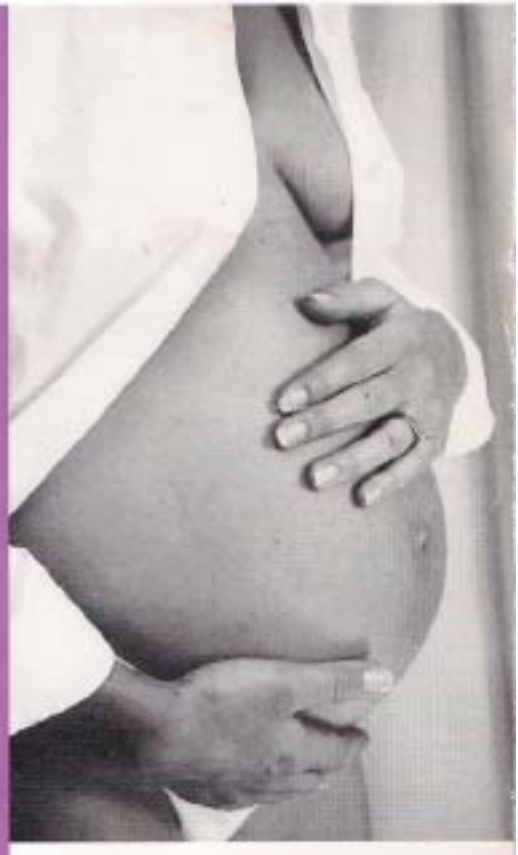
Sit Up and Take Notice!

Positioning Yourself for a Better Birth



by Pauline Scott

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Positioning Yourself for a Better Birth

Pauline Scott

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PositioningYourself for a BetterBirth'
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* Terri McKinney PlwlOgraphy- for moreinformaticn turn to page 185.

Note to the reader:
I have deliberated at great length about using “she” or “he” when writing about the baby. I even considered using “she” or “he” in alternate chapters but it all became too confusing. In the end I decided to go with “he” to help distinguish between the pregnant woman and the midwifeto make it easier for you, the reader, to follow.

Disclaimer

'Sit Up and Take Notice! Positioning Yourself for a Better Birth' has been published by the author to assist pregnant women and their support people in understanding the concept of *Optimal FoetalPositioning(OFP)*. The methods discussed in this book are only intended as a complement to pre-natal care and may not be suitable for all women or all pregnancies. In particular, there may be medical conditions that render the methods discussed in this book unsafe for a woman or her unborn child. Regardless of whether any specific medical condition exists, women are recommended to consult their childbirth health professional/s. The author takes no responsibility for any injury or damage suffered by any woman or baby, whether occurring during pregnancy, delivery or otherwise.

TESTIMONIALS

Just a few excerpts from emails received from all over the world after the first book on optimal foetal positioning was written by Pauline Scott and Jean Sutton.

Thank you so much for your pearls of wisdom.. .for the first time ever I learnt how important it was for the baby to be in the optimal position for labour - not just head down. I am so thankful to have known about OFP. Knowing that my last two babies were in the most effective position for labour and birth made their births so much easier and more satisfying.
Jacki Taiapa, Hamilton, New Zealand

I recently purchased your book on optimal foetal positioning and found it to be quite exceptional. I shall now incorporate your teachings in my childbirth education classes. Thank you for your insights.
Ellen Lewis, Quebec, Canada

Your book was phenomenal, especially since as a doula I have been encountered more OP presentations lately than I could have imagined. Thank you for your help!
Maggie McCarthy, Florida, USA

While I have the opportunity, congratulations on an excellent source of information for parents and childbirth educators!
Mandy Lowrie, Basingstoke, Hants, UK

First, I love your book! I have been seeing an obstetricianwhose mouth dropped open after reading your book and said 'My God that makes perfect sense, why hasn't this information gotten out and why didn't I think of that!'
Laurie Leadbetter, Georgia, USA

I am grateful for a deeper understanding of the importance of foetal positioning in birth through this book. I was blessed to be able to put its principles into practice with very effective results and my confidence grew as I took an active role in a situation most leave to chance.
Laine Holman, California, USA

Thank you so much! I now feel armed for the next pregnancy, both in the area of OP prevention as well as treatment. I wish and hope that this information will one day be known and disseminated by all birth professionals and to every pregnan} woman. So much agony and disappointment, as well as complications, could be avoided!
Cherwyn Ambuter, New Jersey, USA

During my secondpregnancy, my midwife handed me a miraculous little book 'Understanding and Teaching Optimal Foetal Positioning'. I read it and cried. It describedwhy so many modern day mothers suffer OP labours. Needless to say I did a lot of kneeling with number two. The baby positioned itself beautifully and was born within five hours.
Carole McMinn, Hamilton, New Zealand

CONTENTS

		Page
Acknowledgements		9
Foreword		12
About this book		15
PART ONE:	**SIT UP AND TAKE NOTICE!**	
Chapter		
1.	Important decisionsfirst	24
2.	What position is your baby in?	29
3.	Youramazinguterus!	40
4.	Rockthat pelvis!	58
5.	Yourperineum	74
6.	Yourbaby's role	79
7.	Yourbaby'sposition	87

PART TWO: POSITIONING YOURSELF FOR A BETTER BIRTH

	Chapter	Page
8.	Optimal foetal position (OFP)	100
9.	Helpful positions for labour	116
10.	Head down but the other way around!	128
11.	Posterior position and medical assistance	142
12.	Other head down positions	161
13.	Some more birth stories	169
14.	The last word	180
	About the author	184
	Resources	186

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To my family and friends who have supported me to make this book possible.

Special thanks to my daughters -Amy, my first born child who was responsible for starting me on this journey; Joanna, my second born who taught me that I was on the right track -and Sophie, my third born who came into my life in the nick of time and confirmed it all! The production of this book has truly been a family affair with Amy drawing some of the diagrams and J0 studiously proof reading draft manuscripts, as well as taking the back cov"erphotograph.

And sometimes you just need someone who has the technical know-how and patience to help promote a book, especially in the field of TV advertising and video production and Murray was the man! Also, his unfailing support as a hands-on father to Sophie helped towards making this book become a reality.

And further family appreciation, this time to my sister Val for her constant support -and to Arthur, her husband, for his patience as my financial advisor, wearying as it was (for him!).

To Jean Sutton, for teaching me in her no nonsense fashion about giving birth safely and normally. Her wise midwifery knowledge will never be lost now that her pioneering work in the field of childbirth has been recorded in our books. She is a breath of fresh air in today's environment of medicalised childbirth.

To Connie Banack, childbirth educator and birth doula from Alberta, Canada, who gave me some wonderful ideas for the title for this book and who has offered much encouragement and support from afar. Also, heartfelt thanks for writing the Foreword to this book. Youare a treasure!

To Terri McKinney (Connie's sister) for the beautiful black and white photographs of the most gorgeous pregnant women and newborn babies.

What a privilege it is to have connected with Terri through her sister and to have the opportunity to showcase them in this book. Thank you from the bottom of my heart.

To Jeremy, for his thousands of positive, perceptive and pacifying emails and phone calls -even though he hadn't a clue what I was writing about. Such is his faith in me.

To Jane, Carole and Linda who never once doubted that this book would be written (even though I did). Thank you for listening, advising and helping me drink numerous flat whites and consume many wonderful New Zealand chardonnays in times of need, and there were many.

To Jo Ferris, who I persuaded to be my editor. I'm sure she has regretted it ever since. Thank you for your guidance, insightfulness and your wicked sense of humour.

And of course, not forgetting - all the wonderful women and babies who have passed my way over the last 20 years or so. It is they who have helped me to gain a clearer understanding of the miracle of birth.

FOREWORD

By Connie Banack

I am honoured to write this forwardas I have both used and taught the informationand techniquesexplainedin this book extensively throughout my career as a birth doula and childbirth educator. When I first read about posterior positioning in 'Understandingand Teaching Optimal Foetal Positioning', co-authoredby Pauline Scott,I was dumbfounded that this information was not a well-known and well-used aspect of obstetrical or midwifery care. It just makes too much sense!

I had my first son via caesarean section because of undiagnosed posterior presentation leading to to diagnosis of failure to progress. It was in recovering emotionally by seeking information about why I had "needed" a caesarean that I learned of the high number of posterior babies leading to unnecessary caesarean sections. It was then that I decided to become a birth doula and support women in avoiding unnecessary interventions and caesarean sections. This lead to teaching women in classes about this vital information as well, and I have counselled many women all over the globe about the importanceof Optimal Foetal Positioning.

I have used the book 'Understandingand Teaching Optimal Foetal Positioning' since shortly after it was published, yet given its target audience of birth professionals, many of my clients found it difficult to understand. I am excited to be a part of the launching of 'Sit Up and Take Notice! Positioning Yoursel for a Better Birth' as it is easier to understand and more comprehensive than 'OFP', as I fondly refer to Pauline Scott's first book.

Every pregnant woman, every childbirth educator and every birth professional must read this book. With the skyrocketing caesarean section rate, over half of which are unnecessary, this knowledge should be a vital component of every prenatal education class and every birth professional's repertoire.

Countless overdue pregnancies, painful back labours, prolonged first and second stages, and unnecessary interventions can easily be avoided

if positioning is both understood and managed proactively prior to and during labour.

I have seen first-hand the benefits of the information contained within the covers of this book. My many clients, friends, and fellow birth professionals who have benefited from the knowledge of avoiding and correcting posterior presentationswill be the first to herald the publishing of this vital information. Bravo Pauline for all of your hard work in writing this easy-to-understand and well-written book.

Enjoy and learn from the pages ahead of you. Practise the techniques; learn about your baby's position, and Happy Birth Day.

Connie Banack, CCCE CLD CPD
Alberta, Canada

ABOUT THIS BOOK

This book is about informationyou may never hear about anywhere else!

The way an un-born baby is lying in a woman's pelvis towards the end of pregnancy or during labour appears to be of little significance to most childbirth health professionals. As long as the baby is head down during labour, many midwives and doctors are not unduly perturbed.

But how wrong this can be!

A baby's position can have a major influence on the kind of labour a woman experiences and the way her baby is born. Encouraging a baby to lie in the most effective position for his journey through his mother's pelvis increases the chances of a spontaneous and straightforward child-birth, something that every woman hopes and prays for. And what's more, unborn babies instinctively want to move into the most effective position for birth too!

So how did this valuable information come into the domain of a mere mother and childbirth educator?

Over ten year ago I met an amazing midwife, Jean Sutton, who con-vinced me that babies were not being born the way they used to be, or were meant to be, and that the main reason for this was our modern day lifestyle.

Too many babies, Jean believes, are "encouraged" to lie in the woman's pelvis in the posterior position - head down but the other way around - during pregnancy because of maternal posture. What this means is that the modern pregnant woman tends to use postures in her every day life that do not assist in aligning her baby into the most effective position for labour and birth. Women at work are often sitting at a desk on a chair not correctly designed for good posture. Their legs are often crossed to give balance. And that's only at work. What about at home? That's when the pregnant couch potato comes into her own! Semireclining or slouching on

the sofa or armchair, or resting with feet up is a something a heavily pregnant woman looks forward to. Unfortunately, regularly sitting or resting like this may persuade the un-born baby to position himself in the back or posterior part of a woman's pelvis.

So this book is all about helping yourself to some good oldfashioned know-how and using postures that will help align your baby into the front or anterior position of your pelvis so that when labour begins, you are giving yourself and your baby the best possible chance of having a spontaneous and straightforward birth.

Of course, nothing in life is guaranteed, let alone giving birth, but having your baby in the optimum position for labour means you are off to agood head start!

And there's sound reason for this.

The rate of medicalised childbirth (caesarean sections, forceps or ventouse deliveries) has been unacceptably high for many years. If this simple (funny how the best ideas are often the simplest ones!) non-invasive method of appropriate maternal postures and exercises can encourage an unborn baby to move into a position where his head can move through his mother's pelvis without restriction, then it is possible that a more natural, less medicalised birth can be achieved.

A few years ago Jean and I co-wrote a text handbook for childbirth health professionals titled 'Understanding and Teaching Optimal Foetal Positioning'*. Now in its second edition, I thought it was high time pregnant women, their partners and support people were able to read the same information but in a version less couched in midwifery terminology.

In trying to make this book more user friendly I have endeavoured to write it in away that you, the reader, is able to imagine how your body and your baby work together from late pregnancy to the birth itself. You and your baby are designed to inter-relate. It is a fact that is often excluded from antenatal care, classes and books. Sometimes it feels as if you, the mother-

to-be, is quite separate from this baby of yours. That you alone will be doing all the hard work during labour and that your baby has no part in the proceedings at all! It is no wonder the baby is often viewed as the passive passenger waiting to be born.

This could not be further from the truth.

The subtle twisting and turning a baby has to make to manoeuvre himself into the most effective position for labour is often not clearly understood. Of course, all the twisting and turning in the world won't make a tad of difference if there is not enough space provided for him in the first place. And this is where you come into the picture. Knowing how to make room available in your pelvis for your precious cargo is the key to all of this.

And in essence this is what this book is all about.

Your reasons for reading this book could be varied. It might be because you are pregnant with your first child and you wish to be as well informed as possible. Or, it might be because you want to try to avoid a repeat caesarean section or other medical intervention that occurred during a previous birth.

If the information in this book makes sense to you, share it with those involved in your care so that they can support and encourage you. As additional reading for your midwife or other childbirth health professional, the text handbook 'OptimalFoetalPositioning'is available in most countries worldwideand it hasalsobeentranslated into Italian and German.

Whatever the reasons for choosing to read my book, I hope ***'Sit Up and Take Notice! Positioning Yourself for a Better Birth'*** makes a difference to your birth experience.

Pauline Scott

* 'Understanding & Teaching Optimal Foetal Positioning' published by Birth Concepts 1995 (first edition) and 1996 (second edition).

PART ONE:

SIT UP AND TAKE NOTICE!

1.
IMPORTANT DECISIONS FIRST

Your awareness of where baby is lying in your pelvis and the most effective path for him to take can make all the difference to the experience oflabour and birth -for both of you. Undoubtedly, his journey from entering to exiting your pelvis is an engineering achievement, but one that can be easily understood if you have the proper information.

As I have mentioned, the main purpose of this book is to look at ways to encourage an unborn baby to settle into the most effective position for labour so that you optimise your chances of a straigh tforward and normal birth.

It is important to recognise that other factors can influence the birth process as well.

Having a baby is a mind-body process - where the physical andpsychologicalenergiesworktogether.

Indigenous communities throughout the world can teach us much about traditional models of health care. In New Zealand the Maori have their own holistic model where the four cornerstones of Maori health are whanau (family health), tinana (physical health), hinegaro (mental health) and wairua (spiritual health). All four aspects are vital for the wellbeing of Maori society. *

So it is with childbirth.

There are many factors that can affect the way you give birth. Your beliefs, the beliefs of people who are supporting and caring for you (family and professional), your physical health, the environment you live in, your lifestyle choices, your past birthing experiences, how you value yourself as a person -to name a few.

However, it can be difficult to know exactly what you want - especially if you are a first-time mum.

The answer? Become informed!

Talk to friends, new mothers; phone for information and written material from midwifery clinics, hospitals and birth centres. Visit them. Find out about prenatal classes and who runs them. Local childbirth educators, birth doulas (trained labour support people) or parenting organisations can be a great source ofinformation as you explore what is available in your area.

Read books, surf the net - do anything that gives you a variety of information concerning the choices available to you and the questions you should ask. Don't make any decisions until you find someone (midwife or doctor) with whom you feel comfortable.

The same goes for where you want to have your baby. Don't make that important decision until you find the appropriate place -be it a hospital, birth centre or your own home.

In the end, the choice should be what feels right for you. If you change your mind during pregnancy about certain issues, it is your right to make other arrangements to meet your needs. Never feel that you have been coerced into going ahead with a decision you are not comfortable with.

Well known international birth advocate and writer, Doris Haire, writes in her latest book *'Getting What You Want for Your Childbirth Experience*':

'A good childbirth experience should be happy and gratifying, as well as safe. You are much more likely to have a good experience if you establish early a good communication with your doctor or midwife. Sometimes it is the expectant parents who must take the lead in establishing a rapport, but don't let that hold you back. It's your childbirth experience. It's up to you to let the doctor or midwife know what you want. If he or she is not in agreement with your wishes, it is far better to find that out while you still have time to shop around for a doctor or midwife who does agree with you. "#

Key Points

Childbirth is a mind-body experience, embracing physical, mental, emotional and spiritual elements.

Many factors influence how wegive birth.

Try to avoid feeling coerced into making decisions that make you feel uncomfortable about the impending birth of your child.

Choose professional caregivers who are in tune with your needs. The same goes for where you give birth.'

So ..... let's assume you have made your choices and now want more precise information about how you can help yourself have a positive birth experience.

* Maori -indigenous people of New Zealand (Aotearoa). The Maori health model, including traditional healing, is in the process of being incorporated into the New Zealand public health system.

Doris Haire; Chair, Maternal & Child Health Committee National Women's Network, New York and author of several books including 'Cultural Warping of Childbirth'.

2.
WHAT POSITION IS YOUR BABY IN?

During the last few weeks of your pregnancy, your midwife or doctor will want to know what position your baby is lying in. Nestled in your uterus he is likely to be lying head down in the lower part and bottom up and legs folded in the more roomy upper part.

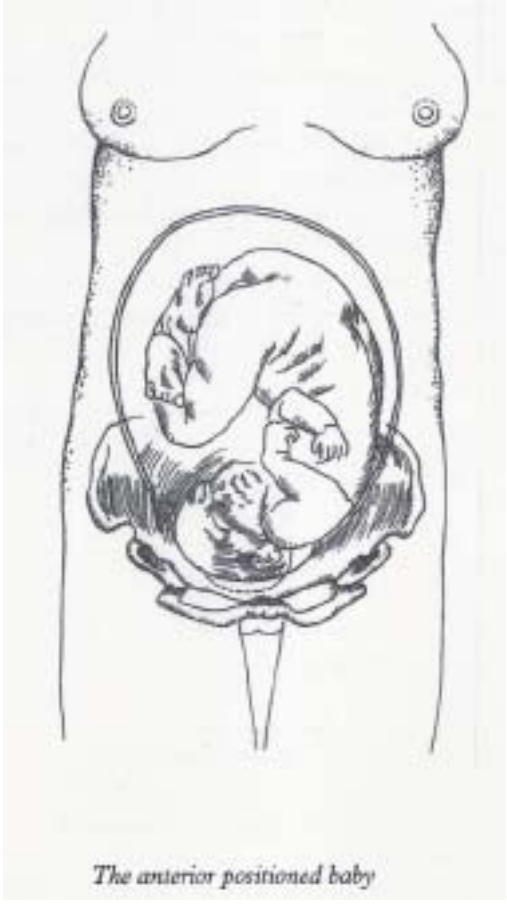
However, although head down, he may be lying in various positions. These are the two most common:

The anterior position

Your baby's back will be facing towards your front (in midwifery terms this is known as the occipito anterior position. This is the most common position and the most effective one for his journey through your pelvis. This angle follows the line ofleast resistance.

The term optimal foetal positioning, or OFp, is often used to explain the anterior position. The occipito anterior position is usually abbreviated to OA in your pregnancy records,prefacedwith the letters Lor R-(meaningeitheron yourleftor right side).

For instance, LOA means that your baby is lying on your left side in the occipito anterior position. Most babies prefer lying on the left.



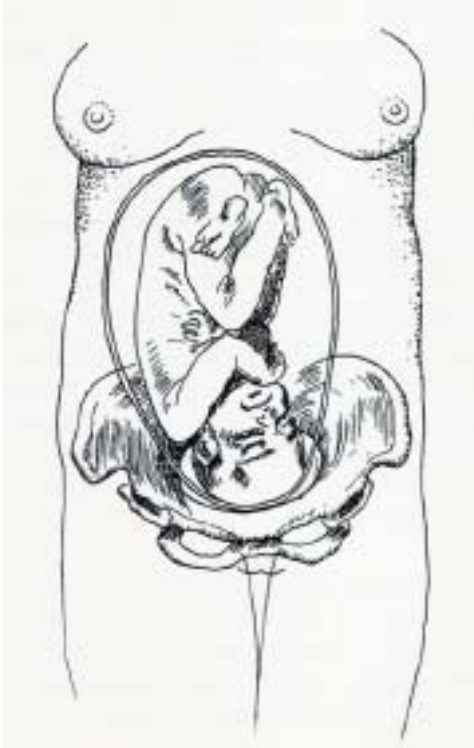
The anterior positioned baby

The posterior position

In the posterior position, your baby's back will be facing towards your spine (in midwifery terms this is known as the occipito posterior position or OP). As with the anterior position, the letters OP are often prefaced with the letters L or R, depending which side your baby is lying. For "posterior" babies, the right side (ROP) is the most common. In this position your baby may meet with some resistance because of the angle he has begun in. His journey through your pelvis may be slower than the "anterior" baby.

This is because he has to turn his head 1800to find the same angle that the "anterior" baby has taken (the 'anterior' baby only has to rotate 900 or less). If you have enough room in your pelvis he may pass through without needing to rotate.

When this happens he will be born face or "sunny side" up.



The posterior positioned baby

However, your baby may decide to lie in between the anterior (OA) or posterior (OP) positions. This is called lying in the lateral position. This is wherehis backis facing towards your side. In midwifery terms it is called the occipitolateralpositionand isnormallyabbreviatedto 0 L.

From this side position he will usually turn to your front into the OAposition (LOL LOA). This may occur prior to labour beginning or as labour starts.

Occasionally, he will turn to the posterior position as described previously. This appears to occur more when he is lying on your right side (ROA).

Both the anterior and the lateral positions (but only if your baby is lying on your left side) offer the line of least resistance. If this is your first baby, it is likely that he has settled into one of these positions some weeks prior to labour beginning.

Bottom First Babies

At just over half way through your pregnancy your baby will be lying in either a head or bottom down position.

However, by the end of your pregnancy (40 weeks) the majority of babies by far are lying head down.

A few (3% - 4%) will remain with the bottom presenting first. This is called a **breech** position. They are likely to remain in that position for birth.

There are many self-help measures you can undertake to encourage your breech baby to turn towards the end of your pregnancy. Ask your midwife for her recommendations.

A wonderful book written by Maggie Banks, an experienced and inspiring New Zealand midwife, is essential reading for anyone wanting to know more about babies who present bottom first. This book is called *'Breech Birth WOman-Wise'*.To order this book turn to page 185.

If all attempts to encourage your baby to turn into a head down position during late pregnancy have been unsuccessful, it may be because it is your baby's intention to remain in a breech presentation. This quote from Maggie Bank's book sums up one woman's decision.

"Sally's baby was palpated as breech from 31 weeks...

*I gave her information on the options for encouraging a breech to turn. It had no effect and her attitude was 'My baby is breech, so what?' ... She did not see her baby's presentation as a problem and for me to pursue it would have created one. So Sally and I decided that she was back to having a baby rather than having a breech." **

A breech baby

Key points

- Most babies lie head down prior to labour beginning.

- Babies lie head down in different positions such as:
  - anterior (OA)
  - posterior (OP)
  - lateral (OL)

- Anterior positioned babies or lateral positioned babies (especially those on your left side) are more likely to find the most optimal foetal position (OFP) for the journey oflabour.

- Some babies lie bottom first (breech).

* Quote from *"Breech Birth Woman Wise"*. Sincere thanks to Maggie Banks for helping with this section on breech presentations.

To help you imagine

how your uterus contracts

how your pelvis works

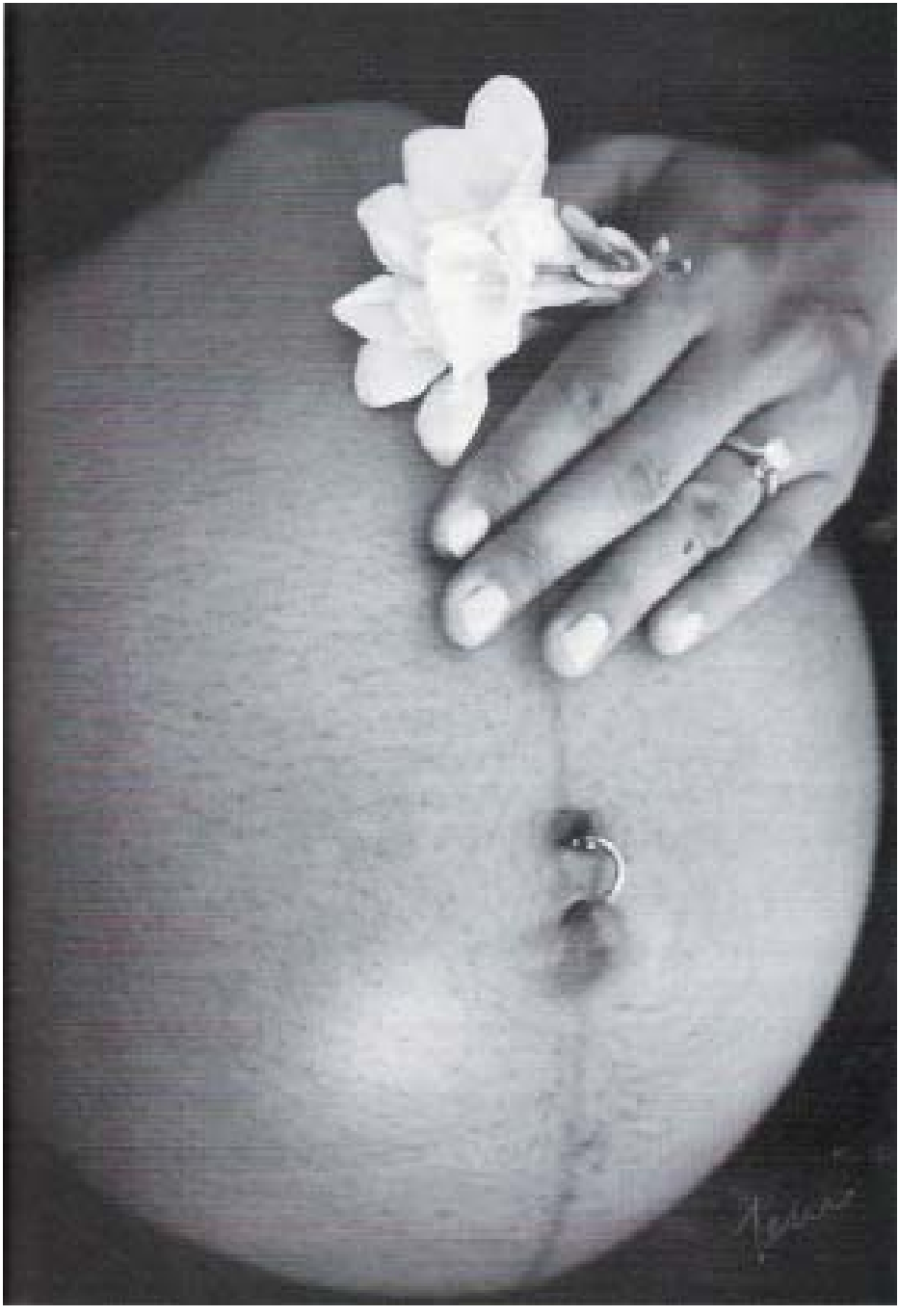
how your cervix opens

how your vagina and pelvic floor muscles fan out

AND HOW YOUR BABY ADAPTS TO EACH PART

.... the next four chapters look individually at hmv each of these parts work together with your baby.

They do this in a miraculous but simple way.



3.
YOUR AMAZING UTERUS!

First, we will begin with one of the most amazing organs in the human body -one that belongs only to women - the uterus! Often called the womb, the uterus is not just a safe and comfortable home for your baby to live in for nine months. When it is time for him to leave, the uterus works in a way that is unique to any other muscle in the human body.

In the non-pregnant state, your uterus is a small, hollow muscular organ about the size of a hen egg, but looking more like an upside down fig or small pear.

When you becomepregnant, your baby grows inside your uterus.The bigger your baby becomes, the more your uterus stretches to accommodate him.

The uterus is divided into two parts: the uterine body and the cervix.

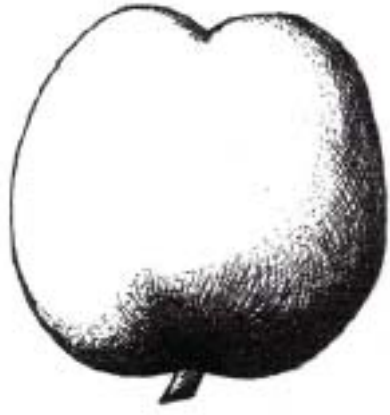
The upper uterine body is the round part of the "pear" (see diagram on page 43). The lower uterine body is the narrow part of the "pear". By looking at the diagram you will see that the upper part has more space than the lower part. This enables your baby to move around much more in the top

half than the lower half. This is ..oK during most of your pregnancy because your baby is relatively small. However, from about 34 weeks of pregnancy onwards, your baby is growing to such a size that he is beginning to fill up your uterus and can no longer flip about as easily as before. At this stage it is important that the position he is trying to settle in, is the most effective one for labour.

If you are expecting your second or subsequent baby, your uterus is more round or apple shaped because your abdominal muscles are softer. Your uterus has already stretched from a previous pregnancy (or pregnancies).

Therefore, because there is more room in the apple-shaped uterus, your baby may move from anterior to posterior and vice versa more readily.

If you are a first-time mum your uterus is shaped like an upside down pear.



If this is your second or subsequent baby your uterus is shaped more like an upside down apple.

Once labour begins the contractions usually help guide the baby into the anterior position. This is more likely to happen if you are using upright and forward leaning postures.

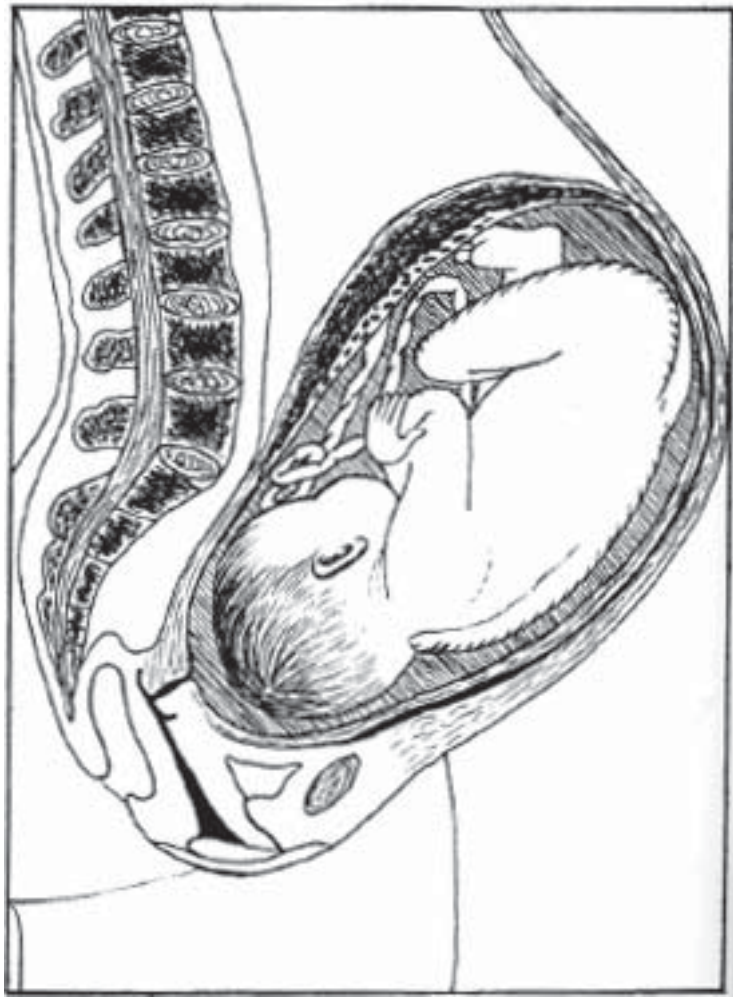
The cervix is the neck of the uterus (imagine the stalk position of a pear or apple). This reaches into the top of your vagina. It is the cervix that opens up during first stage labour to allow your baby to move into the vagina. When this happens, your vagina becomes a canal. It probably explains why the vagina is often referred to as a birth canal.

During pregnancy, your uterus increases in weight some 20 times -from about 40grams at the beginning of pregnancy to 1000grams or lkg at the end. At about 16 weeks, the uterus begins to rise out of your pelvis and you will start to look noticeably pregnant. At the same time, the upper part of your uterus changes in shape to become more oval and with a slight tilt to the right.

By 36 weeks the top of your uterus is level with your breastbone. During the next few weeks (36-40 weeks) it usually "drops" a little as your baby moves into your pelvis in readiness for labour. This happens when your baby "engages" into your pelvis. It is usually a good sign that your baby has settled into the most effective position for labour.

With a second or subsequent pregnancy your baby may not engage until labour commences.

Apart from being a wonderful home for your unborn baby, your uterus also contains a network of muscle fibres that increase in size as your pregnancy develops. From midpregnancy onwards, these muscles stretch and thin out.



At the end of pregnancy

Although you may not be aware, your uterus is contracting and relaxing throughout your pregnancy as it practises for the big event of childbirth. These contractions are called 'Braxton Hicks*, or prodomal, contractions and are felt at the top of your uterus as a strong tightening from time to time.

During the last few weeks of pregnancy, these practice contractions may "hot up". They also tend to occur in sets, stopping and starting over a period of time. This tends to occur around 10 o'clock at night, just when you are ready for some much needed sleep!

If your baby is lying with his back to your left sne, these practice contractionsencourageyour baby to movefurther into yourpelvicinlet.

If your baby is lying in the posterior position, you may experience these contractions on and off for many days or weeks. At times, you may think that you are goi~ into labour. Contractions may become very uncomfortable and last for some time. This is because your baby is trying to move across your tummy to get into the anterior position.

In doing so, his movements trigger your uterine muscles to contract. Take advantage of your baby's movements by adopting forward leaning postures to encourage him to align in an effectiveposition for labour and birth.

Midwives in the past often used to call Braxton Hicks or prodomal contractions "entering pains". This simply means they are the type of contractions a woman often experiences as her unborn baby begins to enter or engage into the pelvic inlet.

The Big Event begins!

Childbirth is roughly divided into three stages or phases.

During each stage of labour, the muscles of your uterus either work in different ways or have a different job to do.

The most obvious difference is between the first and second stage of labour, although the change over between the two can become quite blurred for a time.

The mainfunctions of the muscles:

Open up the cervix during the first stage of labour. The upper uterine muscles do this job.

Apply a downward pressure to encourage baby to move hrough the vaginal birth canal during the second stage of labour. At this point. the lower uterine muscles come into action. The muscle fibres of the lower segment also help shape the baby's head.

Expel the placenta during the third stage of labour.

** so called Braxton Hicks contractions after the doctor who "discovered" them!*

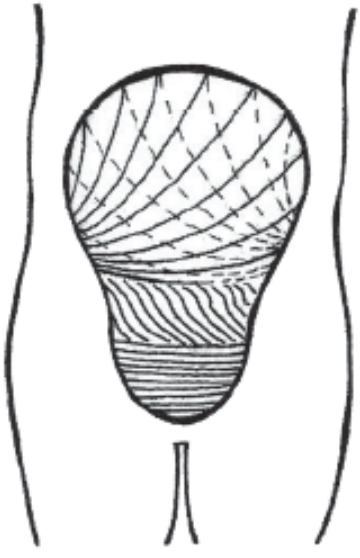
The First Stage

When labour begins properly, the muscles tighten. It is this tightening which is called a labour contraction. These ~ontractions are felt low down in your abdomen as a cramping feeling. They are different from the practice contractions described earlier.

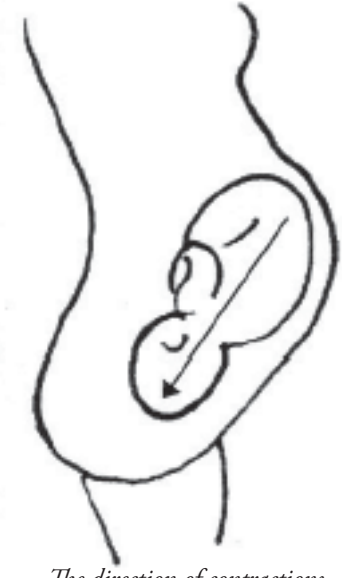
True labour contractions cause your uterus to lift forward, changing the contour of your tummy to an oblong or shoebox shape. Your pregnant tummy now appears flat on top, while the sides lose their roundness.

Your contractions work in a rhythmical manner; often quite slow at first, then gradually building up, becoming closer together and more powerful over time.

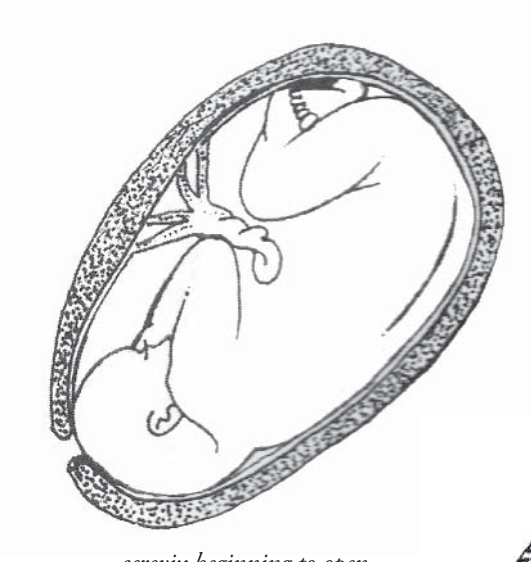
Pressure from the contractions descends at an angle down your baby's back, skimming over baby's tucked-in head to be directed on to your cervix.



The muscle fibres of your uterus.

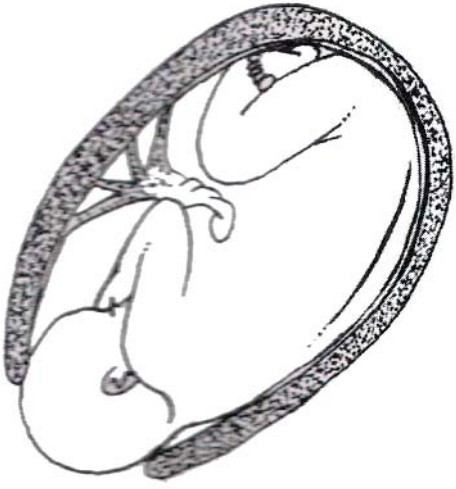


The direction of contractions



cerevix beginning to open

cerevix partially open



cerevix fully open

Little by little, the pressure from the contracting muscles thins and pulls your cervix up into your uterus. Other words used to describe your cervix thinning and opening up are “dilate” or “efface”. Incidentally, the cervix opens in an asymmetrical famion, not in a circle as often described in pregnancy books. It opens, pulling first from the back and then taking up the front of the cervix. In other words, during a contraction, the cervix begins to open from the back, behind your baby’s head, then stretching forward. That is why a contraction is first felt from the back as it sweeps towards your front. See the diagram on the next page.

If it is your first labour, the opening of the cervix may take anything from two to twelve hours. It can be much shorter for a second or subsequent labour.

At the same time, your baby’s head (especially if it is in the anterior position) is pressing on your cervix. The pressure from your baby’s head also helps your cervix to open or dilate.

If you use upright and forward-leaning postures, gravity assists your baby into an effective position for the rest of your labour. Good alignment means that there is even pressure from your baby’s head on to your cervix. If you lie down or sit in a semi-reclining posture, your cervix is not going to get the same pressure. This could make for a longer labour. And who needs that!

As your uterus continues to contract to open up your cervix, it goes without saying that this is a wild time!

Cervix opening from behind baby's head and stretches forward with each contraction.

Cervix opening as a circle (wrong).

Your body is in the throes of an awesome and powerful expenence.

Once the neck of your uterus (cervix) has opened to approximately IOcm, the first stage contractions begin to diminish.

There may be a "rest and be thankful" period, when the contractions finish completely and you can take a much earned breather. It is quite normal for your uterus to stop contracting before commencement of the second stage. You (or your support people) may need to remind your midwife or doctor that, during the process of normal labour, a rest period between the first and second stage is a common occurrence.

On the other hand, the tumultuous first stage contractions may give way to the strong surges of second-stage contractions and you may feel as if you just want to open up!

The second stage The muscles of your uterus now work in a different way.

They start to contract. However, after each muscle contraction, they stay in the position where the contraction ended - before starting again a few minutes later. This action, where the contraction ends and remains in contraction, is called a retraction. This is why your uterus becomes smaller as your baby descends through your vagina (birth canal) to be born.

Each muscle contraction encourages your baby's head to move through your vagina to be born. lf baby is in an optimal position during this stage of labour, your uterus does the job of getting this baby born virtually by itself! All you have to do is move into postures that encourage gravity to work for you rather than against you. (Effective postures for second stage labour are dealt with in more depth further on).

Soon, your vaginal entrance stretches to the pressure of your baby's head. This is called the "crowning" of baby's head.

When baby's head is born, he will turn it towards your thigh. There may be a rest for a minute or two before the next contraction. His shoulders then come out, followed by the rest of his body.

Your baby is welcomed into the world!

As you can see, your uterus is an amazing life-giving organ which cradles your baby for approximately 40 weeks, allowing him to leave -first by pulling up your cervix so that he can move into your vagina and secondly, by using a downward pressure so that baby descends through your vagina into the outside world.

Key points

- For a first pregnancy your uterus is shaped like an upside down pear.
- ~ For second or subsequent pregnancies your uterus is shaped like an upside down apple.
- ~ Your uterus is divided into the uterine body - a roomy upper part, a narrower lower area and the cervix (the neck of the uterus which reaches into your vagina).
- ~ Your uterus is made from muscle fibres with different functions for the three different stages of labour.
- ~ Practice contractions are felt on the top part of your uterus. These are not labour contractions. One of their main functions may be to help your baby to move into the optimum position for labour.
- ~ True labour contractions (or expansions!) lift up your uterus and change its shape to an oblong or shoebox shape. The contractions are felt low down in your uterus or abdomen.
- ~ Your cervix thins and opens during first stage labour.
- A "rest and be thankful" period between the first and second stage of labour is a normal occurrence (especially if this is your first labour).
- During second stage, the muscles of your uterus use a downward pressure to help birth baby.
- Progress through labour can be shortened by using postures that assist gravity (walking, standing, leaning forwards, kneeling, hands and knees, etc).

But. .. while tucked up in your uterus, your baby also has to pass through a narrow bony passage - known as the pelvis.

4.
ROCK THAT PELVIS!

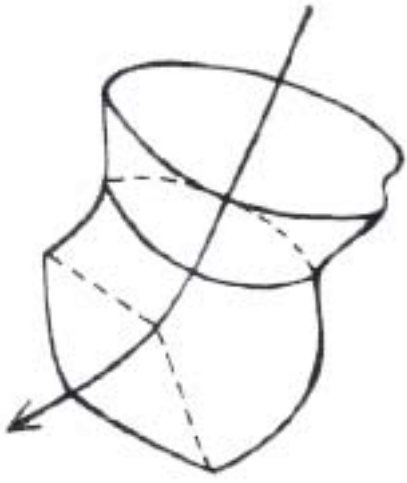
Your pelvis is designed to enclose the contents of your abdomen and provide an attachment for your legs. But, that's not all! As a woman, your pelvis is especially designed to be the base from where your uterus expands.

Contained within the uterus is your baby.

When the time comes for baby to be born he must enter your pelvis, pass through the bowl shaped centre, then manoeuvre himself out the other end.

You will have a better picture if you imagine your pelvis shaped roughly like a tunnel, with a heart-shaped inlet at the top, a hollow cavity or bowl in the middle and a diamond-shaped outlet at the other end.

The female pelvis



Imagine your pelvis shaped like a tunnel with a heart-shaped inlet, a bowl-shaped cavity in the middle and a diamond-shaped outlet.

The pelvis is made up of four main bones:

- sacrum -the lower spine area which makes up the back wall of your pelvis, including the tailbone (coccyx).
- hipbones - the sides of your pelvis.
- groin (pubic) bone -the lower front of your pelvis.
- sit (buttock) bones - these make up the lower bottom of your pel vis either side of your sacrum; often called the “tuberosities” by midwives and doctors.

Each of the bones is connected together by pelvic joints.

Because of this, your pelvis is able to move. This is very important when it comes to late pregnancy and labour, as it is possible to move your pelvis to create more space. This allows baby to turn his body so that he can align himself into the most optimum position (OFP) for labour and birth.

Another important point is that during pregnancy the pelvic joints are more flexible due to hormonal influences.

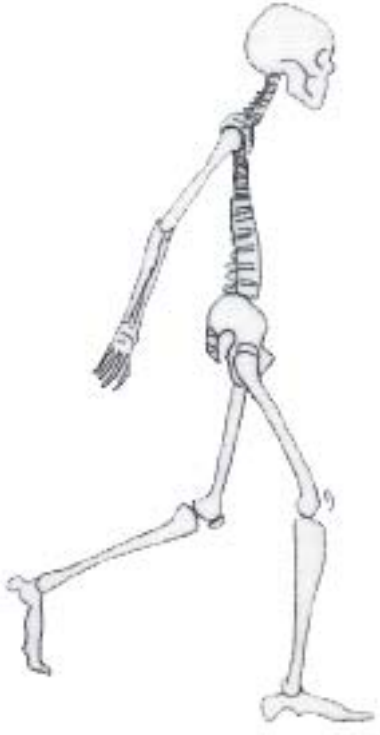
This is because of the increase of fluid in the joints at this time. Therefore, movement of the pelvis is much more effortless than in the non-pregnant state.

Imagine the ball above as your baby and the glass of water as your pelvis. Note that when the glass is tipped to one side or the other, more space is created. For instance, by movingyour lower body from a sitting position to a posture where you are standing with one leg up on a step - more room is available for baby to manoeuvre himself into and through your pelvis.

Thank you to Jean Sutton whose original idea this was. Many childbirth educators throughout the world now use the bottle and ball visual aid.

It is important to remember that your pelvis is tilted. If you look at the diagram of the spine and pelvis below, you will notice the tilt and how it appears to "hang" from the spine.

Your baby has to tuck his head onto his chest and bring his back forward to the front of your tummy to enter into the opening of your pelvis, the inlet.



Your pelvis tilts forwards and "hangs" down from your spine.

Your baby's head moves into the pelvic inlet during late pregnancy or early labour. The inlet is at its widest from side to side, and at its narrowest from front to back. To slip easily into the inlet, your baby's head has to enter with the widest part of his head presenting first. This explains why he enters with his head side on to begin with.

Once he passes through your pelvic inlet he turns until the back of his head is to the front of your tummy. At the same time, he brings his head towards your front. This rotation requires a 90 degree turn or less. His face is now towards your spine -lying under your sacrum, or back wall of your pelvis.

The diagrams on pages 64 and 65 show how your baby enters your pelvic inlet and how he turns his head to settle further into your pelvis.

The first stage

As the first stage of labour progresses, your baby's head inches further down into your pelvic cavity. In his way are two small obstacles that he has to squeeze his head past.

These small knobbly protrusions (known in midwifery terms as the ischial spines) are situated either side of the inside of the pelvic cavity, at the base of your pelvis. To pass these protrusions without getting stuck, your baby has to tuck his head further on to his chest to make the presenting part of his head as small as possible.

The second stage

Once your baby has accomplished this, he now comes through the outlet of your pelvis - the space between your pubic bone in the front of your body and your tailbone at the base of your spine. It is shaped roughly like a diamond.

The widest part is from front to back and the narrowest part is from side to side. If you use a forward leaning posture (examples are seen on page 106) you will be able to move your pelvis in such a way to create even more room in your lower spine area. What was once a diamond-shaped pelvic outlet now becomes more of a fan shape, allowing more room for baby to pass through into your vagina.

This area is known by an exotic name -the Rhombus of Michaelis.

The Rhombus of Michaelis can be seen as a kite-shaped bulge on the outside of your lower spine area during second stage labour. As the bulge lifts up with pressure from your baby's head, your sacrum and tailbone move outwards creating a further Zcm of space! This increases the outlet of your pelvis -a great advantage when birthing a baby!

As you can imagine, if you are moving about during labour using standing, forward leaning or kneeling positions, your baby has agood chance of passing through your pelvic outlet with ease. The second stage is then more comfortably accomplished.

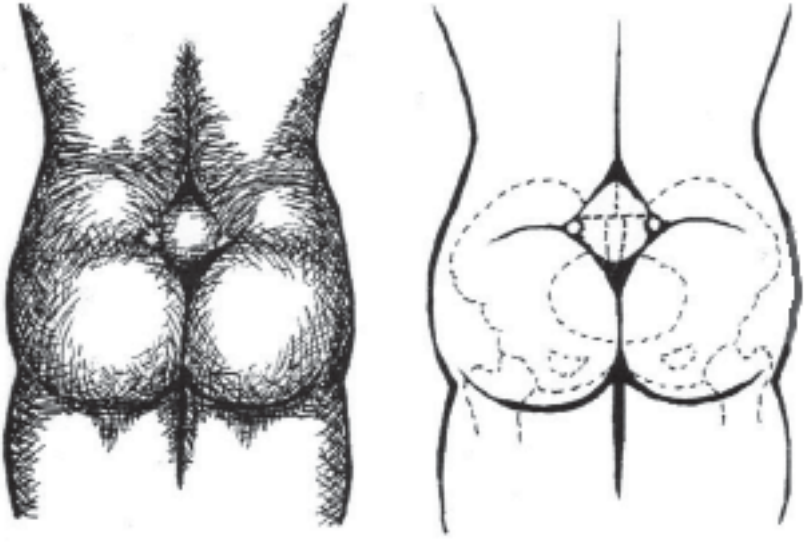
However, if you are lying on your back or sitting on your bottom, the Rhombus of Michaelis is not able to lift outwards effectively. This will prevent extra space being made available.

Your baby's head entering the pelvis

Yourbaby's head in the cavity of the pelvis

Your baby as he passes through the outlet of your pelvis.
Notice how your sacrum and tailbone (the Rhombus of Michaelis) lifts out of the way toallow baby's head to pass comfortably out of your pelvis.

Your baby's head enters the birth canal. He extends his neck and is gently expelled downwards by the second stage contractions to be born



The kite shape in the centre of the diagram shows the area known as the Rhombus of Michaelis. lOur support people will notice this area as a bulge during your second stage of labour.

Exploring your pelvis

Stand comfortably and we will start with your hipbones.

Press your fingers on to the ridges at the top of your hipbones, just below your waist on either side of your body.

Now walk your fingers around and down into the small of your back, where your hipbones join your spine.

What you can now feel with the palm of your hand is the sacrum, the bone that forms the base of the pelvis. The sacrum is very important. It can lift up about 2cm to allow baby more room to pass through your pelvis during the second stage of labour. The sacrum will only move out of the way successfully if you are in an upright or forward leaning posture, thus removing pressure on your lower back.

If you follow the sacrum down further with your fingers (you will probably have to lean forwards slightly while doing this) you will come to the tailbone (coccyx). This curves inwards; at which point it will disappear to your touch. The tailbone can also lift out of the way during the second stage of labour.

Now bring your hands back to your hipbones on each side of your body. Walk them areund to the front, tracing the ridge of your pelvis until it meets the pubic joint. This is quite deep down. You may feel pressure on your bladder as you find the pubic bone. Now feel the bottom of your pubic bone. It may pay to open your legs a little to find this bone.

The open area between this bone in the front and your tailbone at the back, is where your bladder, vagina and anus are located. It is between these two bones - the diamond shape of your pelvic outlet - that baby will be born through your vagina.

Key points

- Your pelvis is shaped like a tunnel with a hearts haped inlet, a hol low bowl-shaped cavity in the middle and a diamond-shaped out let.

- The pelvic bones -
  1. sacrum (induding the tailbone);
  2. hipbones;
  3. groin bone;
  4. sit bones;

  are held together by the pelvic joints.

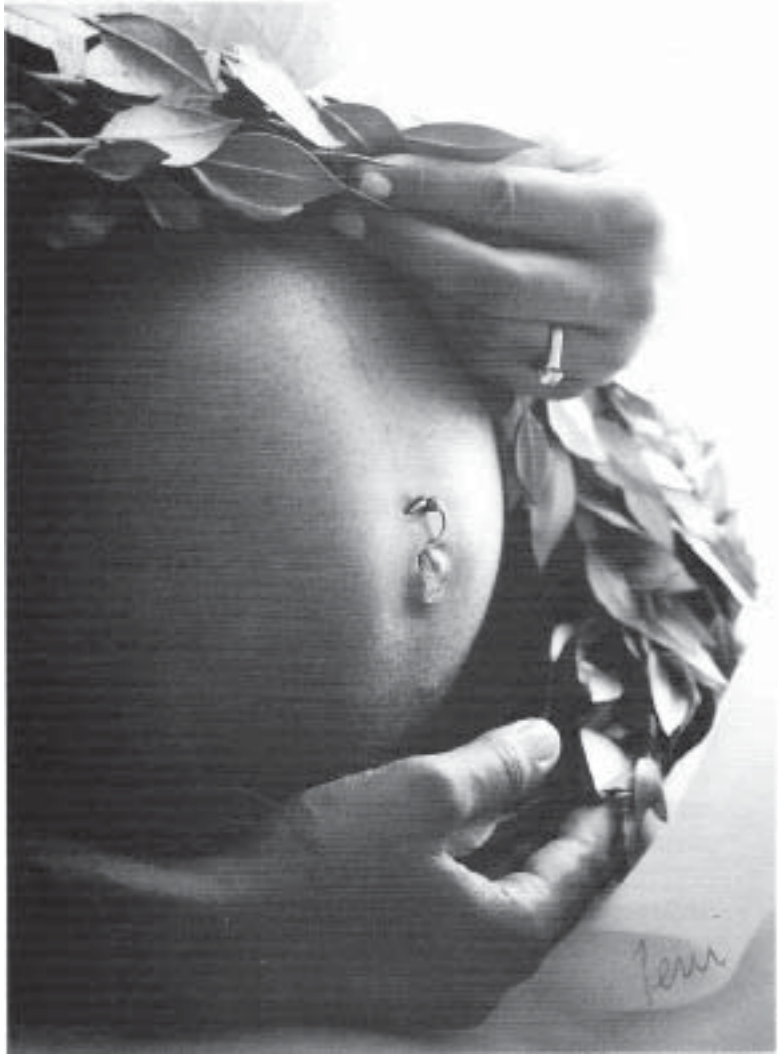
- Your baby enters the heart-shaped pelvic inlet with his head to the side.

- Once in the pelvic cavity, your baby turns his head so that his face is under your sacrum. The back of his head takes up the front of your pelvis. His back is very much towards the front of your tummy.

- To pass through the bowl-shaped cavity during the first stage of labour your baby has to squeeze himself between two knobbly protrusions either side of the inside of the cavity. He does this by tucking his head further on to his chest to minimise the size his head.

- During second stage labour the lower spine area known as the Rhombus of Michaelis is able to lift out of the way to give more room for your baby's head to untuck and extend as he is being born. The Rhombus of Michaelis lifts out effectively if your pelvis is not restricted; i.e. your body is positioned to allow freedom of movement by using upright or forward leaning postures.

Your pelvis is cleverly designed to accommodate baby's head in a particular angle, but it can adapt to other angles if enough room is given for turning.



5.
YOUR PERINEUM

The diamond shape between your pubic bone and your tailbone (described previously as the outlet of your pelvis) is also the site your perineum. Your bladder, vagina and anus are all located here, along with the muscles that join them and interweave at the base of your pelvis. These are called the pelvic floor muscles. For the purpose of birthing babies we only need to look at the vagina and the surrounding muscles.

Your vagina

Many women find it difficult to believe that a vagina can open wide enough to allow a baby to be born. This is not surprising. Normally, the largest thing a vagina accommodates is a man's penis - and that is a lot smaller than a baby's head!

However, the amazing thing about the vagina is its capacity to stretch to allow a baby's head to pass through, and then return to its original shape. The vagina comprises offolds of mucous membrane. When your baby's head begins to come down through your open cervix, the vaginal membrane unfolds and spreads apart. This 'unfolding' is assisted by the hormones associated with pregnancy and birth which ensure your vagina is stretchy and moist. After birth the pregnancy hormones decrease and your vagina returns to its normal size.

Your pelvic floor muscles

These muscles support everything inside your pelvic cavity, including your bladder, uterus and bowel. They also guard the entrances to your bladder, vagina and anus. Although they are called a "floor" of muscles they are, in fact, slanted at different angles and levels.

If you attend antenatal classes or pregnancy stretching classes, pelvic floor awareness and the role it plays during birth is usually discussed. Some childbirth health professionals believe that regular pelvic floor exercise will prevent the muscles becoming stretched and weak, thus leading to discomfort and incontinence when a woman laughs, coughs or sneezes. At worst, the uterus may prolapse.

However, many midwives and childbirth educators believe that, although pelvic awareness is commendable, weakness or damage to the pelvic floor and possible prolapse of the uterus or bladder is more likely to be a result of poor management during t4e second stage of labour.

Orchestrated pushing - where the woman in labour is urged to "push" by the midwife or doctor - may permanently damage the pelvic floor muscles and lead to problems of discomfort or incontinence.

This is more likely to happen if deliberate pushing continues for an hour or so, especially if the woman is in a semi-reclining posture or lying on her back with her legs held in stirrups (called the lithotomy position).

If you use upright postures (or lying on your side with your right leg held up in a position which feels 'open' to you), your baby can take the line ofleast resistance as he comes through your vagina. This will avoid putting heavy pressure on the pelvic floor muscles.

Upright and leaning forward postures also allow for your sacrum (situated near the base of your spine) to lift out during the second stage oflabour. This gives more room for your baby to descend without putting unnecessary pressure on your pelvic floor muscles.

Key points

- The area surrounding your diamond-shaped pelvic outlet is known as the perineum.
- Your vagina comprises of folds of mucous membrane, which have the ability to unfold and stretch to accommodate your baby's head during birth.
- If you are upright or in a leaning forward posture, your pelvic floor muscles are able to move out of the way as baby's head descend through your vagina.
- The possibility of a prolapse of the vagina later in life is reduced if your pelvic floor muscles are not subjected to undue pressure by deliberate pushing (usually due to a restricted posture such as sit ting, semi-reclining, lying down or in lithotomy).

6.
YOUR BABY'S ROLE

Imprinted in the genes of a baby is the knowledge of how to be born. He is not a passive passenger inside your uterus waiting to be born. He is a moving, twisting, turning baby who is very good at finding the easiest angle to exit from his, by now, cramped home.

So how does he do it?

By 36 to 40 weeks of pregnancy, there is not a lot of room in your uterus for him to flip about in, so he must move and turn deliberately to find the best way for his head to enter your pelvis. If he has his back towards your left side, he will begin to bring it further towards the front of your tummy.

As he tucks his head on to his chest to pass through the pelvic inlet, the soft bones of his head are able to lap over each other at the joins between the bones. These joins are called the fontanelles or soft spots between the unjoined sections of your baby's head. These bones overlap in order to reduce the head circumference, i.e. making the head smaller. This makes entry into and out of your pelvis a lot more straightforward for baby and for you.

Believe me! It is a tight fit for baby's head to squeeze through your pelvis. Before labour started his head circumference was about 35 -37cm; too large to get through your pelvis.

But, by tucking his head on to his chest and overlapping the bones at the fontanelles, his head circumference is reduced to 27.5 -30cm. This enables him to pass through relatively comfortably.

Babies are very smart when it comes to assisting the birth process. The smaller they can make their heads, the easier the passage of labour.

Your baby then slips into your pelvic inlet, turning his face towards your sacrum (the lower part of your spine and part of the pelvis). At the same

time that he slips his head into the inlet, the weight from his body brings his back to the front of your tummy.

Voila!Your baby is now in the directanterior position.

While all this is happening, you probably felt your uterus mildly contracting on and off, triggered by your baby's movements. You may even think that you might be going into labour. Remember, these practice contractions are felt at the top of your uterus, whereas true labour contractions are felt lower down.

If you are a first-time mum, engagement of baby into your pelvis may occur during the last few weeks of your pregnancy. You may notice that you seem to have a little more space under your ribs and breathing becomes a lot easier. This is because baby has 'dropped' or engaged into your pelvis.

If this is your second or subsequent baby, engagement into your pelvis may not happen until you go into labour.

Once engagement occurs, your baby's movements slow down because space is at a premium. Any movements you do feel are usually centred under your right rib (m:>vement from your baby's feet). You may also feel your baby's bottom "heaving" from time to time.

Your abdomen looks bulky and untidy and your tummy button protrudes - "pushed out" by your baby's back. His heartbeat is easily heard just below your tummy button and pressure from his head now sitting low down in your pelvis may feel very uncomfortab1.e. In fact, when you walk (or waddle!) it may feel as if he is going to burst forth at any moment. Your back may become quite swayed-normal for the pregnant state.

This description may sound unglamorous, but the good news is that your baby is in a wonderful position for his journey through your pelvis. If you think you look saggy and baggy, take heart. Things couldn't be better!

Although it is not known exactly what triggers labour, we do know that if a baby is engaged and aligned into the anterior position, there's a very good change labour will start spontaneously within two weeks either side of his mother's "estimated date of delivery "(EDD).

With even pressure applied to your cervix from baby's head, first-stage contractions usually progress well. The contractions themselves gradually increase in length and strength as the cervix thins and opens up.

Once the cervix has fully opened, your baby has to pass the two knobbly protrusions (the ischial spines) situated either side of the inside of your pelvis. Around this time, your firststage contractions begin to diminish. You may experience the "rest and be thankful" phase mentioned earlier, or you may go straight into the second stage oflabour.

Whatever occurs, your baby will soon be ready to pass through the outlet of your pelvis into your vagina (birth canal). At this point, he untucks (de-flexes) and extends his head. The ligaments connecting your sacral area near the bottom of your spine lift out in response, allowing more room for your baby's head and chin to pass through.

As described earlier, this part of your sacrum is the Rhombus of Michaelis.

If you are in a leaning forward posture (e.g. kneeling), an upright posture or a supported squat, the Rhombus of Michaeliswill be clearly seen by your birth attendants, as a kite-shaped bulge on your lower back. See the diagram on page ??.

As this phase occurs, you will feel compelled to go along with the second stage contractions. Once the opening of your vagina has been reached, your baby's head begins to crown.

At this point, it may feel very tight. Yourtissues are stretched to their utmost, as baby's head is about to emerge into the outside world. Some women say it feels like a burning or stinging sensation. Whatever the feeling, it is best not to hold back, despite feeling that precise thought! Saying

the words “let go” or “open up”, can help you visualise what you must do to let your baby be born.

If you are upright at this stage, you may find yourself wanting to move your pelvis forward. At the same time your hands may instinctively reach out to grab on to something higher than your waist. It may be a bed rail, or your partner’s or support person’s neck. Some hospitals and birth centres have ropes hanging from the ceiling or a rail situated slightly above at about arms’ length. This position is great for allowing baby to be born. Your pelvis is not restricted; there is no need to push and all your midwife has to do is catch your baby!

Once baby’s head is born, there is often a short interval before another pushing contraction is felt. It can feel strange, looking down or feeling with your hand, your baby’s head resting outside your body. His head is now turned towards your thigh. With the next contraction your baby’s shoulders (one shoulder first, then the other) followed by the rest of his body, are born.

A new little human being is welcomed into the world.

Your baby!

The journey of birth from the beginning of labour to the birth of your baby is a process that your baby is programmed to do. He wants to accomplish it in the most simple and effective way possible. This is more likely ifhe is in the most optimal anterior position to begin with.

As experienced New Zealand midwife Maggie Banks writes, *“The baby should not be viewed as necessarily passive in the birth process. Just as lying on her back immobilises the woman from assuming the positions her body dictates, so it also immobilises the baby preventing him from playing his part in the-birth. He is best able to manoeuvrehis body when his mother is in an upright position.”**

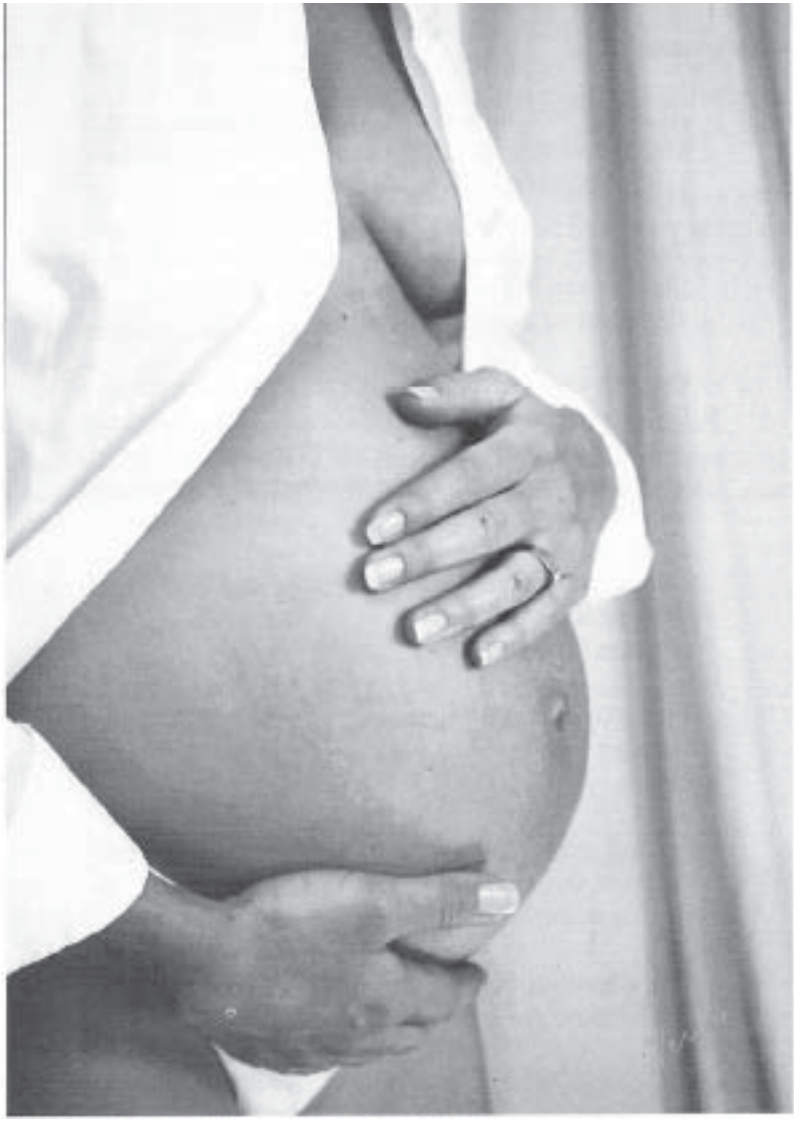
Having a straightforward and normal labour results in very little stress for your baby. The top of his head may appear a little “moulded”. This is more obvious if this is your first baby, due to the length of time his head has been firmly engaged in your pelvis. Bruising or swelling is at a minimum.

Because his entry into the world is unhampered by exhaustion, stress or drugs, your baby is ready to breastfeed immediately. The initial bonding between you and your newborn is off to a great start!

Key points

- At about 36 . 40 weeks of pregnancy, space in your uterus becomes limited so your baby moves his head into your pelvic inlet to be come engaged.
- Your baby's soft head bones lap over each other at the fontanelles to reduce the circumference. This allows for an easier passage.
- Once in your pelvic cavity, he turns to bring his face under your sacrum (lower back area). The weight of your baby's body auto matically brings the rest of his body (back and bottom) to the front of your tummy into the anterior position.
- You may feel very uncomfortableand bulky, but this signifies your baby is in the most effective positionfor labour.
- First-stage labour begins and your baby has to pass through the knobbly protrusions inside the pelvic cavity.
- Second stage labour is underway as your baby emerges out of your pelvis into your vagina, d~ flexing and extending his neck as he does so.
- The Rhombus of Michaelis lifts out of the way, giving more room for your baby to be born.

** 'BreechBirth Woman- Wise' by Maggie Banks. See page 185.*



7.
YOUR BABY'S POSITION

The time to ask your midwife or doctor more serious questions about the position of your baby is atabout 6 weeks before your "due" date. If this is your second or subsequent baby, about 3 weeks from you "due" date is ample. However, if you have experienced a previous caesarean because your labour did not progress as expected or because it was thought there was not enough room in your pelvis for your baby to pass through, it probably makes sense to be aware of your baby's position at least 6 weeks before your expected date of delivery.

Many caesareans are carried out because of "failure to progress" (FTD) or caphalo-pelvic disproportion (CPD).

Loosely interpreted, CPD means the doctor believes your pelvis is too small for your baby to pass through. If you were told that one of these two causes was the reason for your caesarean, it is possible that your baby was in the posterior position during labour.

Some midwives and doctors are not unduly worried about the position of a baby prior to labour starting, providing the head is down. However, there are many other childbirth health professionals who are convinced that being aware of a baby's position before labour begins gives you, the pregnant woman, time to encourage your baby to move into an effective position for birth. And this is accomplished much more easily if your baby is not engaged into your pelvis.

So what do you look for during those last weeks of pregnancy?

Possible indications of an anterior positioned baby (optimum position for labour and birth):

~ Do your baby's movements feel like a rolling sensation at the top of your tummy with some kicking near your right rib?
This indicates that his back is towards your front with his limbs tucked in, apart from a little foot kicking under your rib!

~ Does your tummy button stick out? This may be due to pressure from his bottom "pushing"it out.

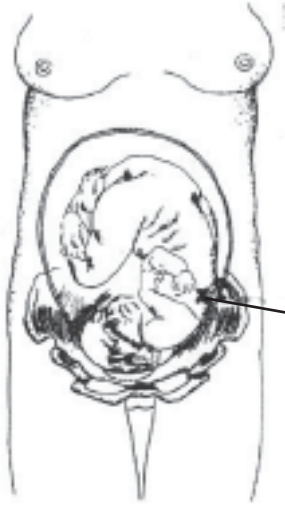
~ Is your "bump" low down? Is your tummy slung low and bulky? Do you feel rather "saggy" and "baggy"?
It sounds like your baby is engaged and his back is out front.
Just perfect!

~ Has your midwife or doctor told you that your baby's head is well tucked in?
Can she/he feel your baby's back towards your left front?
If so, it's likely that your baby is in the OA position.

~ Is your baby's heartbeat felt to the left of your midline?
Does the heart beat "jump out" at the midwife;
i.e. is it easily heard? Your baby is probably OA!

INDICATION OF YOUR BABY'S POSITION

Anterior positioned baby



Left side of woman's body

Baby's back towards front of tummy (between belly button and hip)

Baby's bottom is felt as a heavy moving sensation

Movements from baby's limbs felt here

Baby's heartbeat heard here

Head well tucked in

Possible indications of a posterior positioned baby

Do you feel as if your baby has too many hands and legs?
Is there a lot of movement down the middle of your tummy?
This may indicate that his limbs are towardsyour front.
Therefore, his backis lying against yourspine.

Does your midwife or doctor find it difficult to find the outline of your baby's back? It may appear that your baby's head has en gaged.

Is your tummy button area more concave (saucer- . shape), sug gesting that there is space between your baby's arms and legs?

Does your tummy appear high and flat on top? Does it look tidy and compact? This may indicate that your baby hasn't engaged into your pelvis yet. It may also indicate that your baby is more "posterior" than "anterior".

Do you feel as if you want to pass urine frequently?
This may be because your baby's brow is pressing on your bladder, indicating a posterior position. You or your midwife/doctor may think you have a urinary tract infection because of the constant pressure on your bladder.

Does your midwife or doctor find it difficult to detect your baby's heartbeat? When it is found, is it to the right side of your mid line? Are the tones muffled?*

** This may not always be a reliable method of assessing the position because sometimes the baby's heartbeat can be heard through the baby's chest. However, combined with the other indications, it may complete the "whole picture".*

INDICATION OF YOUR BABY'SPOSITION

Posterior positioned baby

Right side of woman's body

Baby's back towards spine (limbs towards front of tummy)

A lot of movement felt down middle of tummy

Baby's heartbeat heard here

Head upright (cannot tuck in while in this position)

SHAPE OF YOUR TUMMY TOWARDS THE END OF YOUR PREGNANCY

Anterior positioned baby

Belly button is pushed out (pressure from baby's bottom)

Low slung and bulky tummy (indicating baby has "engaged" into pelvis)

Posterior positioned baby

Belly button area is concave or saucer shaped (suggesting aspacewherethehaby's ~ limbs are positioned)

Tummy appears high and flat on top and it looks tidy and compact (indicating that the baby has not entered the pelvis, i.e. not "engaged")

Key points

When to inquire about the position of your baby:
(For a first pregnancy - 6 weeks prior to your estimated date of delivery (EDD).

For a secondor subsequent pregnancy -3 weeks prior to EDD.

For a second or subsequent pregnancy where the previous births have resulted in medical help (i.e. forceps or caesarean deliveries) -6 weeks prior to EDD.

Be observant and aware of your baby's movements. Look at the previous drawings and familiarise yourself with the indications of an anterior lying baby.

Explain to your midwife or doctor where movements are being felt.

Ask your midwife or doctor to show you, by touch, the position of your baby. An outline of your baby drawn on your tummy can assist you in understanding the position. If your baby is not in the optimal foetal position (OFP), perhaps your midwife could draw a mark or cross on your tummy where your baby's back can be encouraged to move to, i.e. your left side just below your hip.

PART TWO:

POSITIONING YOURSELF FOR A BETTER BIRTH

8.
THE OPTIMAL FOETAL POSITION (OFP)

What can you do to encourage your baby into the most effective position prior to labour starting?

The trick is to make sure your pelvis is leaning forward. It automatically comes frontward when your back is straightened. Remember that your pelvis naturally tilts forward from your spine. You can accentuate this posture by deliberately leaning toward the floor from your waist or by going down on your hands and knees. If your pelvis is in these postures it is much more difficult for your baby to roll backwards into a posterior position.

If your baby is already posterior or if your baby is lying on your right side (ROA), by keeping your back straight or leaning forwards, it will encourage him to roll over to your left side and line up in preparation for labour and birth.

Valerie El Halta (a skilled and experienced midwife from Michigan, USA) wrote a very interesting article in a Midwifery Today magazine titled *"PosteriorPresentation:A Pain in theBack!"** In it she says, and I quote;

'An ROA position is watched expectantly, as statistically, ROA is much more likely to become posterior than an LOA ".

So how is it that there appears to be more women with posterior positioned babies than ever before?

Since the 1960s changes in lifestyle have been dramatic.

From being somewhat physically active, we have become far more sedentary. Our leisure time is spent mainly sitting at the computer, watching TV, reading magazines and newspapers, etc.

One of the most important lifestyle chan~s has been the arrival of television. This has meant a change from straigh~ backed armchairs and sofas

(designed in the past for reading or doing needle work in) to furniture that is designed to relax in while watching TV.

Anyone who sits in a modern sofa or armchair will find that his or her pelvis tends to tip backwards. If you are pregnant, your baby tips backwards too. This is more significant if it is at a time when baby is about to enter your pelvis at the end of your pregnancy.

To balance your body while sitting backwards, you are likely to automatically cross your legs. This further decreases the amount of space in the front (or anterior part) of your pelvis, making it more difficult for your baby to enter. If you spend a lot of time resting in modern furniture during the latter part of your pregnancy (an easy habit to get into), it is probable that your baby will be forced into the posterior position. And it is possible that he will enter your pelvis in this position.

The same sequence of events may happen if you travel for lengthy periods in a car with a "bucket" seat. The tilting backwards of your pelvis encourages your baby to turn into the posterior position.

Another important factor in relation to lifestyle changes is the way women now work compared with women in the past.

In times gone by, pregnant women worked physically hard in the home, scrubbing floors on their hands and knees and doing other menial tasks around the house or farm. This usually entailed leaning forwards.

The importance of correct posture and good deportment was also encouraged. Young women learnt to sit upright, with their knees together, and to walk with their shoulders straigh t. All of these postures are ideal for correct alignment of the baby into its mother's pelvis.

Today,many pregnant women are in paid work right up to a few weeks before their due date. Some finish paid work as they go into labour -literally. Torest and relax during those last fewweeks of pregnancy, a woman is

often encouraged to lie down or sit with her feet up. Unfortunately, this is not the best posture to encourage effective positioning.

Perhaps this is one of the main reasons why the incidence of posterior labours is higher today than in our grandmother's day. The lack of emphasis on correct postures and a different working environment may have an effect on the way babies' position themselves for labour and birth.

Here are some suggestions to encourage your baby into the optimal foetal position (OFP) for labour and birth:

Incorporate into your daily life forward leaning postures: e.g. watch TV by kneeling on the floor leaning over a beanbag or cushions. Reading can be carried out the same way.

While sitting down, make sure your back is straight and your knees are below your hips: e.g. while sitting on a sofa or chair (especially at your place of work), place a cushion or pillow behind your back to straighten it.

When resting or sleeping, lie on your left side to encourage your baby to roll over. The "recovery" position is ideal. Add pillows be hind your back for support and place your right leg forwards over your left leg until your tummy almost touches the mattress. This ensures that your tummy is leaning forwards to create a "ham mock" for your baby. To add comfort, a small pillow between your thighs may be needed.

Car trips (especially long-distance trips) have the same effect on your pelvis as modern furniture.

Place a thin pillow under your bottom and lower back (or a rolled up towel) to help bring your pelvis forwards.

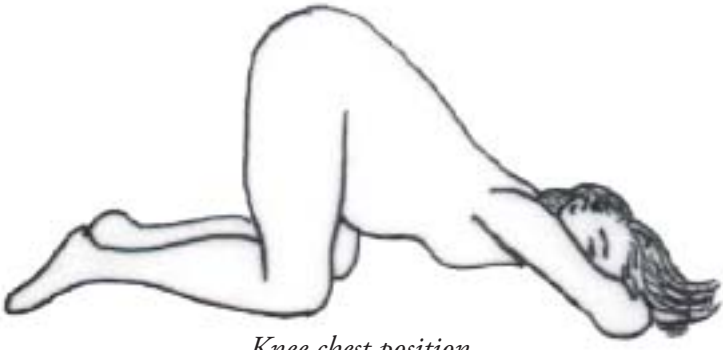
Exercises such as swimming (with your tummy forwards), walking, yoga (except deep squatting*) are great for pregnant women.

- Use a “birth ball’ to sit forward and rock your pelvis on. These are available through many pregnancy and childbirth organisations or businesses.

Tips to encourage persistent posterior positioned babies into the OFP position.

- Pelvic rocking three times daily in sets of20 minutes.
  Think Elvis Presley!
- Knee-chest position three times daily for 20 mmutes.
- Take warm baths. Gently massage and encourage your baby to “roll” over.
- Talk to your baby and visualize him in the position you want.
- Acupuncture, acupressure and/or homeopathies may be helpful. Seek out a registered natural therapist.

Wait until your baby is awake (when you can feel some movement) before starting pelvic rocking or adopting a knee chest position. An awake baby is more likely to be encouraged to move!



Knee chest position

Pelvic rocking

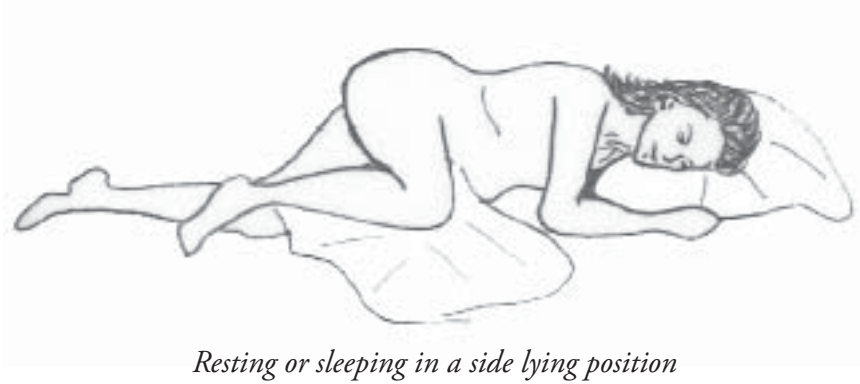
* A word on squatting as an exercise

Deep squatting can encourage your baby to enter (engage) into your pelvis. This is OK if your baby is in the anterior position. However, if he is posterior (or lying on your right side, particularly if this is your first baby) he may engage while in that position. And, as we already know, rotation of your baby's head once engaged can be a lot more difficult.

Deep squatting occurs when you round your back and your tummy comes forward. This type of squatting is observed in some countries where squatting to defecate is common.

If deep squatting is used during the second stage labour, your baby's shoulders may have trouble getting into your pelvis because of the space restriction at the inlet.

Squatting in a modified fashion is OK because your pelvis is not so restricted and is able to move more. If you want to practise squatting during late pregnancy, it is desirable if your feet are flat on the ground with your bottom at least 45cm above the floor. Your hip joints should be in front of your ankles and your back supported against a wall.



Resting or sleeping in a side lying position

Key points

- Leaning forward - rocking or swaying your pelvis and/or a hands and knees posture - are great for encouraging your baby to align effectively into your pelvis. A birth ball can be a very useful addi tion in encouraging alignment.

- Walking, swimming and yoga are excellent exercises for pregnant women.

- Rest or sleep on your left side with pillows for support.
  Avoid deep squatting.
  Above all, make sure your knees are lower than your hips!

** El Halta, V.1995: 'Posterior Labour: A Pain in the Back". Midwifery Today. Childbirth Education. Winter (36) 19-21.*

A story to share

On a personal note I am very grateful that I knew the significance of encouraging optimal foetal positioning. In 1992, at the age of 41 I gave birth to Sophie, my third daughter, after a 12-year gap.

During the last week of my pregnancy my midwife realised that my baby was in the posterior position. Because of my age and the large break in between having babies, I wanted to reduce the chances of complications. Also, I was planning a home birth, so it was even more important to me to avoid any problem that could lead to being transferred to hospital.

By being aware of my posture, I did everything I could to create more room in my pelvis, thereby encouraging Sophie to align well.

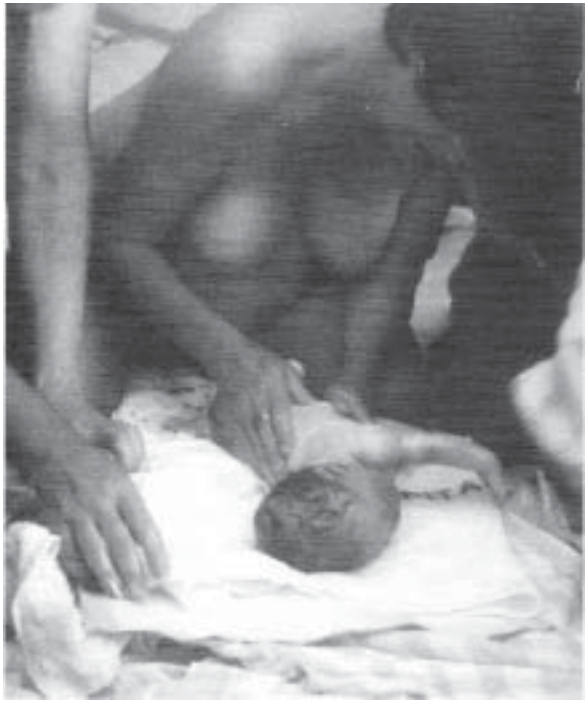
The result was that she turned to the anterior position.

Twenty-four hours later I went into labour -four days before my EDD.

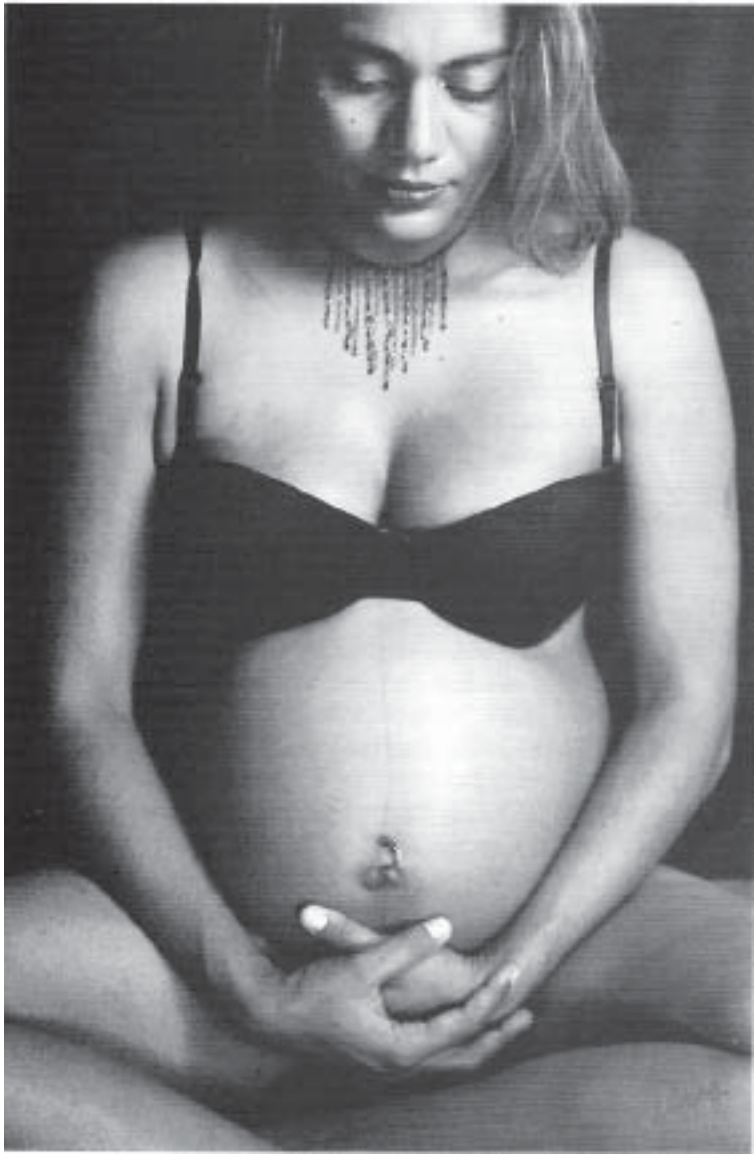
Sophie was born four and a half hours after my first contraction.

I believe one of the reasons I had such a straightforward birth was because Sophie had a head start from the beginning. She was already in OFP well before labour began.

What I discovered from this experience was that my baby was not a passive passenger inside me. On the contrary, by providing her with sufficient space, she was able to move and turn to make the right movements to correct her position.



Sophie Scott-Maunder moments after her home birth



9.
HELPFUL POSITIONS FOR LABOUR

It is widely accepted in midwifery circles that if a woman is mobile during the first and second stage, her labour is often shorter and more bearable than if she were lying on her back or in a semi-reclining position.

Unfortunately, many women experience most of their labour half lying and/or half sitting on a bed. Being confined to bed by order or because they thought that was what was expected of them, can make for more painful contractions and a slower labour. That's because these postures restrict your pelvis.

The funny thing about sitting like this (usually propped up by pillows) means that to avoid sliding down the bed you have to place the soles of your feet on the mattress. Because this is a difficult posture to maintain for any length of time, you end up sitting on your sacrum and tailbone. This curves the inside of your pelvis, thus reducing the available space needed for your baby's head.

To provide space in your pelvis, a kneeling posture would be better. By kneeling, you will be sitting on the edge of your pelvis where the knobbly protrusions (the ischial tuberosities) are positioned within. This cannot be achieved while sitting on a bed.

During the second stage of your labour you may be asked to lie back in a semi-reclining posture on the bed -round your back, place your chin on your chest, lift your knees so that you can hold your legs up with your hands -and then hold your breath, while pushing as hard as you can right through the length of a pushing contraction.

This is not a joke! More than twenty-four years ago I was instructed to do just this when having my first child. The practice is still widespread today.

Nothing could be more physiologically unsound during labour. As we already know, the female pdvis is restricted in a sitting posture. Pushing a baby's head uphill is hard work.

No wonder so many women, to a certain degree or other, notice a prolapse of their pelvic floors after they have had their babies. With all that pushing, something has to give way.

The same is true if you are asked to place one foot up against a midwife's hip while your partner or support person holds up the other foot. Another unsound physiological labouring position.

Avoid positions (as above) which close the pelvis

No wonder so many women with babies in the perfect anterior position end up having medical intervention (such as an episiotomy, forceps or ventouse) because they didn't have enough puff to get their babies born.

Unfortunately, well-meaning midwives and doctors encouraged them to be in postures that made this a very difficult task right from the beginning of the second stage.

If a labouring woman has freedom to walk, lean forwards, use a birth pool, go the toilet, have a shower, kneel, sit upright without sitting backwards on her sacrum -gravity can help her cervix to open up during first stage and her baby to descend during second stage.

If your baby is in a posterior position it is even more important to adopt upright, forward leaning and/or mobile positions.

If you use a supported kneeling or hands and knees posture from time to time during the first and second stage of labour, you will have a firm platform on which to balance your body. You will also be able to adjust your weight between your hips. This increases the internal transverse diameters of your pelvis. If you place more weight onto one hip, the knobbly protrusions (the ischial spines) within your pelvis will no longer be even. This action may help your baby to manoeuvre his head through your pelvis.

As second stage approaches, the supported kneeling posture allows your pelvis to move forwards, automatically raising your sacrum and tailbone (coccyx) higher than your pubic bone. The Rhombus of Michaelis lifts out of the way because your baby's neck is unflexing and stretching out as he moves through your birth canal.

In this upright kneeling postUre, your baby's head is likely to be born unaided. Pressure is rarely needed from the midwife's hands to help birth your baby's head and shoulders. When midwives say they "catch" babies, it is often when women use this upright kneeling position that most of the "catching" is done!

Marching

Yes! Strange as it may seem, but marching on the spot, stepping on to a pile of books (such as phone books), or walking up stairs sideways can help a baby move into a more effective position to get through his mother's pelvis. Again, the ischial spines either side of the pelvic "bowl" become uneven, allowing space for movement of baby's head. This is a trial and error exercise. If labour is not progressing as well as your midwife thinks it should be, experiment with these types of exercises. Youwill probably know which particular movement is right for you to help move baby's head. Sometimes this can happen with dramatic results! Baby can be born very quickly once the head has room to move.

Supported squatting

If you want to use a squatting posture for birthing, it is best accomplished in a modified supported squat. In this position your feet are flat on the ground with your bottom at least 45cm above the floor. Your hip joints are in front of your ankles and your back is supported either by your partner or labour support person. Squatting in this way allows you to throw your pelvis forwards as your baby's head extends, ready to be born.

Supported squatting

Side lying

Our mothers and grandmothers often birthed in a side lying position. This makes a lot of sense. The pelvis is not nearly as restricted when you lie on your side compared to when you lie or sit on your sacrum and tailbone in the half sitting/half lying position.

However, a word of caution. Side lying during the second stage oflabour with one foot held up by your partner, labour support person or another midwife, may inadvertently be at an angle which restricts the outlet of your pelvis. It is more effective to lift your leg to a position that feels open and right for you. This will most likely be parallel to your resting leg and not at an angle where your upper leg is held up and moved towards your hip.

Key points

- Changing positions and movements helps the progress of your la bour and may encourage your baby to move into a more effective position for birth.

- Upright, forward leaning positions such as kneeling or on your hands and knees helps during first and second stage labour. Modified squatting or side lying (especially if you need a rest) can help too.

- Marching on the spot, stepping on to a pile of books and/or side walking up stairs, can help "shift" a baby's head to move into a bet ter position for birthing.

And, most important of a11- avoid semi-reclining, i.e. half sitting/half lying on your sacrum/tailbone region. This "closes" your pelvis.

10.
HEAD DOWN BUT THE OTHER WAYAROUND!

Although babies in the posterior position are thought to account for 10%of all births, many midwivesnow believe that the incidenceof such labourshas climbedmuchhigher.

Certainly, having a baby head down but the other way around seemsto be morecommontodaythan everbefore.

Have a look at the photograph prior to this chapter. It is possible that the woman's baby is in the posterior position because of the indentation around her belly button. Other indicators are necessary to give a more precise diagnosis but the woman's tummy shape looks suspiciously like she is carrying a baby that is head down but the other way around.

It makes sense that if women are able to help themselves to a better birth by encouraging their babies to settle into the most effective position before labour begins, then it is possible that medical intervention can be avoided - or at least significantly reduced. As many women have testified, it can be very difficult to avoid a medical takeover when labour is slow and drawn out. The longer you are in labour, the higher the chance ofintervention.

It is a well-known fact that once one form of medical procedure is carried out; it inevitably leads to further procedures. This phenomenon is recorded in medical literature as the "cascade of intervention".

Before looking at the more medical side oflabour and birth in relation to posterior positioned babies, it is worth noting that there are some physical reasons why a baby may settle head down but the other wayaround. These are as follows:

Position of the placenta

If your placenta is positioned on the anterior (front) wall of your uterus, it is more likely that your baby will favour the posterior position. However,

as labour becomes imminent, the lower section of the uterus develops more and it is possible for the posterior baby to rotate to the anterior position at this time - especially if you are regularly using postures that encourage good alignment of your baby. The position of your placenta can be confirmed if you have had a scan.

Abdominal muscles

You may have tight abdominal muscles due to your body shape or because you exercise frequently. Tight abdominals produce an angle between your lumbar spine and your pelvic inlet that encourages your baby towards a more posterior position than if you have more relaxed abdominal muscles. Women who frequently exercise pull in their abdominal muscles. Ballet dancers, aerobic instructors, horse riders, athletes and those who partake in excessive exercising, are more at risk. Yoga during pregnancy can assist those women who have tight abdominal muscles.

Yoga encourages flexibility, relaxation and maintains fitness.

Posterior (backache) labour

As many women can testify, posterior labours can be a pain in the back - literally. This is because the back of baby's head presses on the woman's lower spine as labour progresses. This kind of labour is not called backache labour for nothing!

The slowness of the labour is to do with the fact that a baby in the posterior position has a lot more turning (rotating) to do than the "anterior" baby. In fact, he may have to turn his head 180^{o} to rotate from posterior to anterior.

It therefore makes common sense to encourage your baby to lie in the most effective position for his journey into and out of your pelvis. This doesn't mean that labour is going to be a breeze. It may still be hard labour but that is what normal labour is all about. Hard, tough, but bearable -

especially if you have loving, positive support and lots of natural pain relief methods to choose from.

This is not to say you can't get through a posterior labour with just as much wonderful support. However, if you are able to encourage good alignment of your baby before labour begins, your chances of a normal straightforward birth are looking positive.

If baby is lying towards your right rather than the left side of your body, encouraging him to rotate over to your left side, has its advantages.

A baby who settles on the right side tends to turn backwards (posterior) once labour begins. In this angle he may find it difficult to tuck his head onto his chest to enter the pelvic inlet. Interestingly, it is often a first baby that does this because of the pear-shaped uterus of a first-time mum.

Remember! The pear-shaped uterus is narrower at the bottom. There is not a lot of space for him to move or to tuck his head onto his chest.

To further confuse matters, the top part of your uterus tilts to the right, while the lower part has a slight twist to it. In midwifery language, the full-term uterus is described as having a "right obliquity of the upper segment and a dextrorotation of the lower segment".

What this actually means, is that the shape of your uterus doesn't make it easy for your baby to turn from right to left across the front of your tummy. He has to turn up and over to do so. From an engineering point of view, this is very difficult to accomplish - more so if you are resting frequently in a semi-reclining posture with your pelvis tilted backwards. Unfortunately, moving from right to left across the tummy is near impossible to achieve once labour has started. -

However, if this is your second or subsequent baby, this movement from right to left is usually managed more easily because your uterus is softer and more stretchy (remember the apple-shape uterus). There is more space.

If this is your first baby, it is very important to find out exactly what side your baby is lying on during the last six weeks of pregnancy. Encouraging him to move over to the left by regularly using effective postures makes sense when you understand that a baby's head prefers entering your pelvis from your left side, given the chance.

Unfortunately, many childbirth health professionals are not unduly concerned about the right-side lying position of a first-time mother's baby. Although the baby may seem to be in an ideal position, i.e. head down, the right-side lying baby is more likely to turn towards its mother's spine and settle into a true posterior position. More so if the mother favours resting postures such as lying or semi-reclining positions during those last few-weeks of her pregnancy. Easy to do when you are feeling heavy with child!

Over the page is an inspirational story by Rosie Denmark from Oxford, UK, who knew instinctively that her baby was in the posterior position during late pregnancy -and what she did about it.

POSTERIOR BABIES

Mothers can trust their instincts:

I first heard aboutthe posterior presentation of babies early in my pregnancy from Margie Polden's article "Getting into Position" (1).

The description of the shape of the abdomen in a posterior pregnancy came back to me as the months went by, as I noticed that my bump, quite small and compact and prominent to the right, and with palpable hand and feet kicks at the front, did not appear to be developing the forward round shape of the other pregnant women I knew.

Indeed, people were always remarking on how small and neat my bump looked, usually with admiration for retaining a slim figure.

I would almost say that I had an instinct that something was not quite right, above and beyond the usual and fairly constant pregnancy worries.

Around week 26 onwards I had thought that I could feel that my baby was in a breech position, normal at this stage of pregnancy as I could feel her kicks very low down in my abdomen. This was so uncomfortable that I slept for a few nights with my hips raised on a large cushion. I felt her turning during one night; and the next day my bladder no longer felt as if I had a foot pushed through it.

However, a few weeks later I became more and more suspicious that my baby was presenting in a posterior position. I tried to confirm this suspicion with my midwife. However, she didn't appear confident to diagnose my baby's position.

Rosie: So does the baby feel as if she's posterior?

Midwife: Well, her head's doum, so that's good.

Rosie: Yes, but is she posterior?

Midwife: Well lots of babies face outwards at this stage.

Nor was she happy to discuss exercises to change the baby's position if she was posterior.

Her opinion was that baby's stay in the position most comfortable to them and there's nothing you can do to change that. She told me that she would tell me my baby's position at 38/39 weeks.

I do not know whether this midwife was unsure of the position of my baby, or whether she simply would not tell me. As this was my first baby and I was booked for a home birth, I was alert for any problems which might indicate a need to transfer into hospital, a scenario repeatedly raised by my midwife. As I knew that posterior labours had a high rate of medical intervention, I decided to find out more. Having spent 10 years successfully using natural family planning, and being therefore quite used to knowing and respecting what was happening in my body, this deliberate ignorance seemed mindless to me.

At this point I tried the exercises outlined in the literature for turning posterior babies (1), but succeeded only in making myself very uncomfortable and bringing a lot of fear and negativity that I wouldn't be able to change my baby's position and therefore would have to have a hospital birth.

I vacillated between wondering if I was making a "fuss over nothing" (which the approach of my midwife seemed to imply); and panic that I was rapidly heading towards a hospitalised, managed labour. I found it far too hard to keep up all these exercises without support and was in a vacuum of selfdoubt, with my body telling me one thing and the midwife another.

So how did my body tell me something was wrong?

I did not feel "settled", and I felt as if my baby was uncomfortable. I felt an "edginess", physically, as her head began to engage, as if two bones were grinding together. I would wake up feeling uncomfortable with the strangest urges, one night wanting to sleep kneeling on the floor with one leg cocked up like a dog! I had a dream of lying sideways on the top of stairs and falling forwards,

with the forward rolling sensation being very peaceful and comfortable. I felt as if my body was "urging me on" - but to what, I didn't know. I noticed that when I was relaxed the baby would do deep churning movements as if she was turning right round. In summary, I had a strong urge to do something physical, but I was not sure what!

In my first two weeks of doing the exercises alone, I simply increased my feeling of pain and agitation. The forward leaning exercises (described below) caused the baby to move more, and the deep uncomfortable churning movements increased, often waking me up for long periods at nights. Along with my own lack of confidence in what I was trying to do, I simply found it too hard alone.

Around this time, I received my copy of "Understanding & Teaching Optimal Foetal Positioning" (2). The morning I read it I realised that my much wished for home birth was in jeopardy because if my baby was indeed posterior it raised a likely spectre of a managed labour, even a caesarean.

It frightened me sufficiently to change midwives. It was clear to me that I needed to have my baby's position properly diagnosed and have some help if possible in trying to change it; and so I eventually changed my booking to independent midwives.

Following their first visit, my suspicions were confirmed that my . baby was in fact posterior, and I was very relieved to get a proper diagnosis. My midwives were very understanding of my fears, but managed to convey a calm and confident attitude that it was perfectly possible for posterior babies to change. They gave me exercises to do, and I wrote out a list that I left in each room of the house of postures to aim for and avoid.

Three times a day, I would spend 20-30 minutes per day on hands and knees, or lying on my front. In the mornings this tended to be reading on my front propped up by cushions in bed, and at night on hands and knees in a warm bath.

I was very strict about never using backwards leaning postures, always sleeping on my side, never sitting back on the sofa (the hardest!), only sitting on a special

back chair that allows you to lean forward with your knees lower than your hips, or sitting forward leaning on a bean bag. I also had a large "birth ball" which I would sitforward and rock my pelvis on.

I am convinced that it is the birth ball that made the real difference for me. After 5 or 10 minutes of rocking on the ball I would feel the baby start churning movements, and if I then went into the kneelingforward positions I could almost feel her fall forwards.

The feeling of agitation that had previously been my instinct that something was wrong now' became more definite: the baby was trying to move and I could help her to do so!

It is worth making central to our understanding that babies themselvesseemto want to move into the right position. Research has begun to recognise that it is babies who instigate the birth process and it therefore seems highly likely that they are active in trying tofind the right position in which to do so.

I was still occasionally woken up at night feeling uncomfonable; now I went and rocked on my binh ball, and did the exercise my midwife gave me of walking up the stairs sideways, two at a time. I had a difficult weekend of pre-labour pains when the agitation peaked, and I awoke constantly with a feeling of bones grinding in my pelvis.

It was at this point, discouraged and worn out by pain, . that I eventually resolved to really work at it, thinking clearly that my baby had to turn at some point: it would be much less painful to do this before labour than during labour. This was a passage through which I had no choice, so weary as I was, I might as well get on with it.

In the last weeks of my pregnancy, my midwife suggested that I go to the swimming pool every day, floating forwards in the water for 20 minutes or so. fm sure the local swimmers thought I was mad; but the combination of relaxed muscle tone caused by being in a warm pool and the forward leaning posture seemed to do the trick as, at my last antenatal visit, direct anterior was diagnosed and I went into labour shonly afterwards.

The main reason I think the exercises worked on the second attempt is that skilled suppon enabled me to 'walk into' the discomfort (which I had anyway been experiencing but which the exercises made worse) and go beyond it. It became clear to me that this agitation was in fact the experience of the baby trying to move; fairly painful in itself, and therefore more painful as it is successful.

On my second auempt at trying to turn her, my baby's head had already begun to engage.

As I continued with my exercises she disengaged, re-engaging as direct anterior. My "forwards kneeling, never leaning back" regime was really hard work, and I was much encouraged by the support and positive attitude of my midwives.

Having experienced both pre-labour pains whilst my baby was turning, and an anterior labour, it is clear to me that contractions with a posterior baby are of a very different nature to usual first stage contractions, and are recognised as being particularly painful (3): the pain is more agitating and exhausting and somehow more "difficult to handle". I do not think I could have coped with a posterior labour at home.

Your baby's position is fundamentally about the relationship between your body and yourself, and your baby and you. Your body gives you clues as to the positioning of your baby, some of which you can begin to learn to interpret yourself, although you may need an experienced and skilled midwife to help. It is the sensations that you feel that guide you through your progress in the exercises. And getting your baby into an optimal position for labour is one of the most important aspects of your relationship with your baby asyou approach birth together.

At a time when medicalisation of labour can act all too often to reinforce our natural fear and apprehension as we approach labour, when a lack of confidence in our abilities to give birth is paramount, perhaps we should start by trying to get the basics right, starting with the position of our babies. And as with the rest of motherhood, it often takes a lot of hard work to get the fundamentals right.

Rosie Denmark

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(2) Sutton J and Scott P. 1996: "Understanding& Teaching Optimal Foetal Positioning". Birth Concepts.

(3) EI Halta, V. 1995: "PosteriorLabour:A Pain in the Back". Midwifery Today. Childbirth Education. Winter (36) 19-21. Extract from AIMSJournal, Summer 2000,Volume 12.

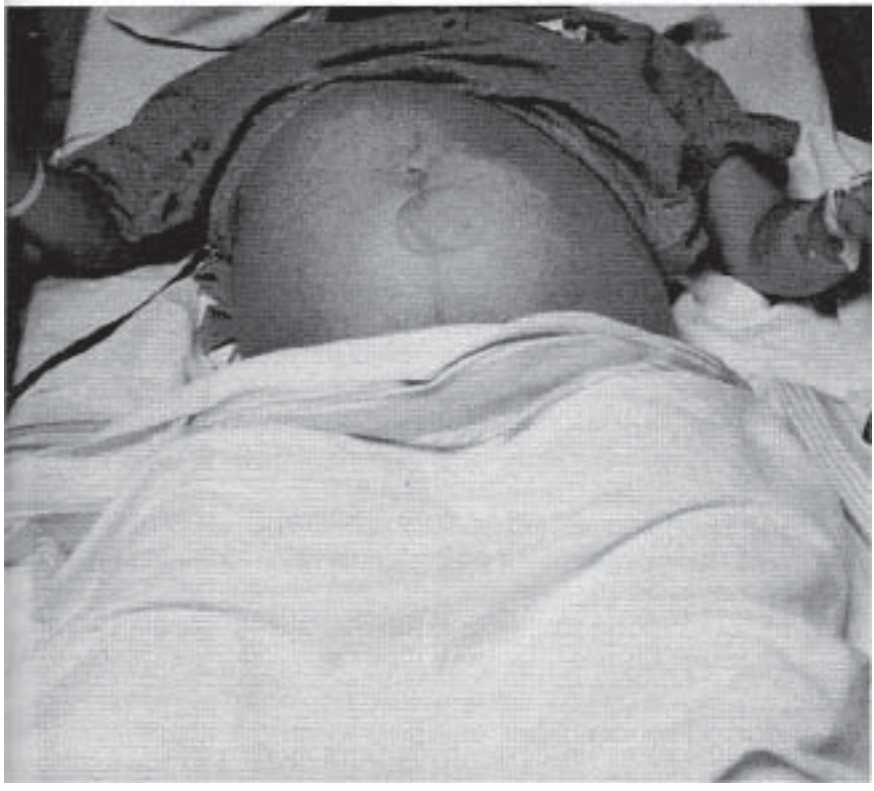
Thank you to Rosie and AIMS for giving me permission to edit and publish the original article.

AIMS (Assoc. for Improvements in the Maternity Services) can be contacted at: www.aims.org.uk

Keypoints

A head down right-side lying baby (if this is you first baby) may turn into a posterior position once labour starts because of the natural right-side tilt of your uterus. Be aware of this so that dur ing late pregnancy the appropriate exercises or positions can be undertaken to encourage your baby to move over to your left side.

Your baby's movements from right to left or from posterior to ante rior may be very uncomfortable for you. As Rosie eloquently de scribed in her article, there may be a lot of churning as your baby starts to rotate and your bones may feel as if they are grinding in your pelvis. Have patience! Expect there to be a lot of discomfort as your baby tries to align himself better. Practice contractions are likely to increase too.



11.
THE POSTERIORPOSITION AND MEDICAL

Assistance

Many pregnant women go past their due date but most go into labour spontaneously before 42 weeks. However, the baby who is in the posterior position often goes beyond 40 weeks (or more) of pregnancy. This is probably because his head hasn't engaged into his mother's pelvis, or - as often described by midwives or doctors - the baby has a "high head at term". The angle of his head (being posterior) prevents it from entering his mother's pelvic inlet. This angle also makes it harder for baby to flex his neck. His head remains straight and midwives sometimes call this the "military" position.

The photograph prior to this chapter clearly shows an unborn baby positioned in the posterior position. In this case, the baby's head was also tipped to one side making descent into the pelvis very difficult. A caesarean section was carried out just after this photograph was taken.

If your baby is in the posterior position (and it might be only now that you discover this fact!), it is important to begin exercises and postures to try and encourage your baby to move over to the left and enter in the anterior position.

However, if baby's head has already entered your pelvic inlet in the posterior position, it can be more difficult for his head to turn, but not impossible. Adopting a knee chest position for 20 minutes three times a day (or more), using a birth ball and swimming on your front may have to be introduced with enthusiasm into your daily regime!

If you are "overdue", much depends on the opinion of your midwife or doctor and your "medical" circumstances. You may be urged to have a medical induction, especially if you are over 42 weeks pregnant.

Medical Induction

A medical induction can be carried out in different ways.

One type of medical induction is a drip. An artificial hormone is introduced via the drip into a vein in your arm.

The name of the drug is usually called pitocin or syntococin.

In another induction method, hormone pessaries are inserted into your vagina in the hope that your cervix will soften and labour contractions will start.

Sometimes, your waters (the fluid surrounding your baby in the uterus) may be artificially broken with a special instrument to help bring labour on or to hasten labour. The breaking of the waters may be carried out as an induction on its own or in conjunction with the other two methods mentioned.

During an induction, you must either lie down or sit in a semi-reclining-posture while the procedure is being carried out. You may have to stay in such a position for many hours waiting for the pessaries or drip to work (dependingon what type of medical induction is being used).

Ironically, if your baby wasn't originally in the posterior position but was lying on your right side, it is very probable that he will turn posterior because of the position you assume while the induction is waiting to work. Because your pelvis is tilted backwards during this procedure, your baby may have no choice but to turn towards your back into the posterior position.

Trying to hurry labour along

Sometimes, labour begins with the waters breaking first. This often happens when a baby is in the posterior position. The waters surrounding

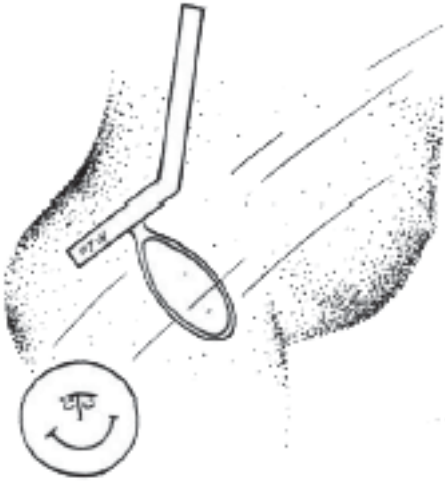
your baby form a wedge between his head and your cervix again, due to the angle your baby has settled in.

Although your waters may have broken, this does not necessarily mean that labour contractions will begin immediately. If they haven't commenced within 12-24hours, your midwife or doctor may advise a medical induction, usually in the form of an intravenous drip.

Sometimes, an elected caesarean section may be carried out if your baby's head remains high above your pelvic inlet. Your doctor may decide that a caesarean is preferable to allowing your baby to try and enter your pelvis in the posterior position. The operation will be performed before you go into labour, hence the term "elected" caesarean.

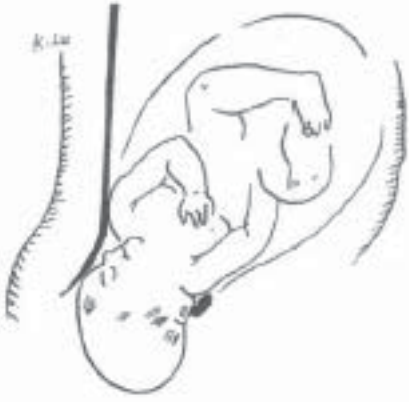
However, if labour does start - either by way of a medical induction or voluntarily - your baby now has to try and enter your pelvic inlet.

Because he is in the posterior position, to get entry into your pelvis he has to reduce his head by way of "moulding". This is where the tissue, skin and soft bones on the outside of his head are pushed forwards so that the diameter of his head can be reduced enough for him to squeeze through. This is not the same as the overlapping of the soft cranial bones at the fontanelles, which happens when a baby is in the anterior position - as discussed in Chapter 6.

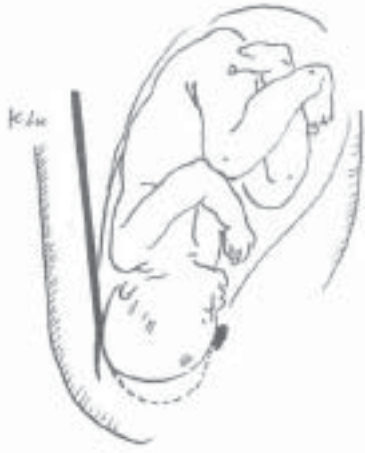


A baby in the anterior position enters the pelvic inlet without difficulty before labour.

A baby in the posterior position tries to enter the pelvic inlet before labour starts. If small enough the baby will eventually do so. Otherwise he will probably enter during labour.



A baby in the anterior position passes through the pelvis comfortbly.



A baby in the posterior position tries to enter the pelvis. Notice the moulding of the baby's head..

Backache labour

Although your labour contractions may start intermittently, by the time they are in full swing a dull backache may have developed. This is because the back of your baby's head (the hardest part) is lying against your lower spine. It is often experienced as a persistent backache that builds up intensity during a contraction.

Adopting a hands and knees posture either on the bed or floor may ease your back pain. The pressure from your baby's head is not as close to your spine compared to lying down or sitting in a semi-reclining position. Also, in the hands and knees posture, you are allowing baby more room in your pelvis. Therefore, it is possible that he could turn,

albeit slowly,into the anterior position during labour.

Another useful tip when experiencing backache is to have a hot shower or bath. You may prefer to use a birth pool.

Heated water is great for easing pain. At the same time, you may be able to lean forward when standing, or kneel, to help rotation of your baby's head.

Some women find posterior labours extremely hard work but would do it all again, providing they had lots of loving and positive support. However, it would be fair to say that backache labour over a long period of time can be a real test of endurance. It is not surprising to find that many women ask for medical pain relief after hours and hours of exhausting labour.

And who would blame them?

That is why pain relief in the form of an epidural is likely to be offered -if it is available where you are giving birth. If it is not feasible (e.g. because you are having your baby at home, at a birth centre or at a small hospital), then transfer to a base hospital may be suggested.

Once an epidural is in place, it is likely that your labour contractions will be "hurried along" by the introduction of a hormone drip (if this hasn't already been carried out during a medical induction). This is called an augmentation of labour.

Also, electronic foetal monitoring is usually performed to record your baby's heartbeat and the pressure of your uterus during contractions. This may be achieved by placing a transducer over your tummy and/or by inserting an electrode through your opening cervix, via your vagina, on to your baby's head. Aprintout shows your baby's heart rate in relation to the work done by your uterus.

Monitoring is important once a drip has been put in place because your baby may become a little anxious. His heartbeat may become slightly irregular, due to the increased strength of the contractions from an induction or augmentation. If this is noticed, the drip may be turned down to see if it relieves the situation. A caesarean section may be carried out ifit is believed your baby will be better off being born as soon aspossible.

One of the disadvantages of being "wired up" to a drip and the electronic foetal monitoring is that it is not easy to move about. Usually, you will be on a hospital bed in a fairly immobile position. It is a good idea to ask if the leads from the drip or monitoring machine to your body, are long enough so that you can at least get on to your knees into, a forward leaning position. If you have an epidural in place as well, it is likely that you won't be able to move much at all.

If you have been given a "walking" epidural, this allows for some mobility.

The best thing to do if you have an epidural is to lie on your side, rather than on your back or in a semi-reclining position. Sitting or lying on your bottom will reduce the space in your pelvis, whereas lying on your side will at least allow some room. The more space you have in your pelvis, the more likely your baby will try to use it to turn his head to a better position.

As labour progresses, your baby will continue to mould his head so that he can pass by the knobbly protrusions (ischial spines) either side of the inside of your pelvis. An internal examination by your midwife or doctor may reveal what has already been suspected; that your baby is indeed in the posterior position. If your baby's head position cannot be identified, it might be due to a caput (a temporary swelling where your baby's head is pressing against your cervix), making it difficult to diagnose correctly.

If he cannot mould his head past the knobbly protrusiom, your labour may be termed as "failure to progress" - FTD for short. If you haven't already received a hormone drip to hurry labour along, it may be carried out at this point to see . if any more progresscan be made.If your baby showssigns of distress, a caesarean is likely to be performed.

"Failure to progress" may also occur when your cervix doesn't open up past 5-7cm.As we already know, the cervix dilates better if the pressure from the contractions is at an angle over your cervix.

However, with a posterior baby the pressure is at an angle that descends down his limbs, through his erect head. It is then directed to an area approximately 2-3cm in front of your cervix (see diagram on page 148). Although your cervix may open up slowly to about 5-7cm, progress may stop after this because the pressure on your cervix is not enough to open it up any further. Your contractions may still be intense, but baby will not be able to get through your cervix if it cannot open wide enough to allow his head through.

Apart from speeding up your contractions by a hormone drip (if this hasn't already been carried out) a caesarean section is likely to be performed to get baby born and avoid further exhaustion or distress -to you or your baby.

Another medical term often used when labour stalls is "cephalo-pelvic disproportion" -or CPD. This means that your doctor believes baby's head is too big for the size of your pelvis. Very often, it is not the size of baby's head or the size of your pelvis that is the problem -it is more likely to do

with the angle that baby is presenting as he tries to enter your pelvis. This angle is invariably the posterior position!

POSSIBLE COURSE OF LABOUR

	Position of baby	
	Anterior	Posterior
Baby's head usually engages easily	Yes	Rarely
Over-due pregnancy common	No	Yes
Medical induction likely	No	Yes
Diameter ofbaby's head entering pelvic brim	9.5 cm	l1.5cm
Most efficient angle to assist head to tuck in	Yes	No (untucked or straight head)
Likelihood of water breaking spontaneously	No	Yes
Uterine contractions often irregular	No	Yes
Labour likely to be hurried along by drugs	No	Yes
Women's discomfort during labour	Tolerable	Hard to bear, often with severe backache
Length oflabour	2-12hrs	12-36hr
Amount of reduction of head circumference needed during the first stage oflabour	Nil	Approx.5.5 cm
Likelihood of pain relief	Low	High
Possibility of baby getting stuck	Nil	Fair
Possibility of rotation to 0A during first stage labour	-	Minimal
Possibility of rotation to 0A during second stage	-	Hopeful
Likelihood of medical assistance from pre-labour to birth of baby	Slight	Probable
Likelihood of medical complications for mother and baby during birth process	Slight	Possible

The direction of the contractions with the baby in the posterior position. Compare this to page 49.

If baby's head is able to squeeze through your pelvis, the good news is that he will most likely turn into the anterior position. This is because once his head enters your vagina he touches the soft tissues of your pelvic floor muscles (which surround your vagina). These muscles form a base for him to rotate his head on. Your energy levels are likely to rise once the second stage contractions kick. By now you realise that it won't be long before your baby will be born.

There is no better incentive than the prospect of your long.

awaited baby preparing to emerge into the world!

Using upright or forward-leaning postures will encourage your baby's descent. Sitting on your bottom, semi propped up, with your feet digging into the mattress or, with your feet up against the midwife's hip are NOT the best positions for this stage of labour, if you are pushing at this angle. It may make this stage longer than necessary and your pelvic floor muscles may not thank you in the weeks and months following the birth of your baby.

Unfortunately, even with your baby now in a good position, sometimes the last part of second stage labour can be just too trying. This is especially so if your pre-labour phase and the first stage of labour has already lasted a very long time.

Posterior-positioned babies sometimes take 12-36 hours to pass through a woman's pelvis. If you have no energy left, have had an epidural or spinal anaesthetic that is hindering your bearing down efforts, you may be given a helping hand to get baby born. This may be in the form of a forceps delivery or a vacuum extraction (suction cup).

An episiotomy (a surgical cut) to enlarge your vaginal opening is likely to be carried out also. This means that after your baby is born you will have stitches in and around your vaginal area.

Sometimes, a baby will not rotate its head during second stage and will be born "face up" (sometimes called "sunny side up") in the posterior position. Midwives often call this position "face to pubes".

Whether your baby rotates or is born face up, his head will have gone through some moulding, to a greater or lesser degree. The side plates of his skull are likely to become elongated, causing his head to be cone-shaped and his forehead will appear flattened. The shape of his head may take 48 hours or longer to smooth out and return to normal.

Not a lot of research has gone into the effects of this slight movement or moulding of a baby's skull plates during birth.

However, it is possible that the fragile softer bones situated in and below a baby's eyes, ears and nose may be subjected to the movement of the skull plates as well. This may mean that the blood vessels, nerves and tubes (e.g. the Eustachian tube) attached to the linings of the membranous tissue could become pinched or slightly compressed.

Although anecdotal, some midwives and doctors believe that irritable, crying and colicky babies may have experienced a difficult birth, e.g. a posteri-

or labour. These same childbirth professionals believe that it is possible for babies to have had some minor bone movement during the birth process and it is this that causes their problems.

Interestingly, cranial osteopaths are having success in treating babies who become very irritable during the weeks following their births. Others say that babies or children with glue ear, mild learning or behavioural difficulties respond well to cranial osteopathy. The treatment involves extremely gentle manipulation of the cranial bones. In many cases, once the bones have aligned better, the original problems are alleviated or disappear altogether.

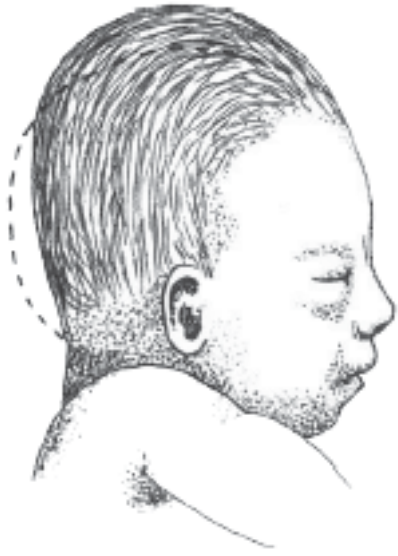
Unfortunately, until more research in this area is carried' out, we may never know if cranial osteopathy is the key to helping make some babies happier, especially those who have been in a mal-position during labour. What we do know is that a baby's head bones can become slightly misshapen during a posterior labour. It is open to question whether they right themselves during the first 48 hours or so after birth or whether this does not always happen completely.

But, one thing is certain. If a baby is posterior during late pregnancy or has the potential to turn posterior (i.e. the right-side lying baby of a first-time mother), then encouraging rotation to the left (anterior) side seems a common sense thing to do in trying to prevent a posterior labour from occurring in the first place.

However, it is important that you don't beat yourself up over the fact baby just won't budge from a posterior lie. As with breech babies, some simply do not want to move.

There may be a good reason for them not to do so.

Knowledge is a wonderful thing. If you know that your baby is more posterior than anterior and you know what may happen during labour, you can plan accordingly. Some women fly through posterior labours, with their babies turning to anterior during second stage. For others, it can be



When your baby is born his head maybe cone shaped,bruised and moulded. It may take aboUt 48 hours or so, for the swelling and bruising to subside and for your baby's head to smooth out.

more difficult. But, if you know how you can help yourself and have Plan A, Band C up your sleeve for any eventuality, it won't be such a shock if your plans need to change mid-labour. Being prepared for any eventuality is a sensible rule to have for babies who are in the posterior position as labour begins.

Midwifery Assisted Rotation

Midwifery-assisted rotation is where a midwife examines a woman internally during labour to help her baby rotate into a position that enhances descent. This is usually carried out oncethe cervixhas openedup considerably-say between 5-10cm.

Although this can be uncomfortable, the purpose of the exercise is to create a false pelvic floor with the midwife's two fingers. If the midwife keeps

her two fingers open, the strength of each contraction brings the baby's head down to touch the "false pelvic floor" -alias the midwife's fingers.

When the baby's head touches the midwife's fingers, the head begins to rotate and the anterior position can be arrived at a lot quicker than waiting for second stage to start. This may save many hours and substantially shorten labour.

Also, persistent backache can miraculously disappear. In fact, in many cases the woman's cervix opens up very quickly. In no time at all, second stage is underway, hastening the possibility of baby being born fairly soon.

As mentioned before, it can be uncomfortable while this assisted rotation is carried out. However, most women agree that if the prospect of a shortened labour with no backache is the reward, it is worth a go!

Some might say that midwifery assisted rotation is another form of intervention. But well-known writer and American midwife, Nancy Wainer Cohen, says there is a difference between an intervention and an intercession.

Nancy believes that an intervention is carried out without any regard for whether or not this action will assist the labouring woman to have a natural birth. She goes onto say interventions are not natural and that induction or augmentation of labour are examples. She says that at times they are advocated in an atmosphere of mistrust of the natural process and in an environment of birth-related fear.

An intercession, on the other hand, is handled with both safety and natural childbirth in mind. As Nancy says: *"We intercede on behalf of the labouring woman to assist her in having a natural birth. Rotating a posterior baby is an intercession, not an intervention."*

12.
OTHER"HEADDOWN"POSITIONS

Sometimes, a woman's labour seems to get stuck, even though her baby is in the favourable anterior position. The progress of labour commonly slows down because the baby's head is not presenting as well as it could be.

Surprise, surprise! Most of these slight mal-presentations can be remedied by changing your posture during labour.

Moving your pelvis can alleviate your response to the discomfort and pressure you are feeling from baby's position.

If your baby's head is not perfectly aligned, invariably, it's because your baby's head has tipped sideways, usually towards one shoulder. In medical terms this is called an ascynclitism.

By slightly tipping sideways, baby's head is unable to fold along the fontanelles and he also has trouble flexing his neck. The mal-position of his head in your pelvis spirks a deep pain in the left side of your body just below the hipbone. Your cervix may not open beyond 8cm, although your contractions continue to be long and strong.

You must create more space in the cavity of your pelvis. To do this, adopt a kneeling or hands-and-knees posture and rock your pelvis sideways. This rocking movement will change the angle within your pelvis and hopefully your baby's head will turn into the correct position.

Another way to create more space is to march on the spot.

Alternatively, walk up some stairs, placing one foot on one step then bringing the second foot up to meet the first one, before proceeding. If stair stepping is not possible, use a small stool to step up on to. You may instinctively know which foot is the one that needs to be raised, to make the difference. Concentrate stepping with that foot.

Rocking and/or stepping can be carried out while you are having a contraction or in-between contractions.

Labour might also be held up when your baby, although in the anterior position, has a hand up by his head as he tries to come through your pelvic outlet. A delay during second stage can indicate that there is an obstacle. A vaginal examination (VE) may reveal a little hand over an ear. Very often baby will pull his hand back after being touched by the midwife's fingers. An upright, leaning forward posture, maybe combined with pelvic rocking, can help in these circumstances.

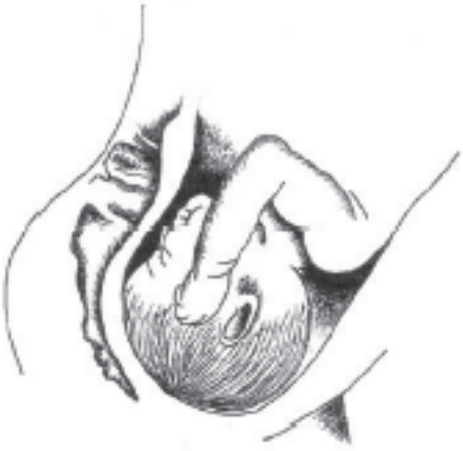
Occasionally, your baby may lie across your tummy with his head on your left side and his back to your front (a transverse lie). This is more common if you are expecting your second or subsequent baby because your abdominal muscles are sometimes softer and baby doesn't always align as well as he could. Encouraging baby's position to change prior to labour beginning is a good idea because if a shoulder decides to enter the pelvic inlet, it maybe more difficult to move it out of the way before it becomes firmly entrenched in your pelvis. Lying on your back on the floor with your bottom supported by pillows or cushions can help dislodge baby. Once movement is felt (usually as a "heave" as he moves lengthways) an upright position will encourage baby's head to move downwards.

Look at the photograph prior to this chapter. Connie's unborn baby is lying across her tummy. This is not unusual when a woman is expecting her second or subsequent baby.

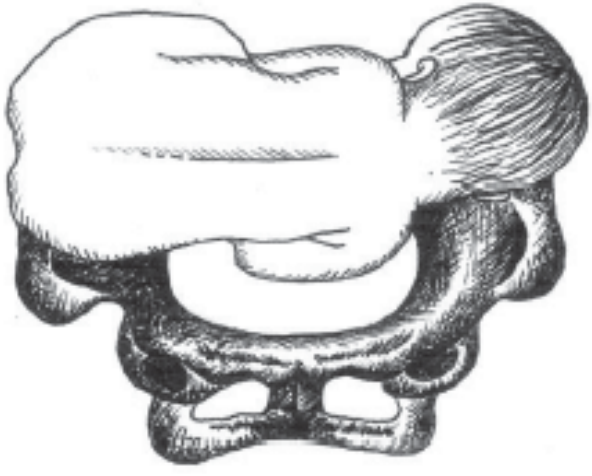
In Connie's case this was baby number four.

After three caesarean births, Connie had a straigtforward and natural birth at home just as this book was going to press! Connie wrote the Foreword to this book.

An ascynclitism



Hand up near baby's head



Transverse lie

Here is a neat story about an ascync1itism by Australian midwife, Andrea Quanchi.

Not long after I purchased my copy of *'Understanding and Teaching Optimal Foetal Positioning'* from Capers Bookstore (because I had kept hearing people on the oz mail list talking about OFP and wondering what they were on about), I was rung from work and asked to bring the book in as they had a woman in labour who was not progressing. My colleagues thought something in the book might help.

The GP was beginning to talk about LUSCS (caesarean section) and they told him to hang on because Andrea was bringing in "the book".

I'm sure he thought that they had two heads but as there was no sign of maternal or foetal distress he agreed to wait "a while". On arriving I sat and listened to the midwives story and immediately recognised a story of ascynclitism.

They had been keeping the woman in bed because of the high mobile head and had a syntocinon infusion up trying to get things happening.

After talking to her I suggested she adopt a head low bum in the air position for a short while to disengage the head and give it room to move. She immediately looked at the midwife and said, "See I told you."

Apparently this is what she wanted to do and they had discouraged her. we turned the synt off and she stayed this way for only about 10-15 minutes after which she said "l have to get up now" and she hopped off the bed and proceeded, with no prompting, to march up and down on the spot for about another 10-15 minutes. After this she said its OK now and proceeded to push out her baby.

When we rang the GP and said she was ready to birth he wouldn't believe us but arrived after her baby. He asked, "So what is this book?" I showed him but he literally flicked and ran his thumb across the pages before putting it down.

The next day I overheard him telling his colleague that he nearly had to take this woman for a LUSCS and I couldn't help myself from saying she never got anywhere near theatre.

It entrenched the book in the hearts of every midwife in our unit and we hardly refer to it any more as we all know it by heart!

Andrea Quanchi
Victoria, Australia

13.
SOME MORE BIRTH STORIES

Laine's Story

Near the end of my second pregnancy I became increasingly concerned about the position of my growing baby. I had endured a caesarean with my first baby due to poor positioning and my goal for a vaginal home birth was clouded with the fear of another caesarean.

When my membranes were artificially ruptUred at the hospital with my first baby, my son floated out of position and settled into my cervix shoulder first. He was then painfully rotated manually using external version, and my labour was re-induced with pitocin. I laboured a total of29 hours two of which were spent pushing before it was determined that a vaginal delivery was not going to happen. I was told he was in an ascynclitic position. Due to this poor positioning the vacuum and forceps only succeeded in wedging him more tightly into my pelvic bones. Desperately wanting a vaginal birth, the caesarean had been devastating for me and I wanted to learn all that I could to avoid a similar outcome with baby number two.

Now I was facing a new pregnancy but with the same body.

Like many VBAC hopefuls I had anxiety that my body could not birth "right". My fear grew when, in reviewing the medical charts from my first labour, I learned my son had been posterior at the onset oflabour. I worried that perhaps my body was inclined to carry a baby in a posterior position.

My midwife assured me at each of our visits that baby was doing fine and that the foetal heartbeat could be found easily along my left side. Each night this was confirmed by the steady thump of hiccups that I felt against my left hip while I lay in bed.

To assuage my appetite for information about all things birth related and to learn anything that might help to settle my baby well into my pelvis

as my due date drew near, my midwife loaned me her recent acquisition *'Understanding and TeachingOptimal FoetalPositioning'* by Jean Sutton and-Pauline Scott. I read it in an evening and was amazed to discover the indication given for my caesarean might have been resolved had my caregivers known of the techniques described therein.

In the book, positions and movements are described that would assist in repositioning an ascynclitic baby. My heart ached at the thought that if my doctor had been familiar with Optimal Foetal Positioning (OFP) my baby might not have needed to be cut out of me.

Reading on, I began to understand the tremendous impact that foetal positioning has on the outcome of labour and birth. "It is not unusual to hear a woman blaming herself for the kind oflabour she had when, in fact, it is the position of the baby which is the main reason for how the labour turned out. Very often the expectation is that everything will go well because the baby's head is down. The woman is given a false sense of security because she is told...everything is fine."

The effects of foetal positioning go beyond the familiar "back labour" of a posterior baby and may include prolongation of labour, in coordinate contractions and failure to progress. Post maturity due to poor positioning may also set into motion the cascade of intervention beginning with induction and often ending in major surgery. Proper pressure of the foetal head plays an important role in initiating and encouraging dilation, which reciprocally assists by moulding the foetal head.

These elements in combination encourage the output of oxytocin, naturally regulating contractions. How many thousands of women have been sectioned for slow dr no progress? What if there was a way to "turn the tide" as it were, by turning the baby?

I would soon learn that there was.

As if by fate, only a few days later while "checking in" with my baby I realised that it's movement had been greatly decreased. I was feeling stroking

movements where none had been before. Then I felt hiccups. Not against my hip as they had been, but somehow almost against my spine. Each little thump pounded the baby's head strangely into my bowels.

I called my midwife and told her I was going to try to turn the baby back round using the techniques in OFP. I spent that evening on my elbows and knees on the floor doing a peculiar sort of hula. I rotated my hips in a circular fashion with my bottom in the air using gravity to pull the baby away from engaging. My husband got some good teasing in and my two year old took advantage of a free pony ride.

When I retired to my bed that night I waited for hiccups.

When they came strong and against my left hip I was relieved and amazed. I knew baby was where he should be and I said a little prayer that he would stay there.

About a week later I felt a peculiar sensation. It seemed as if little feet were moving high on the left side ofmy belly. I was feeling feet where a bottom should be. This was confirmed by my midwife using palpation. Fears returned but with them the faith that I might once again be able to turn my baby.

That night I returned to my strange dance but this time determined that once I did get baby to turn a round again I would encourage him to stay. Quickly the confirmation came. Hiccups. Not rocket science but for me just as good.

My baby had rotated back a round to the left side. It had only taken an hour and a half to turn him.

Taking no more chances I spent the next two nights with my belly in a makeshift nest. Removing the middle cushion from the couch and making a well for my tummy out of blankets, I settled in for the night.

My breasts were tender in this face down position but it felt right. During the day I dicJnot recline and avoided riding in the car for too long as these positions allow gravity to pull the baby into a posterior position.

Instead, I spent resting time on my left side. Sleeping on the couch, which had been most produ:tive, had not been very restful. After two nights I returned to my bed but stayed on my left side.

I went into labour on a Tuesday evening and when my midwife arrived at our home at 4a.m. I was dilated 8 cms and working hard. Knowing that my baby was were he needed to be I laboured without fear.

At sunrise I delivered a pink and beautiful little boy in a birthing tub in our kitchen. Words cannot capture the wonder that filled me as I felt my baby leave my body after only nine hours of labour.

I am grateful for a deeper understanding of the importance of foetal positioning in birth through this book. I was blessed to be able to put its principles into practice with very effective results and my confidence grew as I took an active role in a situation most leave to chance. Ours was a peaceful birth experience that proceeded without complications and ended as I had prayed for two years that it would. My baby is six months old now and still gets the hiccups quite often, usually after a good tickle.

And me? Well, I still sleep on my left side.

Laine Holman
USA

Laine also wrote her birth story in an article for Midwifery Today Magazine. The above story is based on this article.

The article can befound in: Midwifery Today, Issue 57, Spring 2001.
"Optimal Fetal Positioning: Making A Great TurnAround"
www.midwiferytoday.com

CHERWYN'S STORY

We just had a baby boy on Thursday and I don't want to be remiss in not getting back to you with a report on how things went!

I spoke with the two midwives you mentioned and they were both wonderful in offering help.

My baby did turn to the OA from the OP position when I adopted the knee-chest position but then turned back a couple of days later in spite of my efforts to keep my body positioned correctly.

Nothing I did after that would turn him again before labour knee chest, pelvic rocking, leaning forward in a warm bath, prayer, talking to baby, etc. He was good and comfortable!

During labour I did pelvic lifts, which brought pain relief but did not turn my baby. When I adopted the knee-chest position with a BIG back arch (suggested by the two midwives I had previously contacted) he turned in one contraction!

I still had some back pain after that bUt I understand that can still occur even when the baby is OA. None-the-less, I am tremendously grateful for the help which led to the rotation.

Thank you so much! I now feel armed for the next pregnancy both in the area of OP prevention, as well as treatment. I wish and hope that this information will one day be known and disseminated by all birth professionals and to every pregnant woman. So much agony and disappointment, as well as complications, could be avoided!

Thank you again for your help and tremendous kindness and support to a stranger!

By the way, this time we did have our hoped-for home birth!
Cherwyn Ambuter, New Jersey, USA

JACKI'S STORY

Thank you so very much for sending me your wonderful book(Understanding andTeachingOptimalFoetalPositioning).

I've been trying to fmd the words to put my "story" onto paper - as is so often the case, I'm quite at a loss as to explain the tremendous empowerment I've gained from the information you've shared with me via your book.

Thank you so much for your pearls of wisdom. I encourage all men and women to read your book. That is why I ordered it for myself so that I could share it with others and so that they can make informed choices that will empower them for a lifetime. The information gained allowed me to take back "control" from the medical staff. My last two births were at the River Ridge Birthing Centre, simply because I felt like celebrating there and they were everything I wanted... and more!

I was induced with my first baby at 42 plus weeks. After "failure to progress" at 3cms dilated my son was born via a caesarean delivery. He weighed 10 lbs 6 oz.

I was again induced with my second baby (again at 42 plus weeks) and was "allowed" to labour to see what would happen. I managed to birth vaginally but required a ventouse delivery. This baby son was 81b 120z. I was encouraged by the doctor to have "a much easier caesarean section"!

During my third pregnancy a wonderful friend had just qualified as a midwife. She gaveme your book to read and for the first time ever I learnt how important it was for the baby to be in the optimal position for labour not just head down.

No more lying on my back! I leaned forward on a regular basis throughout most-of my pregnancy but especially towards the last fewweeks.

Right on 40 weeks I went into labour and a short 3 hours later my third born son arrived weighing 10 lbs 10 oz! I chose this time to have my baby at a birthing centre. This was a completely natural labour and birth. It was so beautiful! My baby and body worked so well together as I knew they would. I felt so empowered!

Baby number four (yes a boy!) was born at 40 weeks exactly.

A little smaller at 8lbs 150z but an even shorter labour than the last -and this time a water birth.

I am so thankful to have known about OFP. Knowing that my last two babies were in the most effective position for labour and birth made their births so much easier and more satisfying.

Jacki Taiapa
Hamilton
New Zealand

14.
THE LASTWORD

The information contained in this book is not new, but rather rediscovered common sense. It's the sort of information that midwives more than 50 years ago discussed with the pregnant women they cared for.

But, as the medicalisation of childbirth began in earnest during the 20th century, much of the wise information that midwives passed on to other midwives and to the women they cared for, became lost or disregarded as the midwifery model of pregnancy and childbirth was replaced by the medical model.

The recent renaissance of midwifery autonomy in the Western world has caused the skills and knowledge gained by experienced midwives to resurface. And because many midwives work in partnership with women, the sharing of information is spreading to mothers as well.

Although the knowledge in this book is old hat, it is nevertheless new as we begin a new century. And, as we search for ways to prevent the rate of forceps and caesarean deliveries from becoming any higher, the information shared in this book, may in some wayhelp, reduce medical childbirth.

Our challenge now is to counteract the second wave of birth technology.

With more women having fewer babies, those they do have are incredibly precious.

This isn't saying that not all babies are precious. They are.

What I am saying, is that the one or two babies a woman gives birth to in a lifetime these days, are often very well planned. Couples try to organise conception and birth around work commitments, their financial situation, the availability of support - and a host of probably many other reasons.

However, it doesn't always go according to schedule.

Leaving parenthood until later in life means that the rate of infertility is higher. Consequently, some babies are conceived medically through an IVF programme.

Precious babies indeed!

Enter the second wave of technology. When a woman is trying to conceive a baby after many years of infertility and the end result is a pregnancy via the assistance of technology. It is no wonder the unborn baby is "protected" by the use of further technology. Above all else, this precious pregnancy needs to be medically managed from the moment of conception to the birth itself.

The woman, understandably, gives over all power to her medical advisors to ensure a safe outcome. The question is, would the birth be any safer if she chose a midwife and birthed at home or at a birth centre?

In this climate pregnant women are influenced, not only by their sisters' high-tech pregnancies, but also by the media.

The barrage is constant as women's magazines regale the horrors of actresses, super models and TV commentators' birth experiences. The fear of childbirth continues unabated!

Thank goodness for famous women such as supermodel and businesswoman Elle McPherson from Australia and New Zealand actor Lucy Lawless. Lucy is TV icon Xena, in the TV series "Xena: Warrior Princess". Last year in the New Zealand Women's Weekly, Lucy was interviewed and she listed her passions and her pet hates. One of her passions is natural childbirth: "Women are having babies in paddyfields all over the world, out in the rain, not that I would want that. But I do believe in home birthing, a gentle water birth".

What a pity more high profile women are not promoting positive birth experiences.

The good news is that many women question their first birth experience, and in doing so learn more"about childbirth, the choices available and empower themselves with knowledge so that they become part of the decision making - or the decision maker.

And this is what this book is all about...sharing information about birth so women and their support people are more informed. Knowledge is power!

For those approaching their first birth experience, the pitfalls that many second time mum's experienced during the first birth, may be avoided by becoming informed and prepared in advance.

It is therefore appropriate that the last word goes to Cherwyn, who wrote to me following the birth of her second child.

"Thank you so much! I now feel armed for the next pregnancy, both in the area of OP prevention, as well as treatment. I wish and hope that this information will one day be known and disseminated by all birth professionals and to every pregnant woman. So much agony and disappointment, as well as complications, could be avoided!

Thank you again for your help and tremendous kindness and support to a stranger! By the way, this time, we did have our hoped for home birth!

Sincerely and gratefully yours,"

Cherwyn Ambuter
New Jersey, USA

Cherwyn also wrote her birth story on page 175.

ABOUT THE AUTHOR

Pauline Scott is a mother of three children. She trained as a childbirth educator with the National Childbirth Trust in London during the early 1980s.

On returning to New Zealand, Pauline co-founded the New Zealand Active Birth Movement and initially worked as an independent childbirth educator with support from the New Zealand Home Birth Association.

With gradual acceptance of her approach, she moved into more mainstream work and was 'employed' by hospital boards, as well as organisations such as Parents Centre New Zealand.

After organising a nationwide tour by well-known childbirth educator and author JanetBalaskas in 1985, followed by childbirth pioneer and obstetrician Dr Michel Odent in 1987, Pauline became more involved with political issues surrounding childbirth and midwifery. This included such areas as direct entry midwifery training and midwifery autonomy.

In 1995Pauline met midwife Jean Sutton and together they wrote and published a text booklet for midwives and childbirth professionals. This book *'Understanding & TeachingOptimalFoetalPositioning'* has become a "bible" for those working in the field of childbirth.

With the publication of her latest book, *'Sit Up and Take Notice! PositioningYourself for a Better Birth'*, Pauline is now working on an educational video. She is also in demand as an international conference speaker.

For further information on workshops, seminars and conference speaking, please contact Pauline Scott:

RESOURCES

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'Understanding and Teaching Optimal Foetal Positioning'
Jean Sutton and Pauline Scott
Published by Birth Concepts
ISBN 0-473-04135-9
Email: pauline(@birthDositions.com

'Let Birth Be Born Again - Rediscovering and Reclaiming our Midwifery Heritage"
Jean Sutton
Published by Birth Concepts UK
ISBN 0-9541631-0-9 .
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'Breech Birth Woman- Wise'
Maggie Banks
Published by Birth Spirit Books Ltd
ISBN 0-473-04991-0
www.birthsDirit.co.nz

'Home Birth Bound: Mending the Broken weave'
Maggie Banks
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