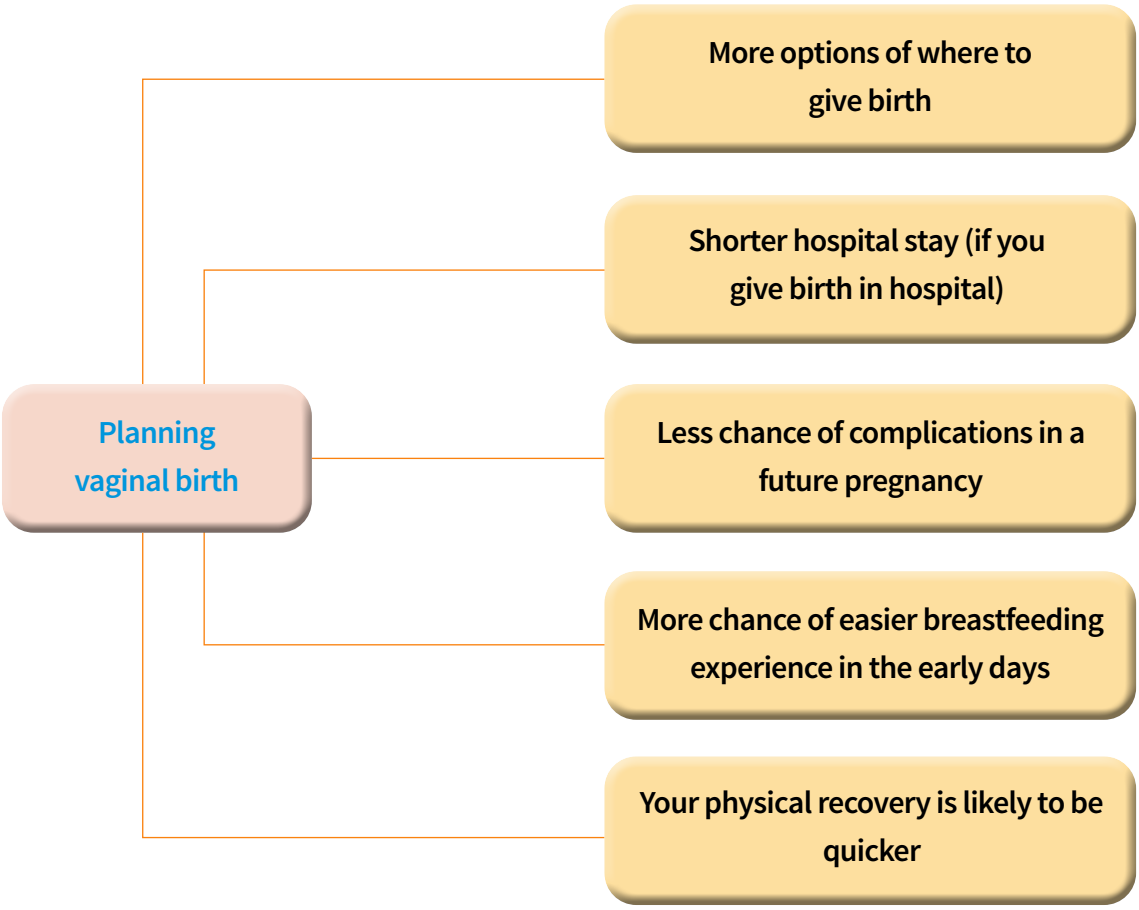


Figure 2. Benefits of aiming for vaginal birth. More details are provided in the next section.
For more information on the benefits of vaginal birth ***click here.***

Benefits of aiming for vaginal birth

Place of birth options

More options of **where to plan to give birth in NHS Grampian** such as at home; in a freestanding midwifery-led unit; alongside Midwife-led unit; or Obstetrician-led labour ward. See this **link** for more information on how place of birth options compare to each other.

Hospital stay

Length of hospital stay may be shorter (if you give birth in hospital)–in NHSG this averages 2.5 days compared to 2.6 days after planned caesarean birth. This is because the length of stay is linked to complications following the birth: you may go home 6 hours after a straightforward vaginal birth or one day after a straightforward caesarean birth.

Future pregnancy benefits

Less complicated future pregnancies if you have a vaginal birth this time:

- lower risk of womb rupture with or without lack of oxygen to baby/heavy bleeding for you - **around 20 in 100,000 women compared to 700 in 100,000 women after caesarean birth**
- lower risk of abnormally attached placenta - **3 per 100,000 women compared to 90 per 100,000 women after caesarean birth**

Breast-feeding

The possibility of successful breastfeeding in the early days - *Continued breast-feeding at 6-8 weeks postnatal - 69 per 100 women after aiming for a vaginal birth compared with 68 per 100 women after a planned caesarean birth.**

Vaginal birth

Experiencing an unassisted vaginal birth (48 per 100 women giving birth for the first time, 88 per 100 women who have had a previous vaginal birth)

These benefits are supported by the best available (low to moderate quality) scientific studies. The hyperlinks take you to the original study reports.

* 2019/2020 NHS Grampian data.

Unplanned events when aiming for vaginal birth

Even when you aim for vaginal birth, there is a possibility that complications arise or unplanned medical care is needed. As this affects at least 5 in 10 (50%) women in a first pregnancy, it may be especially helpful to be aware in advance if this is your first pregnancy.

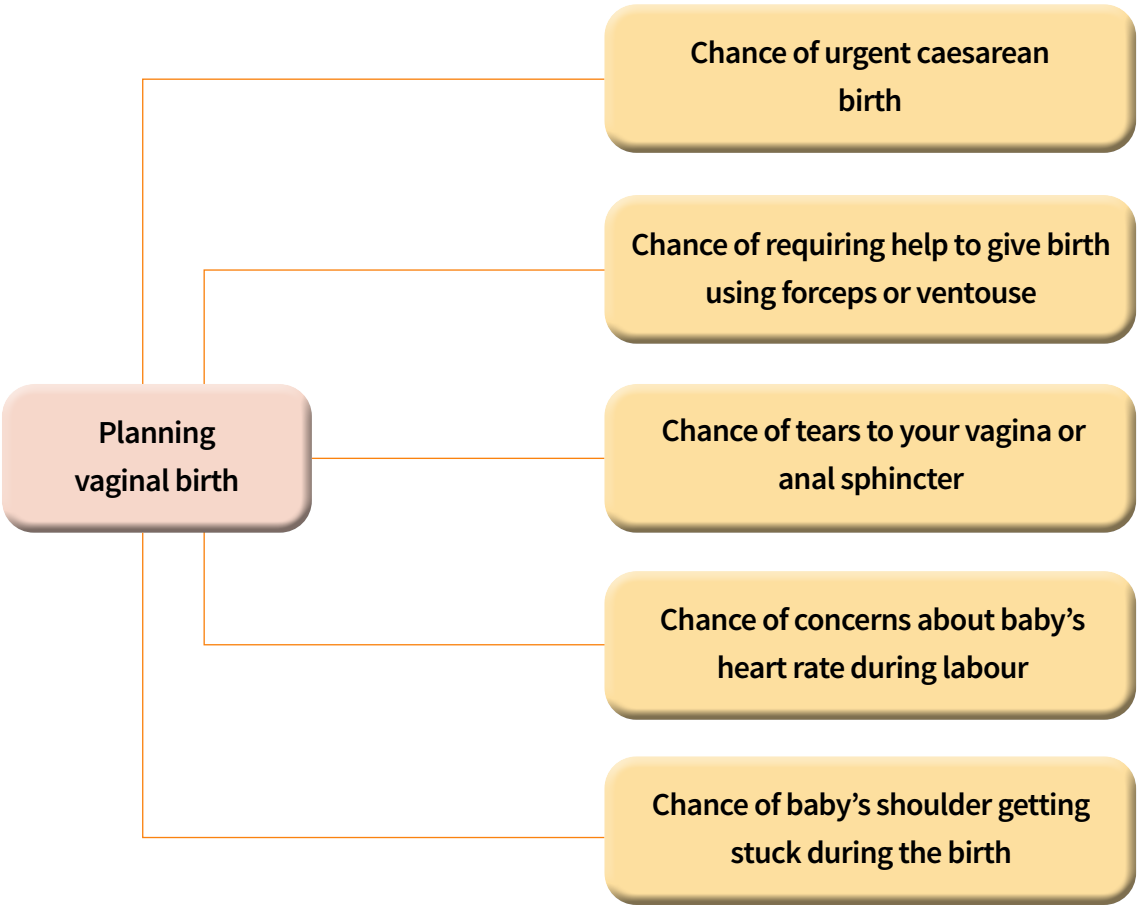
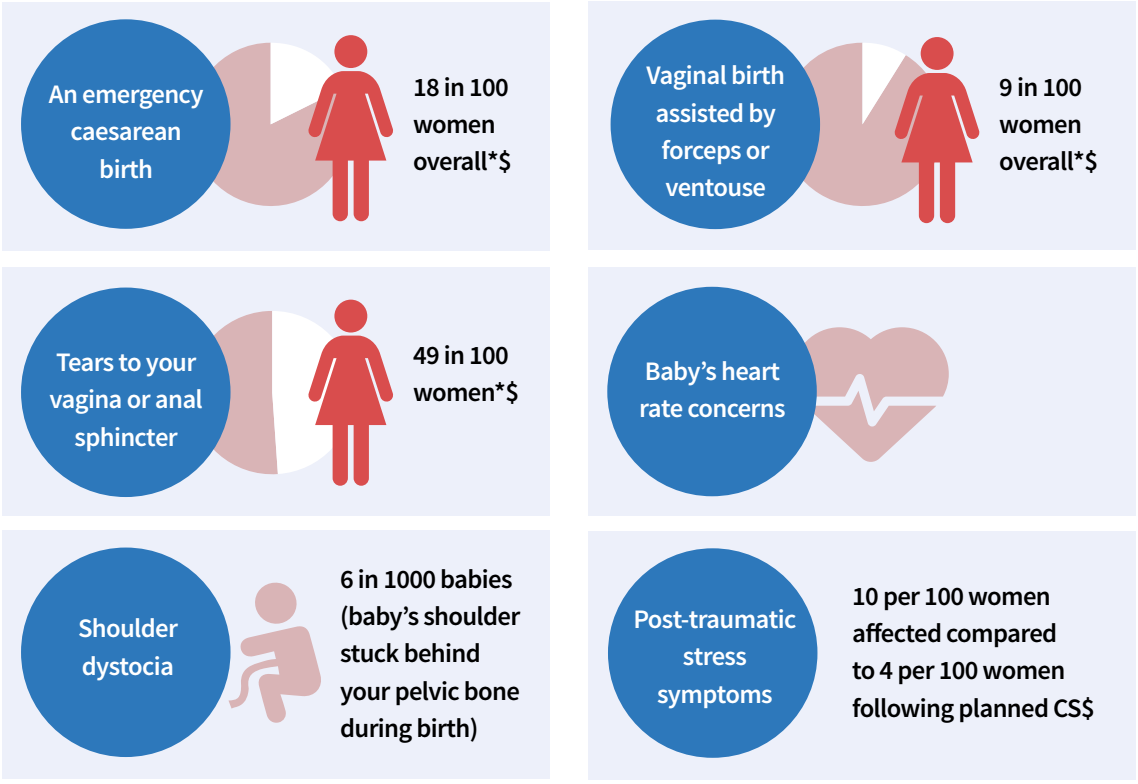


Figure 3. Unplanned events which can happen when aiming for vaginal birth. Details are included in the next section.

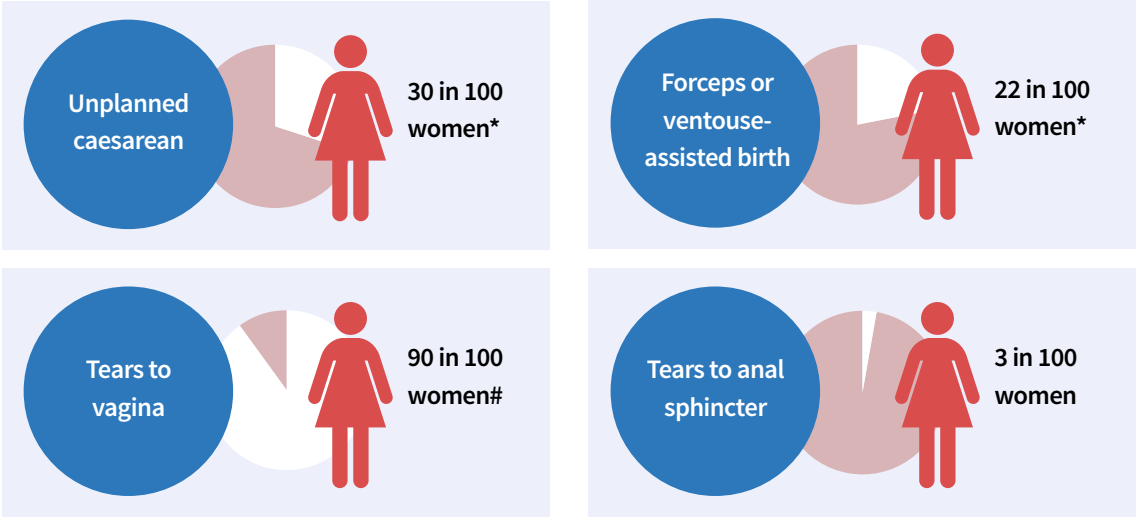
Unplanned events following a plan for vaginal birth can include:



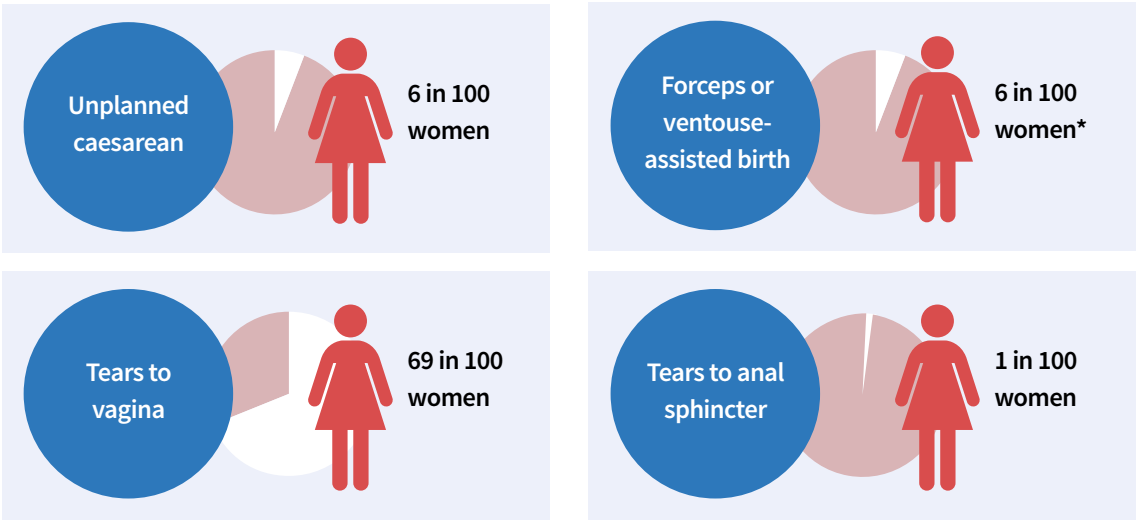
*These are rates from NHS Grampian 2018-2020.$See box below for rates after first births and rates for birth after previous vaginal birth.

Your chance of experiencing at least one of these events is higher if it is your first pregnancy – at least 50 in 100 women will experience one of these events compared to 10 in 100 women who have previously given birth vaginally. These local figures are similar to **National English data.**

Aiming for vaginal birth in your first pregnancy



Previous vaginal birth - aiming for vaginal birth again



*These are rates from NHS Grampian 2018-2020. Data source via links for **Tears to vagina, Tears to anal sphincter.**

Data split by first/subsequent birth was not available for baby's heart rate concerns in labour and post-traumatic stress symptoms.#applies if actual vaginal birth occurs.

Emergency caesarean birth

- You should be informed of the reason why caesarean birth is being offered and have the chance to ask questions and consider any alternative options.
- You should be told of the potential risks involved and usually you will be asked to provide written consent. If there is a very urgent concern then you may be moved to theatre quickly and verbal consent may be requested at this time.
- In most situations you should be given the chance to be awake during the birth, using an anaesthetic in your back (epidural or spinal) to ensure you feel no pain.
- In most situations your birth partner can be present in theatre for your baby's birth. One instance where this may not be possible is if you require a general anaesthetic for the birth.
- Information relevant to risks of all caesarean births is included below via this **link**

Forceps or ventouse-assisted birth

What it means for you

- These types of births will only be offered in the obstetric-led labour ward.
- You should be told why forceps or ventouse-assisted birth is being offered and be invited to ask questions. You should be made aware of the possible risks involved and any safe alternatives (waiting for spontaneous birth or emergency caesarean birth).
- This involves use of metal instruments like large spoons (forceps) or a vacuum device (ventouse) on your baby's head to assist vaginal birth when needed.
- You should first have a vaginal examination to confirm that this type of birth is a safe option
- Sometimes it is not clear if safe vaginal birth by forceps or ventouse is achievable. In this case you should be given the chance to give birth in an operating theatre so that a caesarean birth can be carried out quickly if the use of forceps or ventouse doesn't succeed.
- You may be asked to provide written consent.
- In most situations **pain relief should be provided using an existing epidural, a spinal anaesthetic or sometimes via local anaesthetic.**
- You will usually require a catheter (soft tube) to be passed into your bladder to ensure it is empty before birth, and to avoid your bladder overfilling after birth if you have an epidural.
- You are very likely to need a cut (episiotomy) to widen your vaginal opening for birth.
- Choosing between forceps and Ventouse depends on:
  - whether your baby is premature (forceps are safer at earlier gestations)
  - your progress in labour
  - if you have a working epidural
  - the urgency
- The chance of the forceps or ventouse birth being successful is less if:
  - your bodyweight is high (body mass index over 30)
  - you are less than 161cm tall
  - your baby is expected to weigh more than 4kg, is lying on its back, or its head is not very low down

- **Injury to the anal sphincter or rectum** (called a third or fourth degree tear) affects **4 in 100 women with ventouse birth and 8-12 in 100 women with forceps-assisted birth.**
- After the birth you should be offered antibiotics IV (into the vein) to reduce the chance of you developing infection.
- Your risk of developing a blood clot in your legs or lungs may be increased after this type of birth – you can **reduce this risk** by staying mobile.

What forceps or ventouse-assisted birth means for your baby

- Your baby is likely to be well and unlikely to suffer any long-term problems from this type of birth. Marks on your baby's face from forceps are very common but most disappear in 24-48hrs. A mark or swelling on your baby's head from a ventouse birth usually disappears in 24-48hrs. Small cuts on the baby's head affect around 1 in 10 babies and heal quickly.
- Between 5 and 15 per 100 babies become jaundiced after forceps or ventouse-assisted birth compared to **3 per 100 babies after spontaneous vaginal birth.**
- Between 5 and 15 in 10,000 babies develop bleeding on the brain after these types of birth.
- Much more rarely your baby could experience a skull bone fracture or facial nerve damage.

Prevention of forceps or ventouse-assisted births

- Birth using forceps or ventouse are less likely to be required if you:
  - have someone supporting you throughout the labour
  - have no pregnancy complications and plan birth in a midwife-led unit
  - use upright positions or lie on your left side in labour
  - don't have an epidural
  - delay pushing for 1-2 hours after your cervix is fully open

Tears and episiotomy

- If you had an episiotomy (a cut with scissors to widen the vaginal opening) or your vagina tears during the birth you should be offered for this to be repaired (using dissolving stitches) soon after birth, unless a tear is very superficial and would heal on its own.

Anal sphincter tears

- If your anal sphincter (ring of muscle which holds your poo/stool inside) or rectum is affected (known as third or fourth degree tear) you should be offered a repair in an operating theatre soon after birth (within 4 hours).
- You should be offered antibiotics (may be a single dose) and laxatives to help the healing process.
- You should be offered referral to a physiotherapist for pelvic floor muscle therapy and the postnatal clinic for follow up.
- Tears which extend to the anal sphincter or rectum affect around **3 in 100 women who give birth without assistance, around 4 in 100 women with ventouse birth, and 8-12 in 100 women with forceps-assisted birth.**

Recovery from tears

- You may have swelling and pain after tears or an episiotomy, especially when you go to the toilet to either pass urine or open your bowels. Regular pain relief should help with this.
- You should be encouraged to keep the area clean by showering or washing daily, ensuring regular hand washing and sanitary pad changes.
- **Around 2-4 in 10 women who experience a tear extending to the anal sphincter or rectum will have longer-lasting problems.** Rarely this involves being unable to hold wind or controlling the bowel. Specialist treatment involves physiotherapy or surgery.
- Sometimes your mental health can become affected by injury to your vagina or pelvic floor during birth, especially if you have lasting pain or problems with having sex.
- **You can access more information about injury to the anal sphincter or rectum via this link.**

Baby's heart rate concerns and lack of oxygen

- Your baby's heart rate changes frequently during labour, this is normal, however sometimes further tests are required to confirm that your baby is getting enough oxygen. One of the tests that we can offer involves taking a blood sample from your baby's head (fetal blood sample). If this confirms that your baby is beginning to get too little oxygen then an emergency caesarean section or forceps/ventouse birth may be recommended. This test will only be offered in the obstetric-led labour ward and only if the cervix is open enough to allow the test to be carried out.
- It is very rare for babies to experience a severe lack of oxygen during labour. Around **2 in 10,000 babies die during labour and 15 per 10,000 babies develop abnormal brain function** due to lack of oxygen before or during labour or birth. There is a lack of data on how many of these cases are due to problems during labour alone.

Post-traumatic stress symptoms

- After childbirth, some women are affected by flashbacks, nightmares, repetitive and distressing images or sensations, or try to avoid memories of the birth - these are symptoms of post-traumatic stress.
- It may be beneficial to arrange to talk through your birth experience with your midwife or health visitor.
- These symptoms are least common after a spontaneous vaginal birth (4 in 100 women) and planned caesarean birth (4 in 100 women), more common when plan for vaginal birth ends in emergency CS (16 in 100 women) and most common when plan for vaginal birth ends in forceps (20 in 100 women).
- Should these continue for more than four weeks or become particularly distressing you should seek help from your GP – post-traumatic stress disorder is a treatable condition.

Shoulder dystocia

- During vaginal birth your baby's shoulder could become stuck behind your pubic bone just after the head is born. This is shoulder dystocia. It affects around 6 in 1000 babies.
- Shoulder dystocia is an emergency so several people may come into the room to help.
- If there is a long delay to the birth of your baby's body then your baby could become low in oxygen with risk of brain damage or death.
- Fortunately 9 in 10 cases of shoulder dystocia can be managed by simply by bending your hips and knees to open your pelvis further.
- Shoulder dystocia is most likely to happen in babies that are big, in women with diabetes, if labour is induced or very long, and if you have a forceps or ventouse-assisted birth.

Why do these events happen?

Emergency caesarean birth, forceps or ventouse-assisted vaginal birth are medical interventions to speed up the birth of your baby. These are offered to benefit your health or that of your baby.

As a very prolonged labour can put your health at risk (increased risk of bleeding or difficult birth), speeding up the birth is offered to assist you when labour does not progress as expected despite all routine steps known to help.

Occasionally women develop signs of infection during labour for example a high temperature. If this does not settle with treatment then eventually it could lead to you being offered a caesarean or forceps/ventouse birth to reduce risk to your baby of infection or high temperature.

Concerns about your baby's heart rate usually arise because there is pressure on the umbilical cord. Some pressure on the umbilical cord is normal during labour but when this becomes prolonged then the oxygen supply to the baby can be reduced. This leads to a change in your baby's heart rate. A blood sample from your baby's scalp can help staff understand whether

there is a problem which requires birth to be brought forward through caesarean, forceps or ventouse-assisted birth. **If your baby's heart rate or a blood sample from your baby shows a high level of concern** then speeding up the birth is intended to reduce the risks of lack of oxygen to your baby and subsequent brain damage or death.

Post-traumatic stress disorder can happen for many reasons. It is more common after a very fast or painful labour, a sense of loss of control, a difficult or long labour, concern for you or your baby's wellbeing and receiving emergency treatment. It is a treatable condition.

Planning caesarean birth

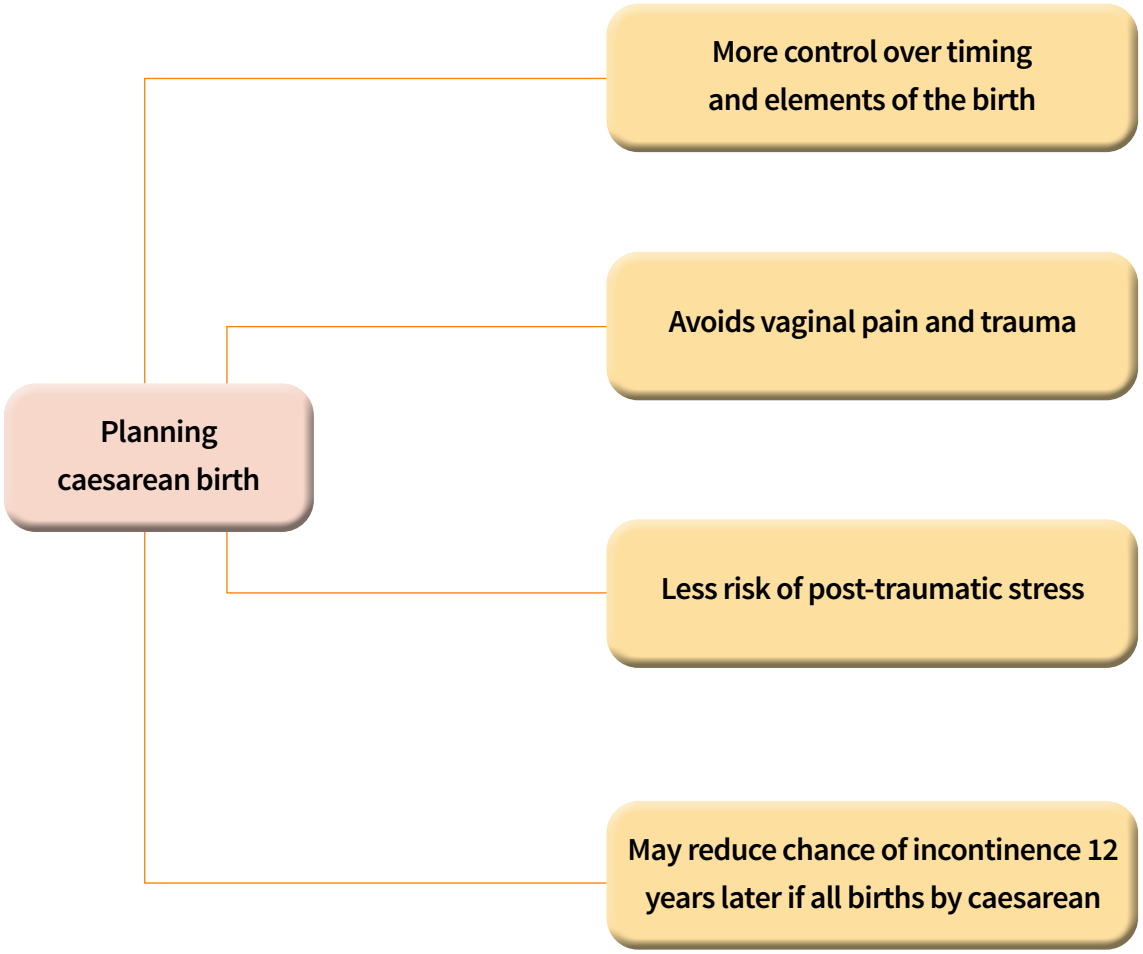
Around 1 in 8 women in NHS Grampian give birth by planned caesarean section, commonly following a previous emergency caesarean birth. Many reasons lead to a woman and her care team planning a CS birth.

A plan for CS birth should reflect a careful assessment of the risks and benefits to both short and long-term health of you and your baby (this baby and future babies). Both your physical and psychological health may be considered when planning how to give birth.

You can make a plan for caesarean birth following discussion with your midwife and obstetrician early in pregnancy, ideally before 36 weeks gestation. You will have a pre-operative discussion with an anaesthetist and come into hospital on the day of your planned caesarean. You will likely stay one or two nights in hospital unless you or your baby require additional care. The option of delayed cord clamping and skin-to-skin time with your baby during the caesarean birth will be offered if you are both well.

Further information on the process of preparing and recovering from caesarean birth in NHS Grampian are provided at **this link.**

Benefits of planning caesarean birth



Control over timing and birth experience

Potential benefits of planning caesarean birth include some ability to control both the timing and certain elements of the birth experience. If you are considering a planned caesarean birth because a predictable timing of birth would help your situation, you can discuss this (and the alternative option of **induction of labour**) with your obstetrician.

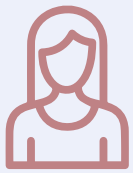
Pelvic floor

Your chance of pelvic floor problems in later life appear to be linked to pregnancy itself and not just the type of birth. If you have all of your babies by caesarean you may have a lower chance of urinary incontinence (**250 in 1000 women vs 400 in 1000 women**)or faecal incontinence (**45 per 1000 women vs 60 per 1000 women**) 12 years later.

Vaginal pain

Planned caesarean also carries less risk of vaginal pain.

Fear of labour



If you have a fear of labour or vaginal birth, or have previously experienced a traumatic birth, you may be considering a planned caesarean birth this time. It is important to have an open discussion about this with your midwife or obstetrician. They will be able to address your concerns and ensure that you develop realistic expectations of the different birth options available to you.

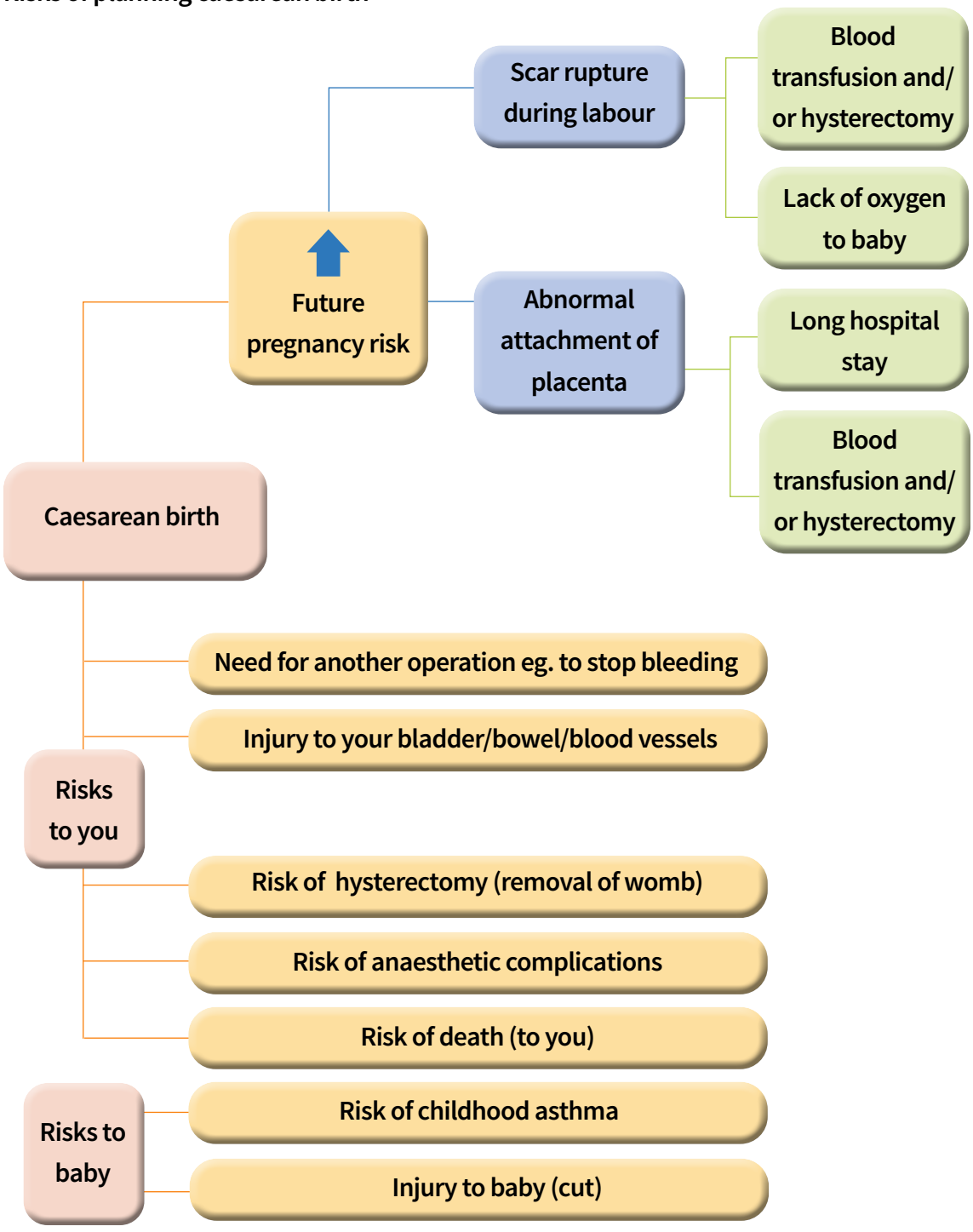
Timing

It is recommended that planned caesarean births are performed after 39 completed weeks gestation unless medical reasons mean that an earlier birth is safer. This is because babies often have more breathing difficulties if born before 39 weeks gestation. Around 40 in 1000 babies develop breathing problems at 37 weeks gestation, 25 per 1000 at 38 weeks gestation and 1 in 1000 babies at 39 weeks gestation.

Unplanned outcomes of planning caesarean birth

There are also disadvantages to planning caesarean birth. These risks also apply to emergency caesarean birth. **Many of these risks are more likely with an emergency caesarean than a planned one.**

Risks of planning caesarean birth



Complications of caesarean birth for future pregnancies.

- womb rupture/caesarean scar opening during a future labour (**approximately 700 in 100,000 women vs 20 in 100,000 women after vaginal birth**)
- placenta praevia **900 in 100,000 after one caesarean vs 400 in 100,000 after vaginal birth**
- placenta accreta (abnormally embedded placenta which can cause life-threatening bleeding for the mother) **90 per 100,000 women compared to 3 per 100,000 women after vaginal birth – this risk rises with each caesarean section**

Complications of the procedure

Risks of the surgery itself are common to both planned and unplanned caesarean births, but some are more common in emergency situations. These are detailed below with rates provided for planned caesarean, actual vaginal birth and emergency caesarean birth where possible. The quality of scientific evidence on these risks is low or very low.

- hysterectomy is more likely to happen in women who plan a caesarean birth, the absolute risk is 16 in 1000 compared to 8 in 1000 when aiming for a vaginal birth.
- maternal death is more likely to happen in women who plan a caesarean birth, the absolute risk is 25 in 100,000 compared to 4 in 100,000 when aiming for a vaginal birth.

	Planned caesarean birth	Planned vaginal birth
		All planned vaginal births
Pain at day 3	Score 4.5 out of 10	Score 5.2 out of 10
Bladder/urinary system injury	0 in 10,000	14 in 10,000
Bowel injury	1 in 1000	3 in 1000
Wound infection	1 in 10,000	0 in 10,000
Other infections	11 in 1000	8 in 1000
Anaesthetic complications	45 per 1000	35 per 1000

Data source

All caesareans carry the risks below. There is currently no reliable data available on planned and emergency caesarean separately – many of these risks are likely to be higher with emergency caesarean during labour.

- Need for further surgery at a later date, 5 women in every 1000 (uncommon)
- Admission to intensive care unit, 9 women in every 1000 (uncommon)
- Developing a blood clot, 4–16 women in every 10 000 (rare)
- Injury to the urinary system, 1 woman in every 1000 (rare)
- Blood transfusion
- Persistent wound and abdominal discomfort
- Repeat caesarean section in subsequent pregnancies, readmission to hospital,
- Minor cuts to the baby's skin

Data source

Childhood risk of asthma

Studies have shown that babies born by caesarean are more likely to develop asthma in childhood (**38 per 1000 babies compared to 30 per 1000 babies born vaginally**).

First hours after birth

In all situations, no matter what type of birth, you will be offered the opportunity to have immediate skin-to-skin contact if you and your baby are well, even in the operating theatre. This means that you can have skin-to-skin contact in the first minutes which helps calm both you and baby, enables colonisation of the baby's skin with your friendly bacteria, thus providing protection against infection and stimulates the release of hormones to support breastfeeding (Insert hyperlink please) **https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/skin-to-skin-contact/"Skin-to-skin contact - Baby Friendly Initiative (unicef.org.uk)**

Events where planned type of birth does not appear to make any difference:

- blood clots in your veins after birth
- excessive bleeding after birth
- postnatal depression
- baby being admitted to a neonatal unit
- infection in your body
- baby dying in the first year of life
- baby experiencing persistent verbal delay

The source of this information can be accessed via this link [updated NICE CS guideline 2021]

Losing Blood

- Women at higher risk of bleeding after childbirth: There are additional reasons why some women are more likely to lose extra blood than others. These include women with:
  - previous excessive blood loss after birth
  - a large baby
  - twin pregnancy
  - low lying placenta
  - high body weight (body mass index over 30)
  - a first baby when aged over 40 years
  - anaemia
  - high blood pressure,
  - fibroids
  - blood clotting problems
  - a long labour
  - delayed delivery of placenta

- ▷ tear or episiotomy
- ▷ a high temperature in labour
- ▷ having a general anaesthetic

- Prevention of bleeding: steps to reduce risk of bleeding include treating anaemia during pregnancy, routinely offering an injection to help the placenta separate, offering additional medication which helps blood clot in women at particularly high risk of bleeding.
- Future pregnancy: You should usually be advised to give birth in a consultant-led unit in a future pregnancy in case you experience excessive blood loss again.

Excessive bleeding can happen due to the womb being overstretched (eg. by a big baby or lots of amniotic fluid), due to it being overworked (eg. following a long labour), due to large blood vessels being damaged during a tear, or for reasons that we do not fully understand. Often the womb does not contract properly. This means that bleeding from where the placenta was previously attached will continue. Many treatments are aimed at increasing contraction of the womb.

The process of making a decision about how to give birth

Your plans for how to give birth may change as your pregnancy evolves. There are many points at which your plans can be discussed with your midwife, or if applicable, with your obstetrician.

If you are not due to meet an obstetrician but would like to do this e.g. because you are considering a caesarean birth or have questions which your midwife cannot answer, you can request this via your midwife. Generally it is advised that you should receive the information needed to help you plan your birth by 28 weeks gestation. Ideally you would have agreed on a plan for birth by around 36 weeks gestation.

There are many factors which may affect which type of birth you plan. One of these may be the number of children you hope to have. As many risks of caesarean birth rise with increasing number of these procedures this needs to be considered when making birth choices.Your midwife will begin discussing your labour and birth preferences and what is important to you from the beginning of your pregnancy, this does not mean that these cannot change, and quite possibly will change as your pregnancy advances. Your midwife or obstetrician will revisit this with you regularly but you can also start the conversation about this at any appointment.

FAQs

What if my personal circumstances or concerns affect my birth choices?

- You will be encouraged to be open with your midwife or obstetrician about how your personal circumstances affect your birth preferences. These are important considerations when planning how to give birth.

What if I have a fear of labour or vaginal birth?

- Some women suffer from a condition called tokophobia or fear of childbirth. This is an extreme anxiety and can influence your birthing decisions. At NHSG we will seek to provide you with information and support to help you come to the right decision for you and your family. If you think you are suffering from tokophobia please speak with your GP or midwife about a referral to the perinatal mental health team.

What can I do to reduce the chance of needing a caesarean birth during labour?

The following are proven to reduce the chance of needing a caesarean during labour.

- One-to-one support during labour
- Non-upright positions with epidural
- Upright positions without epidural

What if I really don't want a forceps birth?

- You are encouraged to discuss any personal concerns about your birth plan with your midwife or obstetrician early in your pregnancy. You can discuss what alternative options are available if you would decline an offer of a forceps or ventouse birth. This would include the risks and benefits of having a caesarean section in advanced labour. Ultimately women should be the primary decision-maker in their labour and birth. NHS Grampian staff will support, inform and advise on the choices available.

What if I want to give birth at home or in a freestanding or alongside midwifery unit?

- As your planned place of birth affects the options available to you during labour and birth, and the experience you will have, your midwife should discuss all options for place of birth with you and share information on these to help you decide.

Planning how you want to give Birth

NHS Grampian