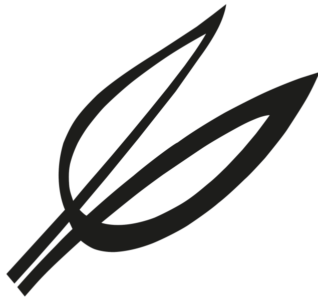
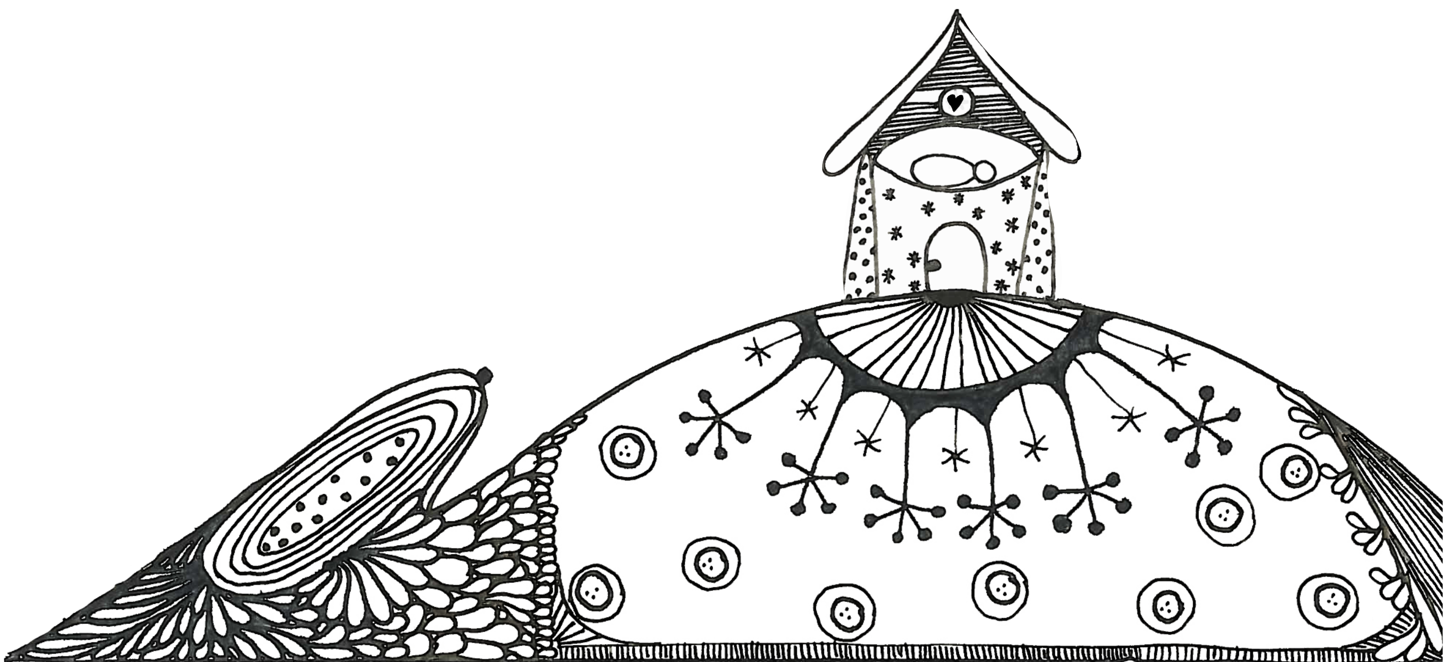


Pointe-Saint-Charles Community Clinic

A neighbourhood's health and solidarity!

MIDWIFERY SERVICES NOTEBOOK



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What is a Midwife?

Source : Ordre des sages-femmes du Québec

A midwife is a health professional trained to provide care and services to mothers and newborn babies during pregnancy, birth and the postpartum period up to six weeks after birth.

A midwife is a self-employed professional on contract with a Health and Social Services Centre. Midwives' services are fully covered if you have a valid health insurance card from RAMQ. Therefore, you do not have to pay for follow-up. Otherwise, you have to inquire about the cost of services, as they will be charged.

A midwife works at a birth centre or at a midwife service. She is a part of a multidisciplinary team consisting of Health and Social Services Centre or reference hospital professionals.

A midwife performs necessary clinical examinations. She can also order sonograms, prenatal screening tests and various laboratory tests. Her care focuses on the normality of the pregnancy, the birth and the postpartum period.

The Course of Follow-up with a Midwife

A team will be assigned to you at registration. The team consists of two midwives to guarantee their availability 24/7. You can reach them at any time. The principal midwife performs most of the follow-up. You will also meet her partner to foster trust. Midwives attach significance to continuity of care for proper follow-up.

The midwife checks all clinical parameters to evaluate the normal evolution of the pregnancy at each visit. She takes the time to discuss all matters that may worry the couples. Each visit takes about 50 minutes. A variety of subjects are discussed and advice is personalized and covers every important aspect of pregnancy. For example, the midwife might talk about nutrition, mild discomfort, available tests, sonograms, prenatal screening and other various subjects. You will have to make choices about your possible options. The midwife can refer you to other professionals if need be.

The follow-up is personalized for each woman. It is safe and respects your values. The midwife considers the family aspect of the pregnancy and birth, so spouses, children or any other important people in your life are welcome to join the process.

The Course of the Birth with a Midwife

You call the midwife on duty when the moment of birth arrives. During labour, the midwife will check all parameters that allow her to monitor the advancement of the labour and baby's well-being. She will attend to your needs and offer you personalized support. You will choose the position you prefer, eat if you want to, listen music or take a bath. Epidural anesthesia is not available at a birth centre, but midwives sometimes transfer women to a hospital so it can be administered to them.

The midwife must consult or transfer the care of the woman to a family physician, an obstetrician gynaecologist or a pediatrician if complications arise during labour. The midwife has all the requisite knowledge to detect potential complications and stabilize the situation before the woman reaches the hospital.

The Course of the Postnatal Follow-up with a Midwife

The midwife will come to your home many times after the birth. She will check all parameters to ascertain whether this period is elapsing normally for you and your baby. She will also provide you with appropriate advice. She can refer you and your newborn to other professionals if required.

Midwife Training

The Université du Québec à Trois-Rivières offers a four-year university program. The Baccalauréat en pratique sage-femme (Bachelor in Midwifery) fulfills all quality requirements and skills for midwife training.

Practitioner midwives have an obligation to acquire new professional skills through continuing education. Some training workshops are compulsory every two years, including training on properly detecting and handling obstetric emergencies, and training on care for newborns requiring resuscitation at birth.

Philosophy of midwifery practice

The midwives practice model is based on the following guiding principles:

- **Confidence in the competence and autonomy of women;**
- **Respect and trust in the physiological process of pregnancy and childbirth;**
- **The importance of continuity of care and of relationship;**
- **The personal and egalitarian relationship with the woman.**

More specifically, the Philosophy of midwifery, adopted by the RSFQ in 1997, is defined as follows:
''The practice of midwifery is based on the respect of pregnancy and birth as normal physiological processes having an important significance in a woman's life. Midwives acknowledge that delivery and birth are moments that belong to the women and their families. The responsibility of healthcare professionals is to offer women the respect and support they need to give birth with their own capacities, safely and with dignity. Midwives respect the diversity of women's needs as well as the numerous personal and cultural significations that the women, their family and their community associate with pregnancy, birth and the experience of being a new parent.

Midwifery is to be practised within the context of a personal and egalitarian relationship, open to social, cultural and emotional needs, as well as the physical needs of women. This relationship is established with continuity of care and services during pregnancy, birth and the postnatal period.

Midwives encourage women to make choices regarding the care and services they receive and the way they are given. They view decisions as the result of a process in which the responsibilities are shared between the woman, her family (as defined by the woman) and health professionals.

Midwives acknowledge that the final decision belongs to the woman. They respect women's right to choose their health professional and where they want to give birth, in accordance with OSFQ standards of practice. Midwives are willing to assist women in the birthplace of their choice, including their home.

Midwives consider that promoting health is essential in the pregnancy cycle. Their practice is based on prevention and includes wise use of technology. Midwives consider that the mother and the child's interests are close and compatible. They believe that the best way to ensure the mother and baby's well-being is to focus their care on the mother.

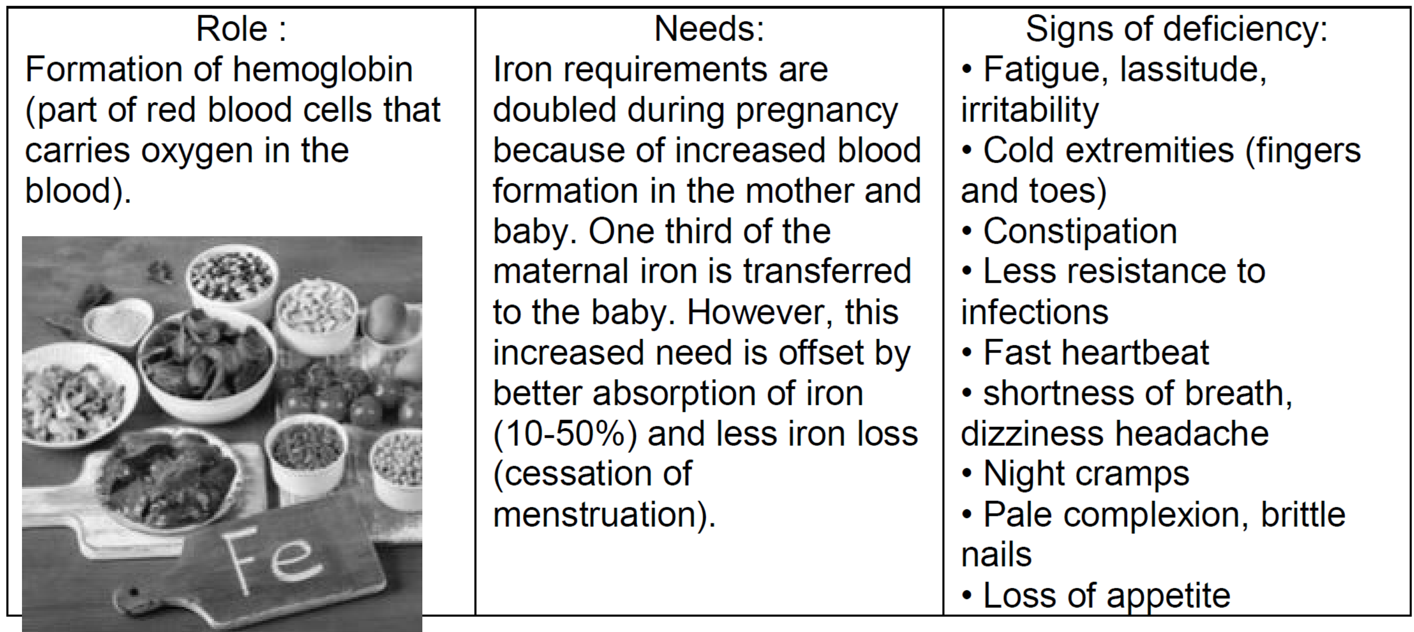
Midwives encourage the support of families and the community as a privileged way to facilitate the adaptation of new families.''

Food during pregnancy

Source : Anne-Marie Chalifoux, dietician

Food is unquestionably a very popular topic throughout our lives. And it is even more so during and after pregnancy. As part of midwifery care, some food concepts will be addressed to help you better manage this important aspect of your pregnancy. The following tables can help you understand your daily needs and potential sources of the different elements of a healthy diet.

Iron deficiency, or anemia, leaves the mother without reserves in case of excessive bleeding during delivery and plays a role in the incidence of low birth weight babies and premature babies.



IRON (Requirements in pregnancy: 30 mg / day)

Role :	Needs:	Signs of deficiency:
Formation of hemoglobin (part of red blood cells that carries oxygen in the blood).	Iron requirements are doubled during pregnancy because of increased blood formation in the mother and baby. One third of the maternal iron is transferred to the baby. However, this increased need is offset by better absorption of iron (10-50%) and less iron loss (cessation of menstruation).	• Fatigue, lassitude, irritability • Cold extremities (fingers and toes) • Constipation • Less resistance to infections • Fast heartbeat • shortness of breath, dizziness headache • Night cramps • Pale complexion, brittle nails • Loss of appetite

IRON (Requirements in pregnancy: 30 mg / day)

What increases absorption :	**What diminishes absorption :**
Vitamin C: Triple iron absorption • 1st choice: Vegetables: cabbage family, peppers, tomatoes, asparagus, snow peas, parsley ... • 2nd choice: Fruits: citrus, kiwi, cantaloupe, strawberries ... Soaking, sprouting (legumes, nuts, grains)	• Tea • Coffee • Calcium supplements (to be taken in between meals) • Antacids • Milk and cheese • Oxalates (spinach, Swiss chard) • Phytates (wheat bran)

Sources of Iron

Legumes (1cup)	4,7 mg
Meats (3 ounces)	1,8 mg
Vegetables	1,2 mg
Nuts (2 tablespoons)	0,8 mg
Fruits (1 portion)	0,3 mg
Dairy products	0,15 mg
Whole or enriched grains (1portion)	1,4 mg

Good sources of Iron

Vegetables	**(mg)**	**Cooked grains 1cup**	**(mg)**
• Spinach 1cup	4	Porridge (oats)	1.7
• Asparagus	2.3	Quinoa	5.3
• Kale	2	Millet	2.2
• Winter squash	1.4	Brown rice	2.1
• Beetroot 1cup	1.3	Cracked wheat (bulgur)	2.8
		Wheat germ	1.4
Cooked legumes 1cup		Other	
• Black beans	7.6	Blackstrap Molasses (2 tablespoons)	4.6
• Lentils (2 tablespoons)	6.8	Sesame seeds	2
• Red beans (1 tablespoon)	6.6	Nutritional yeast	1.4
• Lima beans	5.8	Tofu 100 mg	10.5
Fruits		**Meat and fish**	
• Figues (10)	4.2	Veal liver	5.2
• Avocados (1)	2.8	Horse	5
• Prunes (10)	2.4	Beef	3
• Seedless grapes 1/2cups	1.7	Pork	1
Nuts and seeds (2/3t.)		Tuna	1
• Almonds 1.9	1.9		
• Pumpkin seeds	11.2		
• Sunflower seeds	3.4		

SOURCES OF PROTEINS: Daily requirements 50 à 60 gr/day

5 GRAMS
• Grains: 1 cup pasta, rice, couscous, 2 slices of bread… • Vegetables : 1 cup broccoli, snow peas, Brussels sprouts, spinach… or 1 potato
10 GRAMS
• Nuts : 4 tablespoons of nuts or 2 tablespoons of nut butter • Dairy products : 1 cup of milk, yogurt or 1 ounce of cheese
15 GRAMS
• Meats: 2 ounces of beef, poultry, fish… • Legumes : 1 cup • Tofu : 3-4 ounces

Eating for 2 means twice as well, not twice as much!

- Don’t skip breakfast
- Eat your raw veggies at the beginning of a meal (for better absorption).
- Chew carefully and break up the meals (3 à 5).
- Eat slowly, in a calm environment.
- Reduce animal fat consumption (especially cooked, reduce fried food intake).
- Cook vegetables the least possible (steamed).
- Reduce consumption of refined products (sugar, refined flour, sweetened or refined cereals). Preferably use whole unrefined products.
- Especially avoid: refined foods, fried foods, overly rich or spiced foods (cold cuts, chocolate, coffee, the, alcohol, cigarettes and medications).
- Drink plenty of water (1 L and more/day), preferably in between meals or half an hour before.
- Increase the quality of the proteins but not necessarily the quantity.
- Use seed oils (almonds, sesame, sunflower, nuts, peanuts…) as supplements (at least 3 tablespoons / day) and dairy products (cheese, yogurt…).
- Increased need for CALCIUM: dairy products, tofu, fish (sardines, red salmon), seed oils, green vegetables (dandelion leaves, kale, broccoli, leaks, carrots, dried beans, whole wheat, eggs).
- Vitamin D helps the absorption of calcium (egg yolk, olive oil, sunny green vegetables, yeast, sprouted alfalfa, sunshine bathing).
- Sources of vitamine C : lemon, orange, grapefruit, strawberries, melon (cantalou), apples, broccoli, Brussel sprouts, bell pepper, parsley, cauliflower, spinach, sauerkraut, sprouted grains (especially alfalfa).
- Cigarettes and caffeine destroy vitamin C and B complex vitamins.
- Increase B complex vitamins (especially B1, thiamine), brewer’s yeast, whole grains, sunflower seeds, cooked legumes, broccoli, milk, wheat germ, other green veggies, giblets.
- If the requirements for protein, Calcium, Iron and B vitamins are covered, we get in addition the other nutrients in suitable quantities.

For proper food assimilation, it is essential to get good rest and to do daily physical activities (walking, swimming...)
Bon Appétit!!

Pregnancy discomforts and alternative remedies

HEARTBURN

What can I do about it?

- Eat small, frequent meals. Avoid taking food and drink at the same time.
- Eat raw almonds for a snack.
- Keep good posture, to allow more room for your stomach to function.
- Try stretching your arms over your head, to give more room to your stomach.
- Avoid heavy, fatty foods and spicy foods.
- Try elevating the head of your bed slightly, to get gravity on your side.
- Try papaya enzyme – available at health food stores.
- Acupuncture
- Homeopathic remedies that might work – Carbo veg, Nux vomica, Pulsatilla
- Go ahead and use antacids if they help, or if nothing else works.

LEG CRAMPS

What can I do about it?

- Point your heel down, toes up on the affected leg. Stand or walk on it until the muscle relaxes. In bed, push against the footboard or your partner's hand with the affected foot. Avoid pointing your toes down.
- Take a Calcium/Magnesium supplement, 2:1 ratio (1500/750mg) with a 1000mg Vitamin C and 1000IU Vitamin D before bed.
- Eat a diet with rich in phosphorous and calcium- lots of milk and fresh fruit.
- Often leg cramps can be associated with dehydration so drinking a cup of water may help.
- Take a warm water bath to relax the muscles.
- Massage away the cramp.
- Exercise every day is important for many reasons and will improve circulation and stretch your muscles. Some research shows that stretching exercise combined with water aerobics decrease some of the physical discomforts of pregnancy, including leg cramps.
- Homeopathic remedies that might work – Chamomilla, Nux Vomica, Sepia

NAUSEA AND VOMITING

What can I do about it?

- Small, frequent meals. Keep your blood sugar stable.
- Eat something bland first thing in the morning before you get up
- Don't brush your teeth right after eating – you may stimulate a gag reflex
- Drink carbonated beverages – juice diluted with sparkling water works well
- Reduce fats in the diet. Increase proteins – they take longer to metabolize and therefore maintain blood sugar levels longer than carbohydrates
- Try acupressure wristbands
- Consider acupuncture
- Vitamin B6 (pyrodoxine) is one part of the prescription drug Diclectin – it is worth a try, up to 100mg/day is safe in pregnancy
- Homeopathic remedies that might work – Tabacum, Nux Vomica, Pulsatilla, Sepia

JOINT PAIN

What can I do about it?

- Maintain good posture. Wear sensible shoes!
- Keep exercising. Yoga, walking and swimming are great low impact options
- Osteopathic care can really help. Look for a provider experienced in pregnancy care
- Massage, warm baths, heat and cold pads alternating can help
- Soy or sunflower lecithin supplements can help lubricate the joints – start with 2 capsules 2 times a day and increase by 2 capsules each time until you feel relief. Up to 32 capsules/day is OK but you may notice some loose stool. If it is going to work for you, you should feel better within a few days.
- Homeopathic remedies that might work – Arnica, Hypericum, Pulsatilla, Sepia

HEMORRHOIDS AND VARICOSITIES

What can I do about it?

- For hemorrhoids - do everything you can to prevent constipation. Plenty of fluids, lots of fiber, regular bowel movements (don't wait)
- Don't strain
- Sitz baths or compression with witch hazel (Tucks pads), ice, or Epsom salts
- Avenoc suppositories can really help
- For varicosities - compression stockings really work! We can write you a prescription so you can get them properly fitted for you. Put them on BEFORE you get out of bed in the morning (before all the blood pools in your legs and can't get back up). This may mean you have to bathe at night.
- Wear loose clothing
- Don't stand for long periods. Try to find regular times to elevate your legs during the day. Up against a wall several times a day is helpful
- Maintain good posture, keep exercising
- Consider a Vitamin C & E supplement – studies show they promote healthy circulation
- Wearing an abdominal support can relieve pressure on your pelvic veins
- Acupuncture
- Homeopathic remedies that may help – Kali carb, Carbo veg, Hammamelis (witch hazel), Nux vomica, Pulsatilla, Sepia
- Try a Rutin supplement (bioflavinoid from the Vitamin C family). Or just eat the pithy part of an orange, which is full of Rutin.

A word about homeopathics – each remedy has a "picture" of who it works best for, depending on what kind of symptoms you are having. Check with your midwife or homeopath before deciding which remedy might be right for you.

Signs of concern during pregnancy

- Visual disturbances: double vision and/or black dots and/or lightning steaks in the eyes
- Swelling of the face or hands or lower limbs (sudden or extreme)
- Unusual, frequent and/or persistent severe headaches
- Muscular irritability and/or seizures /severe cramps
- Acute stomach pain (epigastric)
- Violent and frequent vomiting after 3 months of pregnancy
- Vaginal discharge, fluid or blood or causing burns +
- Itching
- High fever > 100° F with or without shaking
- Burning or pain when urinating ≈ often with contractions. If tendency of urinary tract infection before pregnancy: drink +++
- Severe or unusual abdominal pain. No frequent urination
- Very hard uterus
- Absence of fetal movements after more the 8 hours
- Often dizzy

If you experience one or more of these symptoms, call your midwife!

In Due Time...
Pregnancy Beyond 40 and Induction of Labour

As it becomes more common for people 40 and over to give birth, midwives, family doctors and obstetricians have started asking questions about the needs of this group. Recently, two groups representing obstetricians (in Canada and the United Kingdom) published professional opinions suggesting that induction of labour (getting labour started using medical techniques) be considered earlier in pregnancy in those age 40 and over.[1]

These opinion papers were not produced using the same sort of thorough and systematic process used to evaluate research and make recommendations for clinical practice guidelines. However, care providers may be changing their practice, based on these opinion papers, and recommending early induction of labour. The goal of this document is to help you understand research on this topic so that you can make the best informed choices for you and your family.

This document focuses on induction of labour. It doesn't address other decisions that midwifery clients who are 40 and over may face while pregnant.

A note about language

The most common terms used to refer to pregnancy in people 40 and over are "late" or "advanced" maternal age, "older motherhood" or "delayed childbearing." This document will use the phrase "pregnancy beyond 40" instead.

A note about fertility treatment

It is important to note that this document doesn't discuss the use of assisted reproductive technologies (ART) like in-vitro fertilization (IVF), donor eggs or fertility drugs. The research discussed here relates to spontaneous pregnancies without fertility treatment. If you used any assisted reproduction techniques and you are over the age of 40, talk to your care provider about your particular care.

Why does age matter?

Many people 40 and over are in excellent health and most have pregnancies that are not associated with major or long-term problems. Your midwife will talk to you about your health history to get a good sense of your overall health and how any preexisting health conditions may affect your pregnancy. As they do for clients of any age, midwives check during regular prenatal visits to see if any health complications for you and your baby have developed.

However, research suggests that clients age 40 and over are at higher risk than younger age groups of having general health problems as well as developing pregnancy complications (such as having a baby with a chromosomal difference such as Down syndrome, developing gestational diabetes, high blood pressure, or having a C-section). They are also at increased risk of giving birth to a baby that has died before or during labour (stillbirth). This document will explain some research about the risk of stillbirth for anyone who is pregnant and aged 40 and over and help you to make choices about either using medication to start your labour around your due date or waiting for labour to start on its own.

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[1]In 2012, the Society of Obstetricians and Gynaecologists of Canada (SOGC) published a paper on Delayed Childbearing. In 2013, the Royal College of Obstetricians and Gynaecologists (RCOG) in the United Kingdom released a paper called *Induction at Term in Older Mothers.*

This document provides client-friendly information on pregnancy beyond 40 and induction of labour. It is designed to help you better understand some of the considerations and choices you may face while receiving care from your midwife. It is not intended to replace the informed choice discussions that you and your midwife will have. If you have any questions, concerns or ideas after reading over this document, please share them with your midwife.

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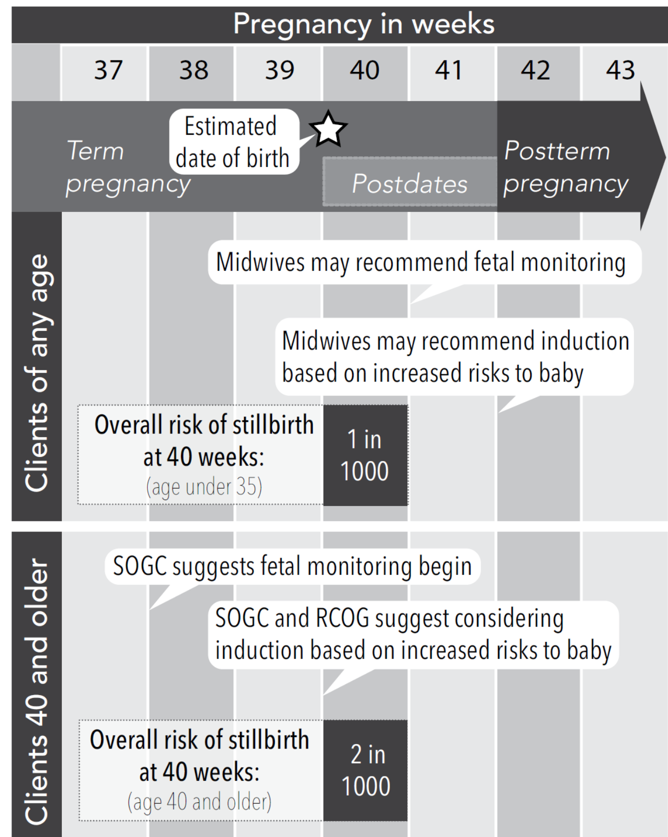
Postdates pregnancy, monitoring and induction of labour

While your estimated date of birth or "due date" is calculated to be 40 weeks of pregnancy, anywhere between 37 and 42 weeks is considered to be a term pregnancy. A "postdates pregnancy" is a pregnancy that goes beyond your due date. A pregnancy that lasts longer than 42 weeks is called a "postterm" pregnancy.

Most babies are born healthy, regardless of whether they arrive at term or later. However, for clients of any age, the chance that a baby will be stillborn tends to increase as a pregnancy continues past the due date. That's why care providers will usually suggest **keeping a closer eye on the baby when a pregnancy gets to 41 weeks**. This means your midwife may offer extra ultrasounds (if available in your community) between 41 and 42 weeks or a non-stress test, where a fetal monitor is used to listen to the baby's heartbeat pattern over a period of time. Midwives will also discuss the risks and benefits of **induction of labour when a pregnancy goes past 41 weeks and may recommend an induction of labour at 42 weeks**. An induction is when labour is artificially started using drugs like prostaglandins or oxytocin or breaking the bag of waters that surround the baby (amniotic sac) to encourage the uterus to contract.



Why am I being offered earlier induction of labour because of my age?

The authors of the Society of Obstetricians and Gynaecologists of Canada (SOGC) and Royal College of Obstetricians and Gynaecologists (RCOG) publications looked at studies that show that if you are 40 and older, your chance of having a stillbirth around your due date is similar to the chance someone under 30 has of stillbirth at one or two weeks after their due date. That's why the SOGC suggests that care providers begin monitoring the baby's well-being earlier in clients age 40 and older, starting around 38 weeks. The SOGC and RCOG also suggest considering induction of labour at an earlier gestational age, around 39-40 weeks.

According to the studies the authors of the SOGC and RCOG papers looked at, the risk of stillbirth at 39-40 weeks of pregnancy is about 1 per 1000 pregnancies in someone under 35 and about 2 per 1000 for women 40 and over. Though risk of stillbirth is higher in women 40 and older, the overall risk of stillbirth is still very low and is even lower for those who don't have conditions like diabetes, high blood pressure or heart, lung or kidney problems.

Risk of stillbirth at 39 to 40 weeks of pregnancy for those 40 years and older	
Pregnancies ***without*** diabetes, high blood pressure or heart, lung or kidney problems	About 1.5 in 1000
All pregnancies	About 2 in 1000
Risk of stillbirth at 41 weeks of pregnancy for those 40 years and older	
Pregnancies ***without*** diabetes, hypertension or heart, lung or kidney problems	About 2 in 1000
All pregnancies	About 2.5 in 1000

The AOM is committed, through our statement on Gender Inclusivity and Human Rights, to reflect and include trans, genderqueer and intersex communities in all aspects of our work.In this document, there are references to sources that use gendered language to refer to populations of pregnant and birthing people. In order to accurately represent these sources, we may have maintained gendered language. We support research and knowledge translation that engages and reflects the entire childbearing population.

Does it make a difference if I've had a baby before?

Risk of stillbirth is lower if you have already had a baby before, regardless of your age.

*These numbers are different than the risks of stillbirth quoted earlier for people at 39-40 weeks (i.e., 2/1000 for clients 40 and over and 1/1000 for people under 35). That's because the numbers to the right represent the risk of stillbirth at any point between 37 and 41 weeks of pregnancy.

Risk of stillbirth* at any point between 37 and 41 weeks of pregnancy		
During a first pregnancy	Age: Under 35 years	About 4 in 1000
	Age: 35 to 39 years	About 6.5 in 1000
	Age: 40 years and older	About 9 in 1000
During a second, third, fourth (or later) pregnancy	Age: Under 35 years	About 1 in 1000
	Age: 35 to 39 years	About 2 in 1000
	Age: 40 years and older	About 3 in 1000

Are there risks if my labour is induced?

Induction is an important option when it's clear that the benefits of inducing labour outweigh the risks of waiting for labour to start on its own. For example, if you have high blood pressure that is causing problems for you or your baby, using medication to start your labour may cause fewer problems than if your pregnancy were to continue. In healthy people with healthy babies, the benefits of induction are less certain.

Although the SOGC's opinion is that clients 40 and over should be cared for differently, no research has been done to show that early induction of labour will reduce the small (but increased) risk of stillbirth in people 40 and older. That's partly because researchers aren't sure why stillbirth is more likely to occur as age increases.

The interventions used to stimulate labour and birth may have their own risks. If you have an induction you may be more likely to need a C-section or an assisted vaginal delivery (with forceps or vacuum). Birth numbers from Ontario show that people who are 40 and older are more likely to have a C-section, whether the labour is induced or starts on its own. Those who are induced have higher rates of C-section than those whose labours start naturally.

It's difficult to draw firm conclusions from these birth numbers, since people who were induced may have been different from those whose labours started naturally. For example, someone who was induced may have been more likely to have medical conditions (like gestational diabetes) that caused their caregivers to recommend induction and may have made a C-section more likely to occur.

Although we know that in Ontario, people who have an induction are more likely to have a C-section, research studies that looked at the connection between induction and C-section in a different way have found different results. Studies that looked at participants of all ages who had healthy pregnancies and were chosen at random to have an induction or continue their pregnancies suggest that those who are induced at or after their due dates are ***not*** more likely to have a C-section. This is confusing because there is conflicting information! What we do know is that despite what the research suggests, someone in Ontario who is 40 or over who has had labour induced is more likely to have a C-section than someone whose labour was not induced.

Babies born between 37 and 39 weeks are usually healthy, but they are more likely than babies born at 39 weeks and later to have problems that require them to be admitted to the neonatal intensive care unit. We also don't know whether using early induction of labour to reduce the risk of stillbirth will outweigh these risks.

For every 100 Ontarians 40 and over who gave birth in hospital and were induced

there were 52 vaginal births

For every 100 Ontarians 40 and over who gave birth in hospital and whose labour started naturally

there were 72 vaginal births

What are my choices if I am 40 or over and my due date is coming up?

Your midwife will help you to make sense of all these statistics and help you to understand these risks for your own pregnancy. Different people will make different choices based on their own values and preferences. Your midwife may have a specific recommendation for you based on what's happening in your pregnancy.

Your choices about monitoring are to

- start monitoring your baby's well-being earlier, at around 39 weeks;
- wait to start monitoring until a later date (around 40 or 41 weeks); or
- not do this monitoring at all.

Your choices about induction are to

- have an early induction of labour (at around 40 weeks);
- have an induction at a later date (around 41 or 42 weeks); or
- wait for labour to start on its own.

Other things you can try that may help to encourage labour

There are several non-medical approaches that midwives and their clients sometimes use to encourage labour to start sooner. One is called a "stretch and sweep." During a stretch and sweep your midwife puts her fingers into the vagina and examines and stretches the cervix, sweeping her fingers around the inside of the cervix. Other methods used to encourage labour include castor oil, acupuncture, homeopathy, nipple stimulation and herbs. Little research has been done to test how well these methods work or in what circumstances they are best used. Talk to your midwife if you would to know more about alternative ways to encourage labour to start.

What we know

- Most clients who are pregnant and 40 and older have healthy babies.
- Health problems (such as diabetes or hypertension) or pregnancy complications occur more frequently in those 40 and over.
- While stillbirths are more likely to occur in older clients, the overall risk of stillbirth is low. Between 39 to 40 weeks of pregnancy, stillbirths are thought to occur in about 2 of every 1000 pregnancies in people 40 and over compared to 1 of every 1000 pregnancies in people under 35.
- The risk of stillbirth for people age 40 and over at 39 weeks of pregnancy is similar to the risk of stillbirth someone under 30 has at about one or two weeks after her due date. This is why some care providers suggest that monitoring of the baby's well-being and induction of labour be considered earlier in pregnancy in people age 40 and older.
- The risk of stillbirth increases with age even in healthy and uncomplicated pregnancies. This risk is further increased if there are also health problems and/or pregnancy complications.
- Stillbirth risk is higher with first pregnancies (this is true for first pregnancies regardless of age).
- Birth numbers from Ontario show that people 40 and over whose labours were induced were more likely to have C-sections.

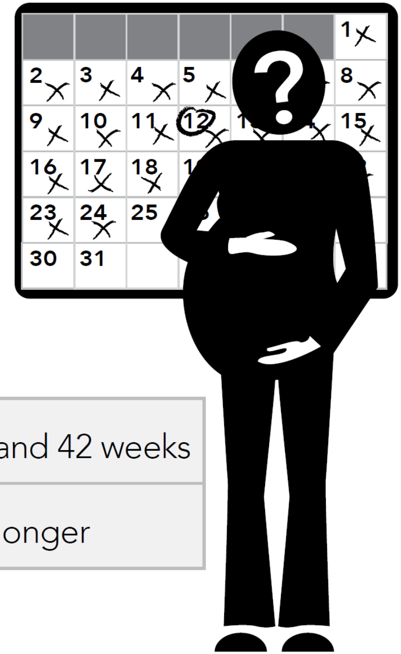
What we don't know

- We don't know why the chances of having a stillbirth increase with age.
- There is no research that shows that inducing labour earlier will reduce the rate of stillbirth in those 40 and older.

Questions? Talk to your midwife

These kinds of choices are difficult to make and may depend on your own preferences or personal health history. You midwife can help you sort out how you feel about the options that are available to you and help you make a plan that's right for you and your family. If it helps, you can write questions and concerns below and bring them to your next appointment.

When your pregnancy goes past your due date

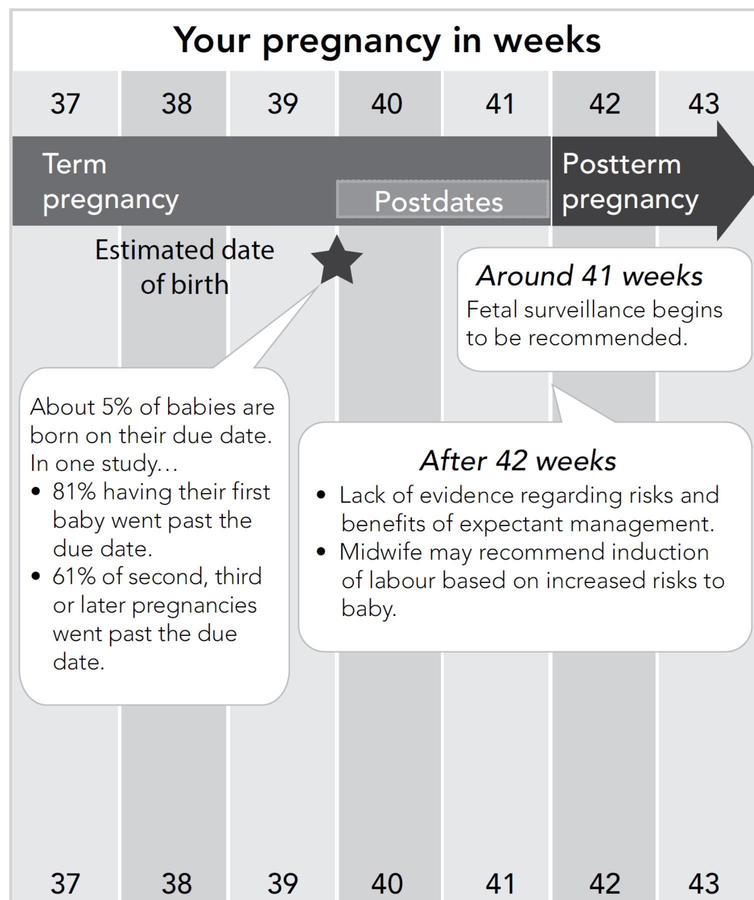


The length of a pregnancy is thought to be about 280 days, or 40 weeks. It is not unusual for pregnancies to last longer than 40 weeks. Anywhere between 37 and 42 weeks is considered a term pregnancy. A pregnancy that lasts longer than 40 weeks may be called a postdates, postterm or prolonged pregnancy.

Postdates pregnancy	A pregnancy that lasts between 40 and 42 weeks
Postterm pregnancy	A pregnancy that lasts 42 weeks or longer

What is an estimated due date?

It's important to keep in mind that estimated due dates are just that – they're best guesses based on the information available (such as the date of your last menstrual period or the results of an ultrasound). Only about 5 in 100 people give birth on their due date.



Your estimated due date may have a lot of emotional significance to you, your partner, and your family and friends. Expectations for your baby's arrival may be high, and you may feel frustrated if your baby doesn't arrive on time.

Your estimated due date is also significant to your midwives because it helps them assess whether your baby's growth is on track.

How often do pregnancies last longer than 40 weeks?

It's not clear exactly how many people experience postdates pregnancy. That's because different methods are used to estimate pregnancy length and different terms are used to describe pregnancies that last longer than 40 weeks. You are especially likely to go past your due date in your first pregnancy.

This document provides client-friendly information based on the Association of Ontario Midwives' Clinical Practice Guideline No. 10: Management of the Uncomplicated Pregnancy Beyond 41+0 Weeks' Gestation. It is designed to help you better understand some of the considerations and choices you may face while receiving care from your midwife. It is not intended to replace the informed choice discussions that you and your midwife will have. If you have any questions, concerns or ideas after reading over this document, please share them with your midwife.

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Why do we pay attention to a postdates pregnancy?

Most babies are born healthy, regardless of whether they arrive at term or later. However, there are certain risks that begin to increase after about 41 weeks of pregnancy, rising even higher after 42 weeks of pregnancy.

- In general, babies born after 41 weeks are at an increased risk of dying before or during labour (stillbirth) or soon after birth.
- When pregnancy lasts longer than 41 weeks there is an increased risk of problems arising in labour for which a caesarean section may be required.
- Babies born at 41 weeks and later are more likely to release a sticky poo called meconium into the uterus. Meconium usually isn't a problem, but if your baby breathes meconium into their lungs they can develop serious breathing problems (meconium aspiration syndrome). Babies who breathe meconium into their lungs receive care in a nursery or newborn intensive care unit (NICU). Most babies with meconium aspiration syndrome recover quickly.

Risk of stillbirth or death in the first week of the baby's life	
40 weeks	About 3 in 1000
41 weeks	About 1 in 1000
42 weeks	About 5 in 1000

Risk of meconium aspiration syndrome	
40 weeks	About 3 in 1000
41 weeks	About 5 in 1000
42 weeks	About 5 in 1000

- Babies born at 41 weeks and later are more likely to require the care of specialists and be admitted to the neonatal intensive care unit (NICU).

It's important to keep in mind that most postdates pregnancies are NOT associated with major or long-term complications. While the risk of certain complications is higher, the overall risk is still low. It's also difficult to predict whether you or your baby will develop problems as a result of postdates pregnancy.

What might happen if your pregnancy is postdates?

You might feel impatient. You, your partner, and your family and friends may have made preparations for your baby's arrival. You might be excited to meet the new member of your family. You may also feel physically uncomfortable – your back might ache and you may have a hard time getting comfortable enough to sleep.

Your midwife may recommend increased monitoring of your baby's well-being. Monitoring activities that your midwife may offer include:

- Counting how often your baby kicks during a specific time period.
- A period of monitoring your baby's heart rate using continuous fetal monitoring, called a non-stress test.
- Using ultrasound to measure:
  - the amount of water (amniotic fluid) surrounding your baby.
  - the baby's movements, muscle tone, practice breathing movements and amount of water around the baby, assigning a score for each measurement (this is called a biophysical profile).
  - your baby's growth.

In some situations, you may be offered the option of induction of labour. This is when labour is artificially started by one or more of these methods:

- Giving you synthetic prostaglandin by inserting a gel, tablet or pessary (like a tampon) into your vagina. Prostaglandin is a hormone that softens the cervix so it dilates more easily. In some cases prostaglandin will also cause the uterus to contract.
- Using an intravenous drip (a needle in your arm) to administer a synthetic version of oxytocin, another hormone that stimulates the uterus to contract.

- Rupturing your membranes or "breaking your waters" by making a small hole in the amniotic sac surrounding your baby in the uterus. This will often encourage the uterus to contract.

Because some methods of induction take place in a hospital (prostaglandin gel, oxytocin), undergoing induction of labour may limit your options for where you give birth. Many midwives will offer herbs, homeopathic remedies, acupuncture, castor oil, nipple stimulation, or stretch and sweep (see below) for those who are interested in natural alternatives to induction.

The alternative to induction of labour is called **expectant management**. This is when you wait for labour to start while undergoing regular monitoring of your baby's wellbeing. If monitoring (for example, ultrasound) suggests that your baby is not continuing to thrive in your uterus, induction of labour may be recommended.

What else may help you to go into labour?

There are other methods that are thought to encourage labour naturally. One that midwives frequently offer their clients is called stretch and sweep or sweeping the membranes. Your midwives will use their fingers to examine your vagina and assess your cervix. Depending on the degree of change to your cervix, your midwives will stretch your cervix open (stretch) and pass their fingers between the inside of your cervix and the bag of waters that holds your baby (sweep). This may feel slightly uncomfortable – you may even find it painful. Research suggests that stretch and sweep shortens the time before the baby's birth by an average of 3 days.

Other methods used to start labour include castor oil, acupuncture, homeopathy, naturopathic and herbal remedies. Little research has been done to establish how well these methods work or to test the ideal circumstances for their use. Please check with your midwives if you are interested in these alternative methods of starting labour.

Induction of labour compared to expectant management

One way that has been proposed to reduce the potential risks of postdates pregnancy is to induce labour once all pregnancies reach a certain point – for example, 41 or 42 weeks. Some research suggests that a policy of labour induction can reduce the already small risk that your baby will die during labour or afterwards. One problem with this approach is that hundreds or thousands of people will require induction in order to prevent a small number of serious injuries or deaths. Plus, the medical interventions used to stimulate labour and birth sometimes have their own risks:

- If your labour is induced you may be more likely to need a caesarean section or an assisted vaginal delivery (with forceps or vacuum).
- If your labour is induced your baby may be more likely to have breathing problems or require admission to a neonatal intensive care unit.

Ultimately, there is little good-quality research to suggest that one option offers clear advantages over the other. What this means is that decisions about whether to choose induction of labour or expectant management can be difficult to make.

As long as your baby is healthy and well-positioned for labour, your chances of having a normal and uncomplicated birth may be highest if you wait until 42 weeks for your labour to begin on its own. Monitoring of your baby's well-being in the meantime will help ensure that your baby continues to do well and will help your midwife determine whether or not induction may be advisable. If monitoring suggests that your baby is no longer thriving in your uterus, choosing to undergo an induction of labour before more serious problems develop may offer the best chance for a normal and uncomplicated birth.

Will a postdates pregnancy affect your choice of birthplace?

Having a postdates pregnancy doesn't necessarily mean you can't plan to have a home birth. There is little research to establish whether home birth is less safe than hospital birth for those whose pregnancies last longer than 40 weeks.

Because some methods of induction take place in a hospital (prostaglandin gel, oxytocin), undergoing induction of labour may limit your options for where you give birth.

Babies born at 41 weeks and later are more likely to release meconium. If you are laboring out of hospital and your midwives notice a certain type of meconium, she may advise you to transfer to hospital.

If you're over 40...

While stillbirth is an unlikely occurrence in any pregnancy, the likelihood that it will occur increases with age. For example, the risk that a stillbirth will occur at 39 weeks if you are between 40 and 44 years old is similar to the risk of stillbirth at 42 weeks if you are between 25 and 29 years old. That's why the Society of Obstetricians and Gynecologists of Canada suggests that clients who are 40 or older be considered postdates at an earlier gestational age (39 rather than 42 weeks). As a consequence, hospitals sometimes have policies in place that recommend that clients who are 40 or older follow different schedules for monitoring of their baby's well-being and/or induction of labour. However, there have been few research studies that evaluate whether or not this approach actually helps to decrease the small number of stillbirths that occur in someone who is older than 40.

Have you got any questions?

Share your questions, concerns and ideas with your midwife. Please write them down below and bring them to your next appointment.

The AOM is committed, through our statement on Gender Inclusivity and Human Rights, to reflect and include trans, genderqueer and intersex communities in all aspects of our work.In this document, there are references to sources that use gendered language to refer to populations of pregnant and birthing people. In order to accurately represent these sources, we may have maintained gendered language. We support research and knowledge translation that engages and reflects the entire childbearing population.

The development of this document was generously supported by the Canadian Institutes of Health Research.

How to recognise "true" and "false" labour

There is no such thing as false labour, only ripening labour.

RIPENING LABOUR	TRUE LABOUR
• Irregular contractions/ Irregular intensity. (ex: changing position may increase or reduce their frequency or intensity.	• Regular contractions
• Irregular length of contractions (2 seconds to 2 minutes)	• Intensity that increases, a change of position does not change anything in the intensity.
• Able to speak and move during the contractions	• Regular length of contractions (45 seconds to 1 minutes)
	• Unable to speak through a contraction
	• Possible small blood loss

When to call your midwife

- If your water breaks
- If you have regular contractions about 5 minutes apart (from begginning of one contraction to beginning of next) lasting 45 to 60 seconds, for at least an hour, or 2 hours for a first baby.
- If you have vaginal blood loss
- If you are anxious
- If you are uncertain

If you are uncertain…
If your waters have not broken, and you don't know that you are in active labour, take a warm bath (30 min) or shower and see what happens.

If this is your first baby…
Try to ignore your contractions completly and go about your daily activities. When this becomes impossible for you, it's the right time to call your midwife!

REFLECTION ON AN EXPERIENCE OF PHYSIOLOGICAL BIRTH

Leap and Anderson 2004: 28 from WALSH, Denis, Evidence-based Care for Normal Labour and Birth: A Guide for Midwives, 2007, p.48

To capture the anthropological perspective I have chosen to quote Anderson's poetic reflection on her experiences of physiological birth:

If you are privileged enough to have witnessed a women giving birth unaided in a place she has chosen, what will you have seen?

You will first be in awe of her strength. Her thighs stand strong and mighty like those of a warrior as she stands, sways and squats to find the best position to ease her baby out.

Then you will hear the deep primal cries she makes as she does her work, sounds that come not from her throat but from her belly as she grunts and moans with her exertion: sounds seldom heard except in the most uninhibited of love-making.

Maybe you will notice the glistening river of mucous tinged with blood and waters that run down her thighs unheeded: she is beyond noticing such things, moved as she has done into another plane of existence.

And then finally you will be struck by her beauty: her face softened with the flow of oxytocin, her eyes wide and shining, her pupils dark, deep and open.

And you will think — for how could you not? — what a phenomenal creature is a woman. But you will only have seen this astonishing sight if you understand that if you disturb her in her work, she will be thrown off course. Like a zoologist, you must first learn how to behave; how to sit quietly and patiently, almost invisible, breathing with her, not disturbing her mighty eternal rhythm. And you will see that the pain of her labours seldom overwhelms her.

Nature would not have organised labour to be intolerable.

Your Guide to Labour

This is a theoretic description of labour. It may or may not describe your own birthing experience.

AS LABOUR IS ABOUT TO BEGIN

What's going on in your body?

- Lightening : when baby drops into the pelvis. If this is your first baby, it'll happen anywhere between 2 to 6 weeks before you go into labour. With following pregnancies, it usually happens once labour has begun.
- Bloody show: light trickling, or a few drops of blood mixed with mucus.
- Mucus plug: might be tinted with blood. You may lose you mucus plug 2 weeks to 24 hours before labour starts.
- Weight loss: you may lose 1 to 2lbs in the last two weeks of pregnancy.
- Lower back pain is common.
- Rupture of membranes: your water may break. If so, advise your midwife! Labour will likely start very soon after.
- **Braxton-Hicks contractions bring blood flow to the placenta, and helps prepare the inferior part of the uterus for labour.**
- Sometimes, Braxton-Hicks give you the impression that your labour has begun.

LATENT PHASE & EARLY LABOUR CONTRACTIONS

What's going on in your body?

- When your cervix dilates from 0 to 4 cm
- Lower back pain, diarrhea, abdominal cramping.
- Bloody show
- Your water may break!
- With back labour, you might only feel lower back discomfort/pain.

How you might be feeling…

- Tired of pregnancy, impatient and ready for labour to start. Staying active seems to get things going.
- A surge of energy, excitement!
- Nesting, getting your space ready for birthing.
- Shivers and tremors.

TIPS:

- It isn't uncommon for labour to start at the end of the day. If you're excited, use that energy! but try to rest often.
- You can even try to get some shut eye if you're tired.
- Follow your hunger cues. It's better to eat up now to give your body some strength for later on. Red raspberry leaf tea is a great drink to have!
- You can get some last minute stuff done for baby's arrival with the help of a close one. Make sure your bags are ready for the birthing center/hospital.
- Go ahead and plan some fun/relaxing activities for these last few days/weeks.
- How to know when it's the real deal: Walk around or take a hot shower. These are tried-and-tested ways to get out of latency and into real labour. The difference with real labour is that contractions become more frequent, stronger, and last longer, and cause the cervix to dilate and efface.

ACTIVE LABOUR

What's going on in your body?

- Your cervix will dilate from 4 to 8 cm.
- Contractions last anywhere from 45 to 60 seconds, usually 5 min apart (or less). They will be getting longer, stronger and closer together.
- There will probably be more bloody show, and your membranes may rupture. If this happens, amniotic liquid will leak or gush.

How you might be feeling…

- As labour progresses and becomes more intense, you might feel the need to turn inwards.
- It will become harder and harder to connect with
- those around you.
- You may find it hard to deal with back/leg pain.

'I'm letting go and trusting my body. My baby and I know exactly what to do.'

TIPS:

- Take deep breaths, in and out. Inhale, exhale. Deep breathing will truly help your body handle labour.
- Massages and hugs from loved-ones can also help.
- Walk around! Do hip rotations, hang on to someone for support during a contraction if you have to. You can try different positions, change position as much as you need to.
- Visualize 'opening'. Surrender and let your body make way for your baby.
- Keep your bladder empty. Munch on some ice, drink water, and use a wet facecloth on your forehead, neck or back. You can take a bath or a hot shower.

Stay in the moment, take on only one contraction at a time; that's the only one that matters, and when it ends, it's gone forever. You can do this!

TRANSITION

What's going on in your body?

- Your cervix will dilate from 8 to 10 cm.
- There'll be 10-20 very strong contractions, lasting anywhere from 60 to 90 seconds and can be really close together.
- You'll be hot and sweaty. You may get leg cramps. Tremors and shakes are common. You may also throw up.
- You may actually even fall asleep during contractions!

TIPS:

- Stay in the present moment. Make eye contact with your loved-one.
- Visualize your body opening up, bringing your baby to you.
- Try as best you can to breath softly.
- Remember, during labour you don't owe anything to anyone. Everybody in your birthing space should be assisting you as you wish during contractions, and not disturb you.
- You have the right to express yourself fully in any way that comes to you in the moment: verbally, by making noises, with words, by moving around, by singing…

Ride each contraction like a wave. Do not try to swim against it, let yourself get taken away by it, trusting it will bring you safely to shore.

THE 2ND STAGE OF LABOUR

What's going on in your body?

- Your cervix is fully dilated.
- Your baby is coming down now. You will feel powerful internal pressure on your rectum.
- Contractions will still be strong, but they may be spaced out more.
- This stage can last anywhere between 30 min to 2 hours.

How you might be feeling…

- You might feel the urge to push, and/or the need to pass stool.
- Knowing that your baby is on his way may give you a boost of energy!
- As you baby is crowning, you will feel a burning or stinging sensation.
- Don't push too hard. Breath, pant and blow.

TIPS:

- Softly massage the perineum in between contractions.
- When pushing, get into a comfortable position (on all fours, squatting, half-sitting) and don't
- hesitate to change positions if you feel the need.
- Try getting 2-3 good pushes per contractions. Push as long as you feel the need to.
- Let the strong contractions guide you. You may need some guidance during this stage.
- Remember that baby will descend, go back up, and so forth, until he is born.

Labour and Birth in water

More and more women are considering, before and during childbirth, the opportunity to do some of their labour and sometimes to give birth in water. This option is interesting for the many benefits it offers. Indeed, the benefits of labouring and giving birth in water are multiple.

On the one hand, immersion in water during labour is recognized as an appropriate and effective option to promote relaxation and facilitate pain management. As a result, it gives rise to a greater release of endorphins (the body's natural painkillers), thus facilitating the secretion of oxytocin (hormone of the uterine contractions) and a decrease of the adrenaline levels (stress hormone). Immersion in water promotes relaxation, which leads to relaxation of the muscles, a more fluid breathing and therefore a decrease in the perception of pain. The flotation effect facilitates changes of position and ensures a great freedom of movement. It also reduces the feeling of heaviness. This helps to reduce the weight on the vena cava, thus promoting a better return of blood to the heart and thus, better irrigation and oxygenation of the uterine muscle.

Immersion also has the effect of creating a safe and soothing environment for the woman in labor. Some women report feeling less naked and thus, more comfortable before the eyes of others in this moment of great strength, but also of vulnerability. Note that the spouse can also immerse himself in the water to better support her weight (less strength is required) and massage his companion. He can also stay there to welcome the newborn.

Main benefits related to labor and delivery in water

- Facilitates relaxation (maternal energy saving)
- Provides relief from pain and muscle tension
- Decreases perception of contraction intensity
- Decrease the use of analgesics and anesthetics

- Decreases the use of oxytocic drugs (to increase contractions)
- Creates a weightlessness effect
- Facilitates position changes and allows great freedom of movement
- Reduces blood pressure (dependent on reduced stress)
- Creates a safe environment (feeling protected by and under water)
- Gives an impression of control over one's environment and the choice of positions ... which favors abandonment and letting go
- Can decrease the number and severity of perineal tears (warm water softens tissues)
- Provides great satisfaction to women - the majority says they want access to the bath again for a subsequent birth experience.

What is Water Birth?
Water birth is when you have your baby in a deep pool of water. Water birth is different than laboring in water. Many people spend some time in a bath or shower to help with their labour pains but don't give birth there. During a water birth, the baby is born under water and guided up to the surface by you and/or your partner or midwife.

If you are experiencing a healthy, low risk, term (37 weeks or more) pregnancy you might want to consider a water birth. Everyone's experience of birth is different, but people typically find that giving birth in water:

- increases relaxation
- decreases pain
- increases the ability to move around and change positions
- provides an increased sense of control
- increases satisfaction with the birth experience

If you are considering a water birth you and your midwife will discuss some important factors to help you make a decision including:

- your health status
- your baby's health status
- your personal wishes for birth
- if water birth is an option where you plan to have your baby
- the possible out-of-pocket cost to rent/buy a birth pool for a home water birth

Water birth is not recommended when:

- you go into labour preterm (three weeks or more before your due date)
- you are having more than one baby (e.g., twins or triplets)
- you are planning a home birth and don't have access to safe, clean water
- you have an active infection such as herpes
- you want certain interventions (e.g., epidural) that require monitoring outside of the tub

Where Can I Have a Water Birth?
If you have a midwife, you can have a water birth at home, or in a birth centre. Your midwife will help you decide which option is best for you.

Water Birth - Home
If you decide to have a water birth at home, you will require:

- a pool that can be filled with water deep enough to cover your belly but not your neck
- a reliable supply of hot water to keep the pool water at a safe and comfortable temperature
- space around the pool so your midwife can reach you and your baby from different angles
- a floor able to support the weight of a full pool of water

Home bathtubs are generally not recommended for water birth. You can rent or buy a portable pool made especially for water birth. These should always come with a special single-use disposable liner to help protect you and your baby from any germs that might be on the pool surface. Your midwife can provide you with information about:

- what to look for in a pool,
- where to buy or rent a pool, and
- how to minimize the risk of infection and plan for a safe water birth at home.

Water Birth - Birth Centre
All birth centres have large tubs that can be used for pain management and/or water births. Birth centre staff clean the tubs according to routine infection prevention and control protocols after every use; they make sure that the tub is clean and ready for you to use when you arrive.

Water Birth Safety

How will my midwife check on my baby's and my health when I'm in the water?

Regardless of where your water birth takes place (home, hospital or birth centre), your midwife will closely monitor you and your baby to make sure there are no complications developing. The monitoring you receive in the water is the same as you would receive out of the water. For example, midwives use a water-resistant tool called a Doppler to check the baby's heart rate. Check out our birthplace options pages to find out more about what happens during labour and birth with a midwife.

Midwives have the skills to identify and correct many complications early. Your midwife may ask you to get out of the birth pool/tub if you and/or your baby need to be monitored more closely. This could happen if:

- you have a fever
- your baby's heart rate is too high or too low
- you need to change positions to help birth your baby or your placenta
- you have heavy bleeding

Your midwife will prepare a space close to the pool/tub suitable for labour and birth. If they have concerns about you and/or your baby, you can quickly get out of the water and move to this space so they can assess you more closely. This space is also there if decide you want to get out of the pool/tub at any time.

Find out more about the education and training midwives receive to help you have a safe birth.

What if my baby breathes in the water?

This is a common question about water birth! It is very rare that a baby breathes underwater. There are a few documented cases of this happening; nearly all of these babies recovered completely.

Newborn babies have what is called the diving reflex. The diving reflex blocks off your baby's airways when they are underwater. This prevents them from breathing water into their lungs or drowning. In the short time your baby is underwater, they are still getting oxygen from the placenta through their umbilical cord (just like when they were still inside you!). When your baby is lifted out of the water and feels the air on their face and the change in temperature, they know it is time to take their first breaths.

Pain Relief

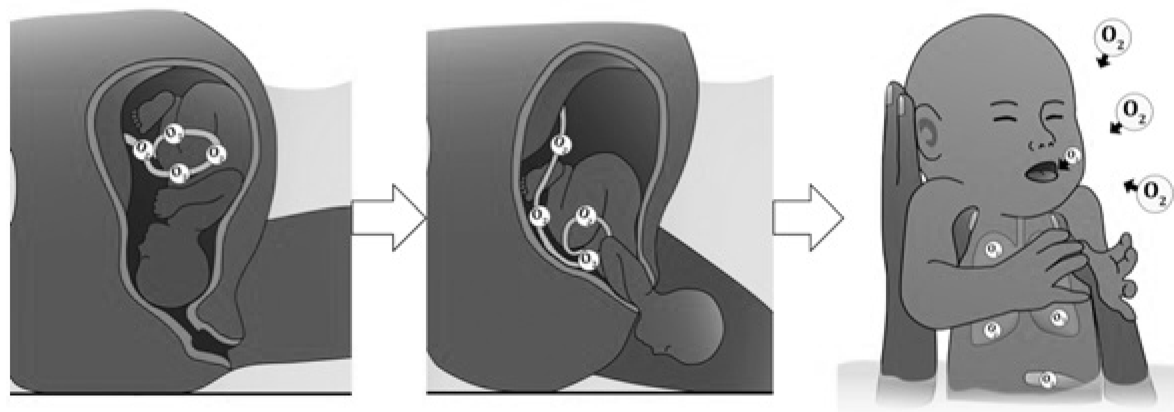
What are my pain relief options if I choose to have a water birth?

For many people in labour, being in a pool of deep, warm water provides adequate pain relief. Other comfort measures include:

- relaxation and breathing techniques
- position changes
- massage
- sterile water injections for back pain

The Research

What does the research say about water birth safety? Water birth is nothing new; it has been practiced around the world throughout history. There is a growing body of research that supports its' safety. The most recent study was conducted in Alberta, comparing the outcomes of water births with non-water births between 2014 and 2017. All of the research to date tells us that there appears to be no increased risk to you or your baby if you have a water birth[i].



Birthing parent outcomes

In general, people who have water births tend to:

- have less or the same amount of tearing
- have less or the same amount of blood loss
- have similar rates of infection
- use less pain medication
- feel more relaxed
- have shorter labours
- have greater satisfaction with their birth experience.

Neonatal outcomes

When you plan a water birth with a midwife there appears to be no greater health risk to your baby than with non-waterbirth. Research shows that neonatal birth outcomes for babies born in water are similar to those of babies born out of water, including:

- Apgar scores <7 at 5 minutes
- need for resuscitation
- need to go to the Neonatal Intensive Care Unit (NICU)
- infection
- neonatal death

There have been case reports that suggest water birth can cause infection and illness in babies. In fact, this is very rare. There are a few documented cases of newborns contracting an infection after a water birth, but these babies generally got sick because proper infection prevention methods were not used. To avoid this rare possibility, you should:

- have and maintain a safe source of clean water throughout your labour and birth
- use a pool that is easy to clean and disinfect
- set up and disinfect your birth pool properly
- avoid water birth if you have an active infection such as Herpes

Sources:

To learn more about the research on water birth, check out Evidence Based Birth.
https://www.ontariomidwives.ca/water-birth

[i] Research adapted from:

- Cluett ER, Burns E, Cuthbert A. Immersion in water during labour and birth. Cochrane Database of Systematic Reviews 2018, Issue 5. Art. No.: CD000111. DOI: 10.1002/14651858.CD000111.pub4.
- Bovbjerg ML, Cheyney M, Everson C. Maternal and newborn outcomes following waterbirth: The Midwives Alliance of North America statistics project, 2004-2009 cohort. J Midwifery Women's Health . 61 (2016), 11-20.
- Jacoby S, Becker G, Crawford S, Wilson RD. Water birth maternal and neonatal outcomes among midwifery clients in Alberta, Canada from 2014-2017: a retrospective study. JOGC [journal on internet] 2018 Dec 14 [cited 2019 May 01]. Available from https://www.jogc.com/article/S1701-2163(18)31036-3/fulltext.
- Nutter E, Meyer S, Shaw0Battista J, Marowitz A. Waterbirth: an integrative analysis of peer-reviewed literature. J Midwifery Women's Health. 59 (2014), 286-319.
- Taylor H, Kleine I, Bewley S, Loucaides E, Sutcliffe A. Neonatal outcomes of waterbirth: a systematic review and meta-analysis. Arch Dis Child Fetal Neonatal Ed. 0 (2016), F1-F9.
- Vanderlaan J, Hall PJ, Lewitt M. Neonatal outcomes with water birth: A systematic review and meta-analysis. Midwifery 30 (2018), 27-38.

How to boost your energy during labour

1. Deep breathing
2. Relaxation
3. Confidence
4. Dive into your labour, instead of resisting or controlling it
5. Surround yourself with love and send loving thoughts to your baby
6. Eye contact with partner or any other person who accompanies us
7. Welcome contractions one at a time, abandon yourself to it and let it go
8. Welcome comforting words and/or touch (massages)
9. Feel protected, confident, strong in your vision of childbirth. Ask for help, if you need it
10. Allow yourself to live out your emotions, to express them; this helps the energy to circulate throughout the body. This frees the intensity of birth on all levels (Power)
11. Recognise and accept the intensity of birth on all levels (Power)
12. Everything is appropriate for me and my child, in this moment
13. Humour
14. Make a nest for yourself. Favorite music, spread your energy in the room, create a peaceful serene environment
15. Provide fruit juices, herbal teas and honey, dried fruit, etc. That keeps up your energy
16. Work together with your child, make yourself a PASSAGE and visualise the route your child is coming down on.

Examples of Affirmations

Nancy Cohen and Lois Estner, « Silent Knife »

Affirmations can help you focus during the labour.
Choose from those that resonate with you, otherwise feel free to create your own.

Woman:

- I am a strong and capable woman
- I create a totally positive childbirth experience
- I accept my job, and I think it's exactly the right job for me and my baby
- My pelvis is relaxing and is opening (like those of countless women before me)
- I feel the love that others have for me during birth
- I treat my companion with love during childbirth
- I have a beautiful body; my body is my ally
- My birth is a learning experience, where I grow and change
- I accept the idea of a good and healthy pain
- I am strong, confident, sure of myself ... and woman
- I help my baby feel safe so that he or she can be born without fear

Man:

- I take care of myself during this pregnancy
- I see my partner as a strong and capable woman and I do not feel threatened
- I support my partner during her labour, even throughout the pain
- I express my love to my partner, easily and often
- I accept feeling helpless
- I accept the labour that is given to us
- I am sensitive, tender, open and confident

Role of partner or support person (overview)

The place of the spouse, partner or person chosen by the mother plays a crucial role during childbirth. Here are some ways to help the mother. Of course, every woman is different as well as the kind of support that will suit her, but here you have an overview.

- If labour starts at night and is still light, encourage her to doze or rest between contractions by helping her settle comfortably and gently massaging her, especially her lower back.
- If labour is long, ask the tired, drained people to leave the room. Send them for a little sleep or rest and call someone whose new energy will recharge your batteries. Better alternate sources of support than to run out.
- If it starts during the day, go to a place where you both feel good and intimate and work together to get used to the contractions
- Remind her that all this work is to birth your baby. Help her stay connected with the baby, in thoughts, in words, or touching him when you start to see the top of his head

- Help her stay active and eat as long as possible and prepare her food she would like to eat
- Organize the physical space for her, find her places to lean, hang, kneel, squat
- Stay in close physical contact with her
- Make sure that everyone in contact with her respects the atmosphere she needs
- Breath with her
- Apply warm compresses as needed
- Help her relax during contractions by gently touching the parts of her body that have the most difficulty relaxing
- Take your attention off the fetal monitor, if you are in a hospital setting where it is permanently connected. Keep your attention on your companion: she is labouring, not the monitor
- Encourage her to make the sounds that suit her, to let go with her contractions
- If she is tired or discouraged, give her an invigorating massage all over her body or give her a vigorous massage of the soles of her feet
- Look at her, make sure she can always find your gaze when she needs it
- If you need to rest for a while, find someone she likes to replace you
- Help her to relax completely between contractions, to think of nothing else
- Take her in your arms and rock her during or between contractions
- Point out what an extraordinary job she is doing by recognizing her efforts and generosity, rather than focusing on her performance
- Keep lighting to a minimum and always indirect. Ask the staff to work with a minimum of light, if you are in a hospital setting
- Encourage her to move, change position, get up to go to the bathroom

BEGINNING OF LABOUR

At night:
- suggest staying in bed with a heating pad or hot water bottle
- experience relaxation by breathing
- sleep between contractions

During the day:
- encourage the mother to keep up her daily activities, avoid falling into waiting mode, encourage rest when she is tired
- eat and drink regularly and encourage the mother to do the same
- later, the contractions will require more concentration
- be creative! It's a birthday celebration!
- be confident: you will find the way to your opening. Encourage the mother to open too
- establish a light and calm ambience, each step teaches us to cross the next
- establish a relationship with the mother through massage and / or eye contact
- express your needs, take your place
- count the frequency and duration of contractions
- allow yourselves to do some of the labour at home
- take care of the logistics (manage communications with relatives, organize the care of other children and pets, finalize the preparation of the suitcase and the infant car seat, etc.)

ACTIVE LABOUR (3 to 6 cm)

- more intense contractions, closer together and more regular; adaptation period
- learn to flow with this new energy
- deep conscious breathing becomes even more important
- the sound of breathing becomes the song of childbirth. Be creative and let it change according to how it feels
- if making sounds helps you, make deep (low pitched) sounds that favor opening;
- suggest moving, walking, changing position, especially if the baby is high. Adopt an attitude of openness

- vary the positions (vertical, lying down ...)
- if all the muscles around the mouth are relaxed, the cervix will be as well. Encourage the woman to leave her mouth soft during contractions
- a little rule if labour is going well: do what you dread most (ex: walk even if you do not always feel like it)
- as the intensity increases, repeat this key phrase: «The best way out of the pain is to enter it»
- continue to eat and drink to avoid hypoglycemia, and regularly provide the laboring woman with water and snacks between contractions
- If food does not go down well, suggest herbal tea with honey, juice or Gatorade, or simply ice cubes
- support the mother during the midwife's interventions (cervical checks, listening to baby's heart, intravenous insertion, etc.), and if the presence of medical personnel is required, be a source of comfort and familiarity facing the unknown and the unexpected

- suggest taking hot baths or apply warm compresses (face cloth with warm water) to the lower abdomen and back
- be attentive: she will need to express things that do not necessarily require solutions: that it is difficult, that it hurts, that she is afraid. Listening with calm and tenderness will help her a lot.
- the midwife can suggest massage techniques or pressure points
- «endorphin» hormones have a softening effect on pain, so encourage her to take advantage of the breaks between contractions

TRANSITION (7 to 10 cm)

** This is often the most turbulent phase of the delivery. At this stage, it is particularly important to serve as a beacon for the mother. Keep calm, speak words of love and reassurance. **

- there are sometimes plateaus (periods of stalled labour) in this phase; do not be discouraged. Offer words of confidence
- the mother sometimes needs to change her mental state, attitude (ex: to transform the perfectionism, the niceness, the docility) to truly embody her power
- the contractions are longer and closer together (some blood loss may occur)
- massage, touch, heat, warm compresses
- sometimes women do not want to be touched; be attentive
- the mother may vomit, shake: reassure her that everything is normal
- visualize the baby: she makes her rotation and comes down. Encourage the mother to visualize it too. If it helps her, remind her that the baby and herself are working as a team
- release the emotional knots by encouraging her to express her fears and her thoughts
- locking eyes will unite you to your strength
- if the labour is long, make sure you give yourself some space. Do not forget to eat and rest

PUSHING

- sometimes there may be a period without contractions or pushing efforts. Do not worry; it's often a time to rest before the expulsion
- pushing is a spontaneous reflex, by which the uterus will seek the assistance of the mother to give birth to the baby
- the first push serves as adaptation to the strong pressure on the vagina and the rectum
- sometimes, there are women who feel that the body is pushing on its own (the pushing action is then involuntary). We can guide so that the expulsion is not too abrupt. This prevents tears of the perineum
- when the woman does not feel this pushing sensation, she must make greater efforts
- each push makes the baby go down; for a first baby, the pushing stage is sometimes very slow, that is to say, that the molding of the head is done slowly. It can last between 5 minutes and 3 hours
- change position if the baby does not come down (semi-sitting, kneeling, squatting, standing, lying on the side). Support the mother physically in certain positions
- support the mother positively. Respect this phase of childbirth
- let the baby pass through, open up
- welcome the baby, take the time to touch her, place her on her mother's belly
- if the mother is not available, encourage skin to skin with partner or support person
- let out your fears, your emotions, your joys. Savour these unique moments in your life

Benefits of exclusive breastfeeding up to the age of six months and beyond

For the baby

- Decreased severity of allergic disease
- Decreases risk of infection
- Decreases the risks of digestive pathology
- Decreases risks of obesity
- The incidence of type 1 and type 2 diabetes appears to be lower in the population of children who have been breastfed for more than 4 months.
- Breast milk contains DHA (omega 3 fatty acid, which is very important for brain and retinal development)
- Psychomotor development is better in breastfed babies
- Better jaw development to reduce the risk of dental malocclusion

For the mother

- Secretion of hormones: contraction of the uterus thus decreased postpartum bleeding; appeasement and somnolence in the mother and infant
- Back to usual weight more easily for some women
- May delay return of menses
- Improves bone mineralization, so less osteoporosis
- Less arthritis and less diabetes
- Decreased risks of cancer

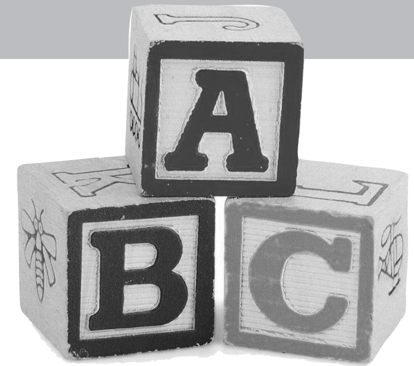
Practical advantages

- Breast milk is always available
- Breast milk is always at the right temperature
- The quantity of breast milk adapts, based on the child's demand
- The taste of breast milk changes according to the maternal diet, allowing the baby to discover the taste of different foods

Length of breastfeeding

The World Health Organization, as well as the Canadian Pediatric Society, as well as Unicef, recommend exclusive breastfeeding until 6 months of age, followed by continued breastfeeding, along with a diversified solid food diet, until the age of two and beyond...

The Benefits of Breastfeeding from A to Z



A- helps avoid allergies; immediately available; antibodies are passed from mother to baby through her milk; nutrients are more easily assimilated
B- creates close bonding between mother and child; reduces risk of breast cancer; contributes to optimal brain development; breastmilk doesn't stain clothing
C- comforting for baby; convenient; changes as baby grows; no constipa tion; colostrum is the perfect first food
D- digests more easily; cannot be duplicated; allows delay of solids; fewer dental problems (promotes proper jaw, teeth and speech development so there is less need for expensive orthodontics later)
E- easy; enjoyable; enhances relationship with your baby
F- fulfilling; always fresh; gives you a free hand for reading, etc; fewer health problems means a happier baby
G- giving of yourself; a great way of meeting emotional and physical needs; less garbage and other environ mental wastes
H- breastfed babies are healthier; babies are meant to have human milk
I- inexpensive; immunity factors are only found in breastmilk
J- joyful experience; ready in a jiffy
K- spend less time in the kitchen (mixing, washing, sterilizing, warming…)
L- loving; you can join a fun mother's group like La Leche League; less spitting-up and stomach upsets
M- delays the return of postpartum menstruation (but not necessarily ovulation); something only a MOM can do for a baby
N- perfect balance of nutrients; night feedings are easier; natural
O- prevents overfeeding; less diaper odour; reduces the chance of obesity later in life
P- prolactin helps you feel motherly; helps prevent serious health problems; milk supply is pure
Q- quiet time together; best quality nutrition; practically unlimited quantity
R- relaxing; less rashes for baby; recommended by the Canadian Pediatric Society, the World Health Organi zation and The Breastfeeding Committee for Canada; completes the reproductive cycle: conception, pre gnancy, birth, lactation
S- satisfies all the senses; superior infant food; saves time, effort money and resources
T- always the right temperature; travel is easier; time-tested through the ages
U- uniquely suited to each baby; contracts uterus helping to expel the placenta and control blood loss; uni versality of breastfeeding is a link with mothers all over the world
V- especially valuable in special situations (prematurity, jaundice); taste of breastmilk varies from skim to creamy during each feeding
W- helps mother's weight loss by using extra calories; no need to worry about baby's food supply; encou rages normal weight gain for baby; called "white blood" because of the life-giving properties
X- x-tra cuddling builds strong ties of love
Y- it's yummy of course!
Z- these are only a few of the zillions of advantages to breastfeeding your baby!

La Leche Ligue - Telephone: 514.990.8917 - Email: information@allaitement.ca www.allaitement.ca
La Leche League offers your family complete and free breastfeeding expertise

Beginning Breastfeeding

Written by Karen Butler based on original text by Sue Upstone, Ginny Eaton and mothers of La Leche League Great Britain.

Breastfeeding is normal and natural but it may take you and your baby time to learn. Milk production speeds up (your body makes more milk faster) if you nurse or pump more frequently. The emptier the breast, the faster your body works to replace the milk that was taken out. Milk is being produced at all times, and breasts are only ever about 75% empty, even after a very long feeding.

Breastfeed early

- Your breasts will already be making colostrum (first milk).
- Lay your baby against you skin-to-skin as soon as you can, to make the most of his inborn instinct to breastfeed. Ideally do this within the first hour after birth before any interruptions such as washing and weighing.
- It's never too late to start Biological Nurturing, even if your baby is sleepy due to drugs you had in labour—spending lots of time skin-to-skin helps babies breastfeed well.

Breastfeed often

- Babies have tiny tummies so they can't wait long for food.
- Encourage your newborn to breastfeed at least 8 to 12 times in 24 hours.
- Your colostrum (first milk) is made in just the right amounts for your baby's tiny tummy.
- Small, frequent feeds ensure that your baby takes in all the milk he needs—the more you nurse, the more milk you will make.

Colostrum

This concentrated milk produced in the first few days clears meconium (first poo), reduces jaundice and is rich in antibodies to protect your baby against infection.

Learn to breastfeed comfortably

- Getting your baby latched on well to the breast is the key.
- Get yourself comfortable and well supported.
- Keep your breast at its natural level.
- Hold your baby so his whole front is close against yours, wrapped around or along your body.
- Align him 'nose to nipple' to encourage him to extend his neck. That will help him open his mouth wide and get a deep, comfortable latch.
- Seek skilled help early on if you are finding breastfeeding difficult or uncomfortable.

Allow him to take a full feed

- There is no need to time each breastfeed—he will let you know he has had enough by letting go or falling asleep.
- Offer the other breast if he wants it. That way he'll get what he needs and your breasts will be encouraged to make plenty of milk.

Watch for signs he is hungry

- Wriggling or fidgeting, rooting (head turning) and fist sucking are all early signs of hunger.
- Offer a breastfeed while he is still calm—crying is a late sign of hunger.
- Just like you, he will be hungrier and thirstier at some times of the day than at others. Many babies 'cluster nurse' and space feeds closer together at certain times of the day, especially during the evening.
- Some babies sleep a lot at first because of the effects of anaesthetics during birth or because they're jaundiced. This can mean they're not able to feed as much as they need. More information about sleepy babies.

Watch for signs he is getting enough milk

After your milk comes in

- Listen for swallowing during feeds.
- At least three yellow 50p coin sized poos in each 24 hours are a sign he's getting enough milk.
- Seek skilled help if your baby seems constantly unsettled, even after a long breastfeed.
- Encourage a sleepy baby to feed actively 10 to 12 times in 24 hours. Hold him more and encourage latching on when awake and during periods of light sleep.
- **Is My Baby Getting Enough milk?**

Give only your milk

- Your healthy full-term baby doesn't need any other fluids or solids until around six months.
- Giving formula milk or other liquids reduces your milk production and may trigger allergies.
- As well as affecting your milk production, bottles or dummies can confuse your baby's sucking technique and make him reluctant to breastfeed. See Dummies & Breastfeeding for more about this.
- If a supplement is needed, try using a spoon, flexible feeding cup or syringe.

Night feeds are important

- Your baby will need to breastfeed during the night to ensure he takes in enough milk.
- Night feeds will help you to establish and maintain your milk supply and avoid engorgement, blocked ducts and mastitis.
- You can make night feeds easier by keeping your baby close by.
- For more information see our page on Safe Sleep & the Breastfed Baby.

Get to know and enjoy your baby

You will soon learn what he needs and enjoys. The easiest way to care for a newborn baby is to accept and meet his need for closeness. Dads and partners can enjoy closeness too —by cuddling, changing, bathing or carrying baby in a sling.

Settle into your own rhythms

The responsibility of looking after a baby 24 hours a day can be quite overwhelming at first. Try to relax—soon you will find gentle patterns emerging. You can then build on these patterns, creating a daily rhythm to suit you both. Read more about Rhythms and Routines.

Get out and about

Going out can prevent you feeling isolated and give structure to your day. It's possible to breastfeed a baby discreetly so that other people may not even notice. It helps to practise at home in front of a mirror. Offer a feed before your baby gets frantic—after all, a crying baby will guarantee an audience!

As time goes by

Your healthy baby needs only your milk until about the middle of the first year, when he starts to show signs of readiness for solids. If you are returning to work, you can express your milk and continue to breastfeed when you are together.

Growth spurts

Babies have frequent growth spurts starting in the first few weeks. During a growth spurt your baby will be extra hungry—nurse as often as you can to increase your milk production. Your breasts will also feel softer and more comfortable as your milk production is established. This can coincide with a growth spurt. Don't panic, you are still producing plenty of milk and feeding will settle down again soon. Have a look at the ways you can tell if your Baby Getting Enough Milk?

Coping with engorgement

Breastfeed as often as you can. Reverse pressure softening moves fluids away from the nipple area so your baby can latch on well:

- Press all five fingertips of one hand around the base of the nipple.
- Apply gentle steady pressure for about a minute to leave a ring of small dimples on the areola. You can also press with the sides of your fingers.
- Place your thumb on one side of the nipple and two fingers on the other side where your baby's lips will be. Gently hand express a little milk if needed.
- Warm moist heat just before feeding helps milk flow. Cold compresses between feeds help reduce swelling and pain.

Help for sore nipples

Remember—getting your baby latched on comfortably is important for preventing sore nipples. Pain is a sign that something needs changing—seek skilled help. Nurse your baby before he is really hungry. Offer the least sore breast first and try different nursing positions. Insert your finger between your baby's gums if you need to remove him from the breast. If you experience itchy or burning nipples or shooting pains during or between feeds consult an LLL Leader to help identify the cause.

Help for sore breasts

Redness, a tender spot or a sore lump may be a blocked duct. Avoid mastitis by nursing frequently to keep milk flowing. Use different nursing positions and check your baby's attachment at the breast. Rest and treat as for engorgement. Avoid bras and clothing that cause pressure on the breast. Seek medical help if things don't improve.

Seek support

It is OK to ask for help—it can take a while for breastfeeding to become easy, or for your baby to learn to breastfeed effectively. It will get easier as time goes on.

Vitamin D supplementation in infants

What is Vitamin D?

Vitamin D is a fat-soluble vitamin synthesized mainly in the skin under the effect of the sun. It can be absorbed through diet, but almost 90% of vitamin D comes from exposure to the sun. It's the sun vitamin!

It is essential for healthy bones and teeth and for good neuromuscular function. It is involved in the absorption, setting and elimination of calcium, according to the needs of the body. It allows tissues to grow, renew and solidify.

Rickets, although very rare, is the extreme manifestation of vitamin D deficiency. This disease affects the growth and development of bones. This can lead to stunted growth, lethargy, irritability, convulsions and being prone to respiratory infections (10). Rickets is a preventable and reversible disease with adequate vitamin D intake. Other health problems can be caused by a lack of vitamin D during the fetal period and in the baby, but the focus is usually on the prevention of rickets.

What are the sources of vitamin D?

The main source (90%) of vitamin D is the sun (1). Vitamin D is produced by direct contact with ultraviolet UVB rays with the skin. According to some studies, thirty minutes of full-body exposure at midday provides 50,000 IU (3) while a 20-minute sunbath during the summer months provides 10,000 IU to 20,000 IU of vitamin D (4). This exposure time is, however, contraindicated for a newborn.

Note that people with darker skin must expose themselves 5 to 10 times longer to receive their daily dose of vitamin D, because of the increased presence of melanin in the skin that acts as a protective screen UVB (5), and are therefore at greater risk of vitamin D deficiency.

Note that pregnant women who have adequate vitamin D intake during pregnancy and breastfeeding pass it on to the baby through the placenta and breastmilk, which helps them build their own vitamin D reserves.

Diet provides a certain amount of vitamin D. Here are some effective sources of vitamin D:

- 1 teaspoon of cod liver oil: 400 IU
- 100g of salmon: 400 IU
- 100g of tuna: 200 IU
- 3 ½ oz (100g) of trout, herring or walleye: 200 IU
- 1 cup (250 mL) of fortified milk or soy beverage: approximately 100 IU
- 1 egg yolk: 25 IU

Why give a vitamin D supplement to your baby?

The Canadian Pediatric Society and Health Canada recommend that all healthy, term newborns who are exclusively breastfed receive 10 µg / day (400 IU / day) of vitamin D supplements until their diet includes at least that same amount.

The rationale for this recommendation is based on the following factors: the northern latitude of Canada prevents full advantage of UVB rays representing the main source of vitamin D, the current practices of sun protection, the prevalence of rickets due to vitamin D deficiency and the safety of recommended doses (6).

Risk factors associated with vitamin D deficiency

- Lack of exposure to the sun
- The latitude
- The pigmentation of the skin (dark skin)
- Mainly indoor living
- Living in a big city where there is not much sun due to buildings
- The systematic use of sunscreen
- Wearing clothes that cover a lot of skin
- Low vitamin D diet

What do the studies say?

Some studies on the subject conclude that newborns without risk factors who are exposed to enough sunlight, meaning 30 minutes per week (4 min/day) wearing only a diaper or 2 hours (17 min/day) with a bare head only, could maintain a sufficient level of vitamin D (2). The latitude remains however an important factor. Indeed, these studies were conducted at lower latitudes (39th parallel) than the majority of Canadian territories. The Eastern Townships region, for example, is located at the 45th parallel.

That's why Health Canada says it's impossible to get a sufficient vitamin D skin synthesis between October and March. A study on the subject showed that between these months the dermal absorption of vitamin D could decrease by 80% and up to 100% (7). However, the populations looked at in this study came from Newfoundland and Labrador, populations living much further north (60th parallel) than us.

Various Vitamin D supplements :

There are several vitamin D supplements on the market, but one must be careful, as many of these products contain dyes and sugar.

D-drops vitamin D supplement for baby is from a natural source and of good quality. It is tasteless and odorless, and contains no added preservatives, artificial flavors or colors. It is free of wheat, gluten, soy, corn, sugar, milk and peanuts. A single drop on the breast before feeding allows the infant to receive his daily dose of 400 IU vitamin D.

Breast milk averages 5 to 136 IU / L (11). Note that around 3 weeks of age the baby drinks between 750ml and 1L / day of breast milk. Researchers have shown that a 90-second sun exposure of the entire skin surface of a breastfeeding Caucasian mother can increase her milk's vitamin D level by 10-fold (12). Another good reason to go get some fresh air !!!

References

1. Mistretta, V. I., Delanaye, P., Chapelle, J. P., Souberbielle, J. C., & Cavalier, E. (2008). [Vitamin D2 or vitamin D3?]. La Revue De Médecine Interne / Fondée ... Par La Société Nationale Francaise De Médecine Interne, 29(10), 815-820.
2. Edwards, Hertzberg, Specker, BL., Valanis, & Tsang, RC. (1985). Sunshine exposure and serum 25-hydroxyvitamin D concentrations in exclusively breast-fed infants. The journal of Pediatrics, 107 (3), 372-6.
3. Yu, C. K. H., Sykes, L., Sethi, M., Teoh, T. G., & Robinson ,S. (2009). Vitamin D deficiency and supplementation during pregnancy. Clinical Endocrinology, 70(5), 685-690.
4. Stiff, L., & Miller, S. M. (2009). Vitamin D: bringing light to the issue. MLO: Medical Laboratory Observer, 41(6), 24.
5. Holick, M. F. (2008). Vitamin D: a D-Lightful health perspective. Nutrition Reviews, 66(10 Suppl 2), S182-S194.
6. Santé Canada (2004) Les suppléments de vitamines D chez les nourrissons
allaités au sein. www.santecanada.gc.ca/nutrition
7. Sloka, S., Stokes, J., Randell, E., & Newhook, L. A. (2009). Seasonal variation of maternal serum vitamin D in Newfoundland and Labrador. Journal Of Obstetrics And Gynaecology Canada: JOGC = Journal D'obstétrique Et Gynécologie Du Canada: JOGC, 31(4), 313-321.
8. Specker BL, Valanis B, Hertzberg V, Edwards N, Tsang RC. Sunshine exposure and serum 25-hydroxyvitamin D concentrations in exclusively breast-fed infants. J Pediatr 1985; 107(3):372-6
9. http://www.llli.org/faq/vitamin.html
10. Wagner, C. L., & Greer, F. R. (2008). Prevention of rickets and vitamin D deficiency in infants, children, and adolescents. Pediatrics, 122(5), 1142-1152.
11. Heinig, MJ., (2003). Vitamin D and breastfed infant: Controversis and concerns. International Lactation Consultant Association, 19 (3), 247-49.
12. Greer, FR., (2001). Do breastfed infant needs supplemental vitamins? Pediatric Clinic of North America, 48(2), 415-24.
13. Godel, J (2007, renewed on Jan 30, 2017). Canadian Pediatric Society. Vitamin D supplements: Recommendations for mothers and their infants in Canada. Paediatry Child Health 2007;12(7):591-8

I'll take care of my perineum.

by Marie Panier, D.O., Perinatal Osteopathy

A little history

Western medicine has only recently become interested in the function of the perineum, and even more recent is the interest in its rehabilitation and protection.

Recently, reconstructive surgery was the only alternative when problems appeared.

It was only in 1984 that perineal rehabilitation was given pride of place in Europe, while here on the American continent, there was still no mention of education or prevention.

The only preventive proposal during childbirth was episiotomy.

The fact that the perineum is still considered as a «taboo area» does not work in favor of this knowledge, let alone education. It is surprising that nowadays, many women discover this part of their bodily intimacy during their first pregnancy during prenatal sessions.

In Europe, education and perineal rehabilitation have been the subject of special care for almost 30 years now, integrated into the traditional pre- and post-natal care.

Fortunately, this interest has now been present on our continent for about ten years.

It involves people trained in this type of work (physiotherapists, doctors, nurses, specialized yoga teachers, etc.), motivated by bodywork, and having a good perception of their own bodies, which implies personal work. This is indeed crucial since it has been proven that urinary incontinence problems can be caused in 35% of cases by poorly adapted post-natal gymnastics sessions.

We are therefore lifting the veil on a problem that is modestly hidden by women, but fortunately identified by health professionals, who are committed to preventing, educating and rehabilitating women during the perinatal period or even later.

We know that 80% of pelvic floor disorders in women are inherent to pregnancy and childbirth. And since we also know that a good education or rehabilitation by professionals accredited for this purpose can positively and drastically change the social and intimate life of 3 out of 4 women, we encourage you to consult during the prenatal and post-natal period.

Dear perineum, who are you? Where are you?
The perineum, to describe it very schematically, is the muscle hammock that closes our abdomen from below. It is located between the pubis, the lateral ischials, the coccyx behind and contains 3 openings from back to front: the anus, the vagina, and the urethra.

The back of the pelvic floor is the thickest, more toned and stronger than the front. The anus must hold the stools, while the urethra is thinner and more adequate to manage urine fluctuations. Many muscles cross and intertwine from front to back, from one side to the other, superficial, deep, sphincter level... Very schematically and without going into the details of an anatomy class about it, it is important to visualize it and perceive it in its entirety.

Some people call «perineum» the only small part between the vagina and the anus. It is precisely this one that will be relaxed, stretched and distended when the baby passes through. It is therefore reintegrated into the entire pelvic floor that it is interesting to educate or re-educate.

What is perineal education?

It would not be crazy to teach little girls (and little boys, for that matter, because incontinence also concerns men through anal incontinence) to locate their pe-

rineum, to become aware of it and to lock it during intense efforts (coughing, carrying loads, changing positions, sports, laughing, climbing stairs...)

It should be remembered that 60% of female Olympic athletes suffer from urinary incontinence when practicing their discipline and that 13% of teenage girls are also incontinent in physical education classes. Yet both are still young and have not given birth. This shows how poorly this area of the body is protected and deserves attention.

Perineum, oh perineum, what can I do to get to know you?

1) LOCATE YOUR PERINEUM
Sitting on a chair, leaning with the forearms on the thighs (to release the perineum from the weight of the abdominal muscles), contract the perineum like this:
- A little bit
- A little bit +
- as much as possible

Hold for a few seconds and release:
- a little bit
- a little bit +
- absolutely

The image of the elevator going up from the ground floor to the 3rd floor, then down after a few seconds can help you. This exercise can be completed by further relaxing by lowering the elevator to the (-1) basement.

This same awareness can be done lying on your back, legs bent, feet on the ground.

2) Once this awareness is integrated, in the same position to begin with, integrate breathing into it.
- lock the perineum (=maximum contraction)
- exhale while maintaining the contraction
- at the end of expiration, release the contraction and inhale
- repeat this sequence for a few breaths without shortness of breath

- to increase the effect of this exercise, intensify the contraction throughout the exhalation, or again, extend the exhalation.

CAUTION: It is important to create a rhythm with your breathing so that the perineum has time to contract and relax in its entirety (in the entirety of the tissues and in all its thickness, i.e. +/- 5 seconds)

On the other hand, if you feel that the perineum relaxes in the middle of the exhalation, stop the exercise and return to the first one.

If you have any difficulty locating your perineum, here are some «little tricks»:

1) Try to stop (or slow down if stopping is not possible) urine when urinating. Do it only once and in the middle of the urination (at first the flow rate is too high, at the end you might stop the urination and keep urine in the bladder).

2) Sitting comfortably, leaning, back against cushions, legs bent and spread, soles of the feet against each other. Choose a quiet time in a place where you will not be disturbed. Place your hand flat on the pelvic floor (heel of the hand near the pubis, fingertips

towards the coccyx). Contract the perineum, according to the previous instructions; your hand will give you a sensation even if you do not yet feel the contraction of your perineum through it well.

3) In the same position, but this time without clothes, place a small mirror in front of you and repeat the same contraction. Here you will have visual confirmation of what you are doing.

4) Lying on your back, knees bent and feet rested:
- Lock the perineum
- Exhale by pushing against the floor or carpet with the lumbar region (tilting of the pelvis), keeping the contraction of the perineum throughout the exercise;
- Release at the end of exhalation and inhale.
- Repeat a few times according to the rhythm of your breathing.

Now that the perineum is well located, it is more interesting in the context of a good perineal education, to work on it: in different positions, in movement, in gravity, because it is in everyday life that the pelvic floor must be able to respond to the demands.

Repeat exercises 1, 2 and 3 to relearn the sensation in different positions and situations:
- Lying on your back. Feet against a wall
- On all fours
- standing with your back against a wall
- standing without support (in a lineup for example)
- by walking
- sitting on your heels
- by going up the stairs
- lying on one side, head supported by one hand
- sitting in a car (at a traffic light for example)....

The more you resist the air outlet by pinching the lips as you exhale, the more you stimulate the contraction of the abdominals and thereby increase the contraction of the perineum.

5) While standing, place one hand on the lower abdomen (just above the pubic bone)
- Lock the pelvic floor
- Exhale quickly and strongly by contracting the abdominals in jerks until the lungs are empty.

6) Since the pelvic floor and the thoracic diaphragm are in synergy (these 2 diaphragms are parallel), be aware of your rib cage, closed at the bottom by the thoracic or respiratory diaphragm, just like the perineum that closes the abdomen.

To become aware of this, sit comfortably on cushions, bent legs, knees apart, soles of the feet against each other. Place your hands flat on the edge of the rib cage, and breathe deeply, paying attention to its movements. As you inhale, the ribs widen and rise, as you exhale, they tighten and descend. Once this awareness is achieved, continue without the help of your hands and accentuate the movement of your ribs.

Thirdly, try to mobilize your rib cage according to the same parameters but this time independently of your breathing.

When this has become easy for you, add the contraction of the perineum and compare the degree of ease of this contraction according to the position of the chest diaphragm, i.e., diaphragm up and ribs apart or diaphragm down and ribs tight.

You have become an expert in the «art of perineal education». As you have understood, this is an excellent way to prepare for the birth of your baby, but a wonderful prevention to keep your pelvic floor healthy (less episiotomies and perineal tearing after proper preparation). Moreover, your sex life, as you might expect, will be all renewed.

Protecting your perineum

The concept of protecting the perineum during labour is paramount in the prevention of incontinence (urine leakage)

This includes:
1. exercises to facilitate proper muscular strength
2. good habits to develop and maintain on a daily basis. During physical effort, most of us have a tendency to contract our abdominal muscles and block our breathing. This actually lowers our diaphragm, which in turn pushes into the organs of our pelvic region (uterus, bladder, intestines). The more intense is the physical effort, the more intense is the push on our organs. In the long run, the accumulation of 'microtraumas' creates a literal descent of the bladder and uterus in women, and inguinal hernias in men.

Breathing exercises
1. Sit at the edge of a chair, elbows resting on your knees and back straight
2. Tighten your perineum (as if to prevent urination)
3. While keeping your perineum tightened, exhale by squeezing your belly from the bottom up (as in, do not lower your thorax while exhaling)
4. Release your perineum
5. Release your stomach muscles (which will automatically make you inhale)

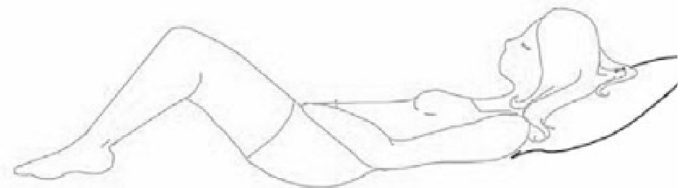
This can be done in sets of 12 breaths. Do not do too many, as that can cause unnecessary stress to the perineum.

Protection in everyday movements
Whenever you use your abdominal muscles, try thinking of tightening your perineum muscles as well. This helps protect your perineum. You can do this by:
1. Locking the perineum muscles before any straining physical effort
2. Exhaling before any straining physical effort.

You should note that this is hard to think of at first. With practice, the brain will automatically do it. At that point, you'll even be able to notice what type of movements create pressure on your perineum!

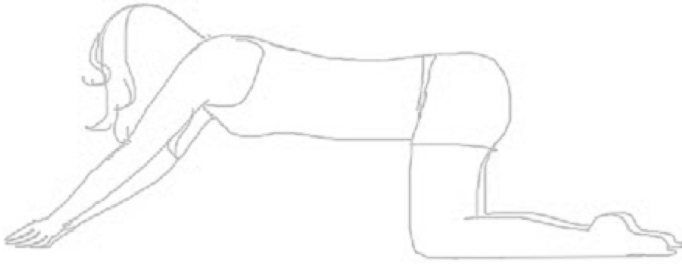
Before giving birth:
You can do all of the above mentioned exercises in preparation for labour. The exercises can be done as described above. Placing your elbows on your knees will even help make room in your belly.
Strengthening your perineum is perfectly safe during pregnancy and can even help with incontinence, which is common because of the hormone relaxin that relaxes the ligaments in the pelvis. This is especially common in subsequent pregnancies.

After giving birth:
1. Right after birth, you can practice tightening your perineum. It is very likely that you won't feel anything at all in the beginning. You should continue anyways. You should also think of exhaling every time you move around (like when you straighten yourself up, when you get up in and from bed, etc.)
2. As soon as possible, and as soon as you feel ready, you can start exercises while lying on your back in bed, legs bent and feet flat on the mattress, as pictured below.

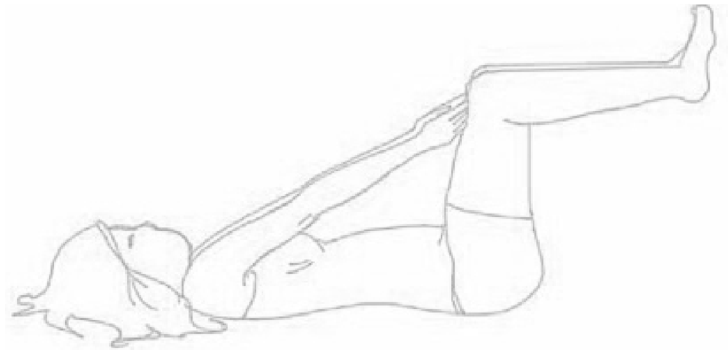


3. If you have difficulty feeling the correct movement, you can also try going on all fours. While kneeling on your bed, put your toes together and sit on your heels, as pictured below. Your hands should be stretched out as far as possible in front of you.

Once you are comfortably in this position, pull yourself up on all fours, bringing your hips up and aligned (parallel) with your knees. Note that your shoulders should not be parallel with your hands, allowing your hands and wrists to be comfortable.



a) Clench your perineum
b) Blow air up and down by pushing on your hands
c) Release your perineum
d) Release your belly (and thus inhaling)



BASIC POSTNATAL EXERCISES

These exercises aim on one hand to strengthen the perineum and, on the other, to make your abdominals work in a way that is not traumatic for your perineum.

The physiological diastasis that manifests during pregnancy on the rectus abdominis (the two, parallel muscles that run vertically down the front wall of the abdomen) should be strengthened to avoid any weakness to the linea alba (the white line of connective tissue that runs in between the rectus abdominis)

1. Repeat the basic breathing exercises from above while lying on your back, your legs bent, in sets of 10 (make sure to never force exhalation from the top of your chest/thorax).
2. While lying on your back, put your feet up against the wall.
3. Place your hands on your knees with your fingers turned inwards and elbows apart. Perform the breathing exercises while clenching your perineum muscles. When it's time to exhale, push your hands towards your knees (as if you're pushing your feet into the wall). If the exercise is done well, your back should be pushed into the ground, allowing your neck to stretch and your belly to move inwards, towards the spine.
4. In the same position, continue by putting both hands on your right knee. Repeat the same brea thing exercises as above. Do this 5 times, then re peat on left knee.
5. In the same position, continue by putting both hands in the middle of your right thigh. Repeat the same breathing exercises as above. Do this 5 times, and repeat on middle left thigh.
6. In the same position, continue by putting both hands at the base of your right thigh. Repeat the same breathing exercises as above. Do this 5 times, and repeat on the base of your left thigh.

These four exercises will help bring your rectus abdominis closer together.

If you feel like these exercises are well integrated, you can make them even more effective by tightening your perineum muscles a second time right before releasing them. The perineum muscles will tighten more profoundly than the first time, thus strengthening the muscles that run alongside the entire length of the vagina (the external and internal muscles are antagonist, and therefore cannot contract together).

My perineum, what about after the birth then?

by Marie Panier, D.O., Perinatal Osteopathy and Caroline Gauthier, Professor of Pre- and Postnatal Yoga

This is where perineal rehabilitation begins because the muscles have been so distended that it is advisable to reappropriate them. Even if you have given birth to a small baby, even if you have not had an episiotomy or tear, even if you have given birth by caesarean section, it is advisable to re-educate your pelvic floor. The mere fact of pregnancy and the hormonal impregnation associated with it has an influence on the relaxation of the perineal muscles.

That said, the more the integrity of the perineum is respected, the shorter the rehabilitation will be. It has been shown that the earlier rehabilitation is undertaken, the better the results. In addition, pelvic floor muscle contraction exercises promote uterine involution, have a beneficial effect on intestinal peristalsis, proper bladder function and increase local circulation (thus promoting the regression of hemorrhoids and the healing of cesarean section or episiotomy).

According to Ayurvedic medicine, the ability to control contraction and perineal relaxation through appropriate exercises also promotes the concentration of vital energies in the base of the body like a good home fire in a house. When the base is sufficiently toned, the rise of this energy in the spinal cord to the brain increases in the person, vitality, concentration, memory, endurance, sexual strength, joy, health and creativity.
At first, limit yourself to a simple contraction of the perineum for a few seconds.

In the following days you will be able to resume the exercises1, 2 and 3 that you were already doing during the prenatal period (see the previous article on the prenatal period)

At the beginning and for a few weeks, (depending on the condition of your perineum, the time of expulsion, the cranial perimeter of your baby...) the exercises are done in positions that free the perineum from gravity and the weight of the organs.

- Dorsal layer
- Lying on the side
- On all fours
- Lying on your back with your feet against the wall
- Sitting, forearm resting on thighs
- These exercises should under no circumstances be painful or tiring.

At first, you may feel like you're not contracting anything at all, but persevere and you'll see it evolve very quickly.

The ideal (and the speed of rehabilitation will depend on it) is to repeat these exercises several times a day. A good way to think about it is to do it after each feeding.

And at all times, what is true and good before the birth, is the same after the birth:

LOCK YOUR PERINEUM BEFORE ANY EFFORT.

The abdominal rehabilitation phase begins later (when the perineum has regained its effectiveness, strength, tone); usually 6 to 8 weeks after delivery. It will follow this sequence: prolonged exhalation, accompanied by contraction of the pelvic floor, pelvic tilt and deep transverse contraction (just above the pubis). The relaxation is done on inspiration.

For prevention, classes are usually given collectively, in the presence of the babies and are an opportunity, when you feel ready, to meet other new mothers; they therefore allow you to take care of yourself both physically and morally.

And be aware that in more problematic situations (urinary incontinence, significant tearing of the pelvic floor during childbirth, rectocele, bladder descent...) there are now different specialized individual follow-up. Check the competence of the people who offer them; because a poorly guided post-natal activity can create more damage than benefit.

It is always advisable to check the mobility and integrity of your pelvis at the very beginning of perineal rehabilitation, which can fix or even aggravate pelvic disharmony.

Courage and good luck. May your daughters and granddaughters benefit from your knowledge.

But Why do Babies Cry?
Night wakings, Cries, and the Needs of a Newborn Baby

Ingrid Bayot, Instructor of physiology of neonatal adaptations and breastfeeding, Institut CoNaître
Translation: Julia Goernet

The human baby makes a lot of noise while crying. The position of her vocal cords in her larynx allows her to produce a powerful sound. If we were to compare in terms of decibels, it compares to the noise of a diesel engine or a lawnmower! An adult trying to vociferate in this way wouldn't last an hour. A baby, on the other hand, is able to cry loudly, and for a long time.

If we go back in time to our distant ancestors, it seems at first glance illogical that it be this way. How could natural selection favor the ability of such a vulnerable species at birth to scream so loudly? Surely, the loud noise of a screaming baby would attract predators, putting the small settlement at risk. Wouldn't a discreet squeak, like that of baby giraffes, kittens or puppies, have been more careful?

Certainly... But giraffes, cats, and dogs, like most mammals, learn early on to move quickly to their mothers in case of danger. In terms of its locomotor abilities, the small human baby is born 'prematurely', meaning that our species has a very large cortex and therefore an important cranial perimeter. In determining the duration of pregnancy, «nature» made a trade-off between the size of the female pelvis and that of the fetal skull. Brain maturation, far from being completed at birth, makes human babies highly dependent towards their caretakers. In fact, babies depend on the food and warmth we provide them with, and also the attention we give them. This long-term care creates intense bonds between the babies and the caregivers, and participates in the complex psychogenesis of the human being.

We like to romanticize the «primitive good mothers" and the «good savages» who knew «instinctually» how to take care of their babies. But if that were the case, human babies probably wouldn't have needed such an impressive vocal apparatus. As a matter of fact, their reality was harsh: women would die in childbirth, and injury was a lot more common. Sometimes, women had little to no desire to take care of their babies. We love to idealize women… Alas! Women are not archetypes.

So put yourself in the shoes of a newcomer. You have just arrived and perceive the urgency to communicate, but you do not yet have access to the language. Because your basic needs need to be met for survival, you find the most effective way to make these people take care of you: you produce an unbearable noise that potentially endangers them all! This noise effectively ends once you feel better, safe and secure suckling at the breast. Of course, babies cannot reason all of this consciously, but let's say natural selection definitely favored those who knew how to get noticed. It is more of a strategy of the species than of the individual, per se. And this primal instinct seems to have done the trick! Our species has proliferated, prospered and invaded all the biotopes on the planet.

In rich countries, concepts of pregnancy and birth monitoring, responsible parenting, contraception and their frequent corollary have emerged: the desire for a child. In terms of human history, this vision of reproduction is very recent. Women now have a say in their biological destiny, or can even refuse it, and in any case no longer suffer from it. The project of having a child can be discussed, thought out, and acted out in a more conscious manner. Many parents are intentional and caring. They are not the first of our species to behave in this way, far from it, but new freedoms of choice can ultimately contribute to a better welcoming of a child.

However much we are more prepared and intentionally becoming parents, newborns are not privy to all of this. Despite all the well-meaning attention of parents, babies of the twenty-first century howl as vigorously as hunter-gatherer babies once did when they are upset. Old survival reflexes developed over

millions of years do not fade in a few generations. Yet today's parents, with their intentionally small families that they have decided upon, have now little opportunity to witness what it's actually like to have a baby. Babies in magazines don't cry (except perhaps in diaper ads, especially when they don't yet have that special, leakproof diaper). In fact, babies in magazines stop crying when their parents buy them a bunch gadgets, toys and creams for their sensitive buttocks, and babies in magazines smile when their parents put money aside for their college tuition.

After two sleepless nights with a real baby in their arms, dismayed parents ask themselves this now existential question: «But why is my baby crying?»

And that's when they will get to know the opinions of relatives, maternity ward staff and early childhood professionals. Everyone seems to have their own explanation: some, full of common sense, others fuelled by fear. There's **projection** of our own emotions, there's confusion on how a baby's neurological and digestive systems work, and there's downright unrealistic, **pseudo-educational fantasies**. These three pitfalls in understanding the rhythms, cries and needs of baby humans deserve to be stopped; they are failing us.

To **project** is a mental mechanism that involves assigning to others our own cues, abilities, problems or emotions. It generates many errors of judgment and misunderstandings. Adults have well-established **benchmarks** to assess time of day. Our chronobiology has successfully evolved on the day-night rhythm; we have high energy in the middle of the day, and feel fatigued in the evening. In general, we work during the day and sleep at night. More or less consciously, we expect that newborns will already have an adult circadian rhythm. "*She wakes in the middle on the night ready to start her day!*" says the desperate parent of a newborn.

Adults are easily programmable: in a few days we adapt to summer or winter time, time shifts or even night work. But to think that babies can be programmed so quickly is getting ahead of oneself.
We also attribute many of our emotions, such as sadness or anger, to baby's cries, but the emotions linked to crying and hunger are much stronger… indeed, they stir visceral fears of absolute despair and abandonment, or even death (from starvation).

Let's try to sort this out a little bit....

First observation:
What we're imagining about babies' cries is disheartening.

In most settings, a crying adult makes everyone uncomfortable. We do not know how to react; approach him, leave him? We've lost our spontaneity. An admission of weakness, of overwhelm or, even more suspicious, a desire to manipulate, crying has become indecent and taboo. We have lost the habit of seeing people cry; adults hide to break down in tears when, not too long ago, Victorian novels were much more realistic in depicting emotion, dedicating pages to torrential tears. The collective mentality focused on beating, winning and performing is imposed on adults of both sexes and does not have room for tears. How dehumanizing is that! Isn't crying the simplest and most effective outlets for tension, the most natural way of self-soothing? (Let's reinstate crying and watch the average Westerner consume less and less chemical tranquillizers!)

Second observation:

We're confusing hunger for starvation.
In our countries, we're not used to feeling hunger anymore, mostly because we eat a lot, and because we follow a schedule based on work shifts. Could this be why hunger is so dramatized? 'I'm starving', 'I'm dying of hunger' and other similar expressions are just a tad exaggerative, yet are common usage. The concepts of hunger and starvation are often blurred. We hear a lot of 'world hunger', when the actual problem is actually malnutrition (which leads to starvation). Why so much confusion?

Food has never been so readily available. And fast food, junk food, and sugar have never been so easily accessible! In a consumer — or should we say 'wasteful'— society, we seem pretty obsessed with the notion of deprivation… Is there a void that we're trying to fill?

We seem to have forgotten that hunger cues are actually preventative. We need to feel hungry before our bodies tap into its energy reserves. And an adult has quite the reserves! In fact, if staying properly hydrated, an adult can fast for a few weeks without putting his life in danger. Hunger cues do not express an imminent end, rather, that the time to eat is coming up. Mealtime varies greatly from one culture to the next, and has changed over time as well. Typically, eating is a convivial activity that humans partake in together, either with friends or family, at a specific moment of the day. Our hypothalamus is responsible for controlling our biological clock, and it does a good job at remembering our daily habits, letting us know that we're hungry at the established times. What we consume maintains our reserves, but does not overturn deficits we may have.

Lest we forget: we are physiologically wired a certain way thanks to distant ancestors who had no refrigerators and no supermarkets. If their bodies had given hunger cues at an advanced stage of depletion, they would never have been able to muster the energy to hunt or gather. It seems that creating energy reserves and preventative cues that are highly sensitive to our social habits is a pretty good way of making sure the human species survived throughout millennia.

Even if we did widely accept this fact, we would be hard-pressed to change; our habits and tendencies regarding food are so intertwined with our feelings and emotions, that there would hardly be anything more challenging to change. Deep down, hunger is still associated with deprivation and shortage.

Third observation:
Cries and hunger make for a jarring combination.

In a society where crying is so shunned and hunger is so dramatized, one can only imagine how a baby's cry for hunger, being as urgent and desperate as it is, can only mean the baby is starving. (That, or that she's colicky. Colics are one of our most revered narrations around baby discomfort. After all, there aren't any diaper pins to poke babies anymore.)

In the same vein, feeding a baby who hasn't shown explicit (and vociferous) hunger cues is considered overindulging. Apparently, intense stress can be the only way to know for sure that baby is starving…

In today's specific context, the notion of 'feeding on demand' becomes a trap. Feeding on demand is a relatively new notion that sounds pretty permissive, and our habit of projecting has generated confusion and misunderstandings from it.

Parents, and especially the breastfeeding mother, will face tremendous — if not unbearable — pressure when their baby cries a lot. '*Has she had enough to eat? Is she still hungry? Well, obviously, since she's still crying*.'

Enter: the Bottle. This contraption is manageable and is easy to fill. Because of this, parents can 'know how much baby got'. But more than filing baby, we could say that the bottle also fills new parents with reassurance. Whether we like to admit it or not, we often doubt mothers, and mothers oftentimes doubt themselves, especially when it comes to nursing.

It should be noted in passing that humanitarian organizations readily use images of crying babies to illustrate the extreme destitution of the populations that need to be rescued by the charitable West. Vulnerable children, hunger, famine, and suffering are all amalgamated to create an image that resonates with our deep abandonment fears. And so, we donate. In a lot of ways, donating to a charity is like giving a newborn 'just a little' supplement from a bottle: both come from the same logic; that of appeasing some sort of deep wound within.

If we wish to calmly understand the cries of a newborn, we must first acknowledge our own fears of deprivation and abandonment in order to move past them. Our projections, infamous at misleading us, span towards the subconscious of our caregiving minds. This is especially important for our society's newborn 'specialists' (nurses, midwives and doctors) who play a major role in informing new parents on how to care for a baby. Because when it comes down to it, knowing all the facts on colostrum and all the benefits of exclusive breastfeeding led by baby's cues

is just no match for the overwhelm and desperation of new parents when you think you've failed your baby.

'Babies wake because they're hungry,
cry because they're very hungry,
fall asleep because they're full,
sleep long stretches because they've had enough to sustain them.'

These are few sentences that demonstrate how we've gotten the neurological and the digestive systems, and their respectful functions, mixed up. And these beliefs still persist in our collective mind, conveyed through healthcare professionals and well-meaning relatives, by books, media and TV shows. Indeed, it's let on that the nervous system is submitted to the level of fullness of a baby's stomach. When the stomach is empty, the nervous system is triggered to waken; when the stomach is full, it is induced to sleep.

It is obviously far more complex than that. Breastmilk is quickly digested, and yet babies can sleep for many hours at a time. Colostrum, the first form of breastmilk, is produced in small quantities after birth to not disrupt baby's immature digestive system, yet newborns manage to sleep. Inversely, some babies stay awake after a long feeding, and others cry for other reasons than digestive ones.

True, there are mechanisms to ensure a mother's production will regulate itself to baby's needs. When baby wants more milk, she will be awake to suckle at the breast more (demand), which in turn makes the breastfeeding mother produce more (supply). After a few days, supply and demand will have adjusted to baby's needs. Most experienced mothers will easily recognize these episodes as growth spurts.

In some cultures, the concept of waking-crying-eating is hardly an issue. In fact, when the mother-baby dyad is the norm, unrestricted breastfeeding is valued, and baby can go ahead and regulate her mother's production as she pleases. Baby will suckle a little or a lot, softly or tirelessly, depending on her appetite, but will never have too much to eat. Furthermore, breastmilk is easily digestible and is ever-changing, adapting itself perfectly to baby's needs. Baby wakes up and is looking for the breast? Let her latch on. Baby is crying? Let her latch on. For millions of years, anthropoids, early humans and then humans haven't second-guessed any of this.

Complications arose when breastmilk 'substitutes' (made of cow's milk diluted in water, then sweetened) and industrial milk came along. These alternatives were convenient, but not exactly well digested. Moreover, bottle nipples size was too big, which allowed for the milk to flow too easily to baby, regardless of the quality of her latch and suction. With the very real risk of overloading baby's digestive system, leading to indigestion, doctors were sensible enough to impose measures around feedings, which included imposing schedules with a minimum time gap in between feedings. This is, of course, where the rule of '*every four hours, six times a day'* comes from. Anxiety-induced control thus began.

Historically, the first healthy baby to end up in hospitals were orphans and those abandoned at birth, as well as the babies of severely impoverished women, who were the only ones who gave birth in the hospital at that time. Indeed, giving birth at home was significantly safer because the risk of infection was so high anywhere else. All these babies were put into the hospitals' nurseries, where formula-feeding followed strict schedules. This is why, today, the notions of mother-baby bonding and maternal instinct are relatively 'new' in hospital settings (the fact that it takes several years for a hospital to implement the Baby Friendly Hospital Initiative steps speaks for itself).

All women started giving birth in maternity wards in the second half of the twentieth century, at which point they were obliged to comply with the routines and regulations already in place. Hospitals promoted a culture of separation of the mother-baby dyad. After all, this was all it had ever known. But this culture, of course, generated many harmful consequences: strict schedules, lack of understanding of the physiology of breastfeeding and the normal rhythms of newborns… Still, hospitals had become the materialization of science and modernity. The progress of medical and pharmaceutical technologies inspired confidence. Coated in a prestigious scientific polish, outdated hospital policies were assimilated with all the rest and became known as the golden standard of newborn care. For the last fifty years, we are witnessing an exceptional anthropological phenomenon: mothers and babies sleep apart, and feedings have become systematized, even when babies are breastfed.

We are currently easing into more supple recommendations for mothers and babies. Nursing 'on demand' is recommended, but is prescribed with various guidelines such as '*five minutes per side*', '*two hours minimum between each feeding*', for a 'maximum of x, y, z hours', which gets mixed with conflicting advice such as '*on demand, yes, but only if she's actually hungry*'. Ergo, mothers are expected to be able to distinguish between 'hunger' cries and all the other types of crying. What a nightmare.

Admittedly, how can we expect a newborn baby to understand the concept of hunger as we adults grasp it? Our hunger cues as adults have been physically conditioned by cultural, daily routines, and we tend to dramatize them into meaning starvation. A newborn baby cannot interpret any of this.

A baby's first rhythm isn't that of food intake, but rather that of awakenings. Her neurological rhythms and her different states of alertness go hand in hand with her brain development. Though the brain has been growing in-utero, it will continue to develop after birth. In the first few days of life, a baby's state of alertness, from quietly alert to sleeping, are somewhat aleatory. At best, we may notice a tendency for a state of active alertness somewhere between five and 10 PM.

On the other hand, nature did need to find a preventative way to get babies fed before getting too exhausted to let their caretakers know. Up until then, this baby was fed automatically, effortlessly and continuously via umbilical cord. Now she is discovering discontinuous feeding, and orally — meaning that she has to participate if she wishes to be fed. Luckily, baby has **primitive reflexes**, such as the rooting reflex (when baby actively searches for the breast) and the sucking and deglutition reflex. Although babies are born with these reflexes, they peak when she is in a **quiet alert state**. Therefore, feedings are timed with baby's awakenings. And ergo, a healthy baby born full term is in a quiet state enough on a 24-hour period to eat sufficiently. In the early breastfeeding days, it's much more accurate to talk about nursing upon awakening rather than nursing *on demand*. A baby who is wide awake nurses efficiently because she has better muscle tone. A baby who is crying because we '*have to make sure she's actually hungry'* or because *'it's not quite time for her next feeding*', is actually very restless and thus much less efficient at nursing.

Keeping baby close at all times allows parents to observe and recognize baby's cues. She will make eye contact and gentles gestures, she will turn herself in her parents' direction: this is baby's way of seeking connection. A straight back, head turned towards the breast, open mouth, are signs that baby is ready to nurse. By making parents are caregivers aware of these signs, baby is much less likely to need to cry to get her needs met. And that is a relief for everyone!

It is now proven that fetuses perceive and store memories of their intra-uterine life, such as tactile, kinesthetic, gustatory, olfactive, auditory and visual sensa-

tions. This rich sensorial experience becomes baby's reference for life outside the womb. At birth, they discover the intensity of light, the forcefulness of gravity, unknown smells, the stillness of a crib… With each awakening, they are confronted with so many new sensations that radically differ from the intra-uterine environment they are used to. Their very first vital need is therefore sensorial: having to reacquaint with her mother's body, voice and smell, rediscovering comfort in positions, rocking and warmth… but of this, mothers have always known. Of course, babies cannot return in-utero; the goal is rather to soften the transition between both worlds.

We could say that baby's need for connection translates to her first experience of 'hunger'. And God knows how good babies are at getting their needs met! Within minutes of being born, newborns will scream and shriek when put on an exam table. Are they actually hungry? Surely not, as of this time, they had been continuously fed by the umbilical cord. They are wailing because they need contact, and they need warmth. Infrared lamps do not replace human connection. When baby is routinely placed on her mother, however, she does not cry. Instead, she will put an extraordinary amount of energy into coming in contact with her mother. In fact, all of her body and all of her senses are put to use as a survival instinct to

find her mother's breast (rooting reflex). In return, she will feel 'rewarded' from the pleasurable, multisensory experience of nursing, and will want to do it again. This establishes a 'pleasure-desire' cycle.
Young mothers will admit that they 'don't know why the baby keeps crying', as though admitting that they aren't good enough to parent. In reality, newborns are 'hungry' for many more things than just milk: being held and being soothed, the smell of their mother, warmth. And with time, babies will learn how to distinguish all of that from actual hunger. They all learn eventually how to explicitly ask to be picked up, or nursed, or to take a bath. In other words, they learn how to perceive their different needs, and they will learn how to communicate them, too. Parents will learn to distinguish these different types of cries, at which point it makes more sense to 'nurse on demand'.

A third roadblock is our **pseudo-educational fantasies**, that is, certain statements that are widespread in our culture and that are deemed true and unquestionable. As we have seen, the time at which we eat dinner varies from country to country. This is because these human habits are conditioned by the culture from which we come. Québécois usually eat their supper around 5 PM, whereas Europeans countries have their last meal anywhere between 7 and 10 PM. So, when do we start 'enforcing' this schedule? And how to put it into practice? Obviously, every recommendation, from the strictest to the most lenient, has already been suggested, confirmed and imposed to parents.

Mothering (and parenting) is the first form a parent's love takes. Human babies are born much more dependent than any other mammal, and will stay dependant for much longer, too. During this time when they rely entirely on their caregivers, they are building the foundation for their emotional security and well-being. This assurance of feeling safe and cared for is what allows baby humans to grow into independent and capable adults, able to navigate in society with all of its frustrations and challenges.

Education is the other form of parental love. It encompasses teaching our children to be autonomous, to build their self-confidence, to offer necessary structure, rules and limits. It includes the transmission of technical and intellectual knowledge, as well as the cultural customs they were born into (such as eating habits and routines).

So, mothering reassures, whereas education structures.

Except that, in a world where high productivity and total independence represent the pinnacle of suc-

cess, interdependence and attachment do not get a good rap. Add to the mix our emotional projections and confusion regarding self-regulation and it becomes legitimate and even desirable to regularize and structure babies into a predictable routine. Indeed, to self-regulate is a very trendy term.

'*The neediness of babies is boundless. If a mother successfully satisfies her baby's every need, this neediness will forever continue to have no boundaries*' can one read in a psychology course from the 80s.

Furthermore, to **educate** our children without having **mothered** them beforehand isn't viable. It's a make it or break it scenario: in the 'best' of cases, you will 'make' a discreet child, and you will 'break' the rest. Some will bend, but at what cost? The others will learn that to defy is their only option.

What's more, it is still common belief that a baby will neurologically regulate by imposing schedules around time and food as soon as possible. These absurd practices make life in general way more complicated, make feedings complex and unnatural (have you ever tried waking a baby to nurse?), and disrupt the natural evolution of baby's rhythm. Seeking to do good, new parents keenly listen to medical professionals and family elders talk of getting baby on a schedule, without knowing that there's a better, more instinctive way.

This rhetoric is readily integrated because it resonates with many values within our culture. People obsess over the ability to measure, control and predict. Baby's cries get thrown into the mix, adding chaos and instability and dependence. Of course it seems brutal! Attachment parenting is still considered by some health professionals as enslavement from which young mothers need to be shielded from.

In the first few nights after birth, many babies wake frequently. They'll cry and they'll nurse a lot. Parents and caregivers find themselves torn between two paradoxal obligations: because we dramatize baby's cries and hunger cues, parents must do something to save baby from suffering; because we dramatize attachment parenting, parents must protect themselves from needy babies. Parents find themselves with a heartbreaking **dual constraint**: whatever they do, or don't do, the feeling of having done the wrong thing will linger. It's a catch-22.

The pressure can become so overbearing for parents that the need to distance themselves from the burden seems like the only solution: this distantness, of course, is executed through an "intermediate' object (such as a pacifier or a bottle), by restricting feedings, or by putting babies in nurseries very early on. But can you imagine, at that age, how it would feel to lose your bearings, or to be subjected to the rationing of food, and even the rationing of emotional connection?

The vast majority of adults of our society have been subject to early separation, behavior training techniques and the consequent loss of their reassuring emotional benchmarks. What trauma do they still hold today from it? Could this explain their fear of deprivation that leads to defense mechanisms such as overconsumption, both of material goods and of food? Could this underlying fear be the reason why they aim to suppress and contain babies' primal needs?

What if this was indeed a cyclical phenomenon? What if the unrealistic expectations we hold of our babies are the product of fear and confusion, pushing adults to further dissociate themselves from their babies? What if these adults held past trauma so profoundly within the depths of their memory, that it tinted everything they think and do, carrying it along with them on the journey of parenthood?

It's time to have an open conversation about all of this. It's time to listen to what parents and caregivers have to say about how they feel, in order to acknowledge it and then move beyond it.

Becoming a parent means welcoming a baby and also many, many emotions. Unraveling these emotions, as well as knowing that babies do indeed cry (and that that's okay), allows for peace of mind when the day finally comes to meet your baby.

Normal Newborn Behaviour

Newborns look and act differently than older babies and children, as they are adjusting to life outside the womb. This handout is to help you figure out what is normal and what to do if signs arise that may indicate illness.

What to expect in the first few days	
Breathing	• Your baby may breathe in clusters—there may be times when your baby's breathing seems shallow and rapid. At other times your baby's breathing may seem deep or slow. • Your baby's breathing may be irregular.
Colour	Your baby may get: • blue/purple feet and hands in the first 24 hours. • blotchy and red when cold or crying. • mild jaundice (yellow face) after 24 hours.
Temperature	Normal temperature range: Armpit 36.5°C to 37.5°C (97.7°F to 99.5°F)
Feeding	• After the first 24 hours, your baby should eat every two to four hours, eight to 12 times per day. • Your baby will usually feed for a minimum of 20 minutes, though longer is very common. A satisfied baby will detach from the nipple after finishing a feed. • Your baby may cluster feed (feed many times in a row) and then have a longer stretch without feeding.
Diapers	• Day 1 = 1 wet diaper • Day 2 = 2 wet diapers • Day 3 = 3 wet diapers • Your baby's stool will appear black-greenish (meconium) for the first couple of days, until your colostrum (thick, sticky and yellowish first milk) transitions to mature milk. • Once mature milk comes in (between third and fifth day), expect six to eight wet diapers a day and two or more stools that are liquid yellow, green or brown. Stools that look 'seedy' are normal.

It is important to watch your newborn for any unusual behaviour during the first hours and days of his or her life. In very rare circumstances, babies can develop an infection from bacteria such as Group B Streptococcus (also called GBS), which can cause serious illness. The signs of illness from GBS are most likely to occur within the first 24 hours, but sometimes occur later. It is important for all parents to know what is within the range of normal newborn behavior and when you should contact your midwife or 911.

This document provides client-friendly information based on the Association of Ontario Midwives' *Clinical Practice Guideline No. 16: Group B Streptococcus: Postpartum Management of the Neonate*. It is designed to help you better understand some of the considerations and choices you may face while receiving care from your midwife. It is not intended to replace the informed choice discussions that you and your midwife will have. If you have any questions, concerns or ideas after reading over this document, please share them with your midwife.

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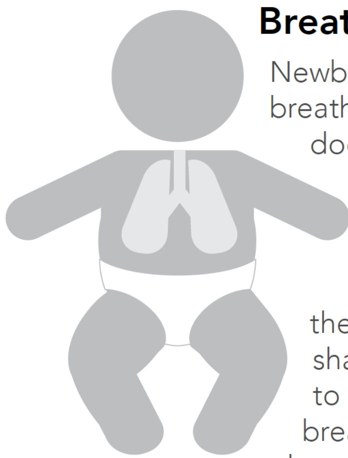
Behaviour

Your baby will spend his or her early days and weeks in different states: deep sleep, light sleep, drowsy, quiet alert, active alert, crying. While newborns sleep about 16 hours out of every day, their sleep patterns are unpredictable; they may sleep for a few minutes or a few hours at a time. Babies should always be put to sleep on their backs. Because your baby's stomach is so tiny at this age, he or she needs to wake to feed often. In the first days and weeks, your baby should sleep for stretches no longer than four to six hours in a 24-hour period without waking to feed. If your baby is sleeping for a long period, wake your baby up and try to feed him or her. Some babies are difficult to wake; if they don't wake up with your first attempt, try again in half an hour. An effective way to wake your baby is to undress him or her, change their diaper and talk to them. It is normal for it to take a while for babies to latch. Be patient! If your baby seems unusually sleepy and uninterested in feeding upon waking, try again in 30 minutes or wipe a cool cloth on their face to help wake them up.



Breathing

Newborns often have irregular breathing patterns. Their breathing does not look or sound like an adult's. At times, newborn babies will breathe progressively faster and deeper, and at other times their breathing is more slow and shallow. It is normal for babies to occasionally pause their breathing for 10 seconds and then start up with a deep breath. It is not normal for a baby to gasp for breaths or pant (quickly breathe) for 10 minutes or more. Babies make lots of different strange sounds and faces, and it can be difficult to know what is charming and normal and what should be concerning. It is normal for newborns to sound like a cat coughing up a hairball as they try to bring up mucous; they may also have bubbles at their mouths.

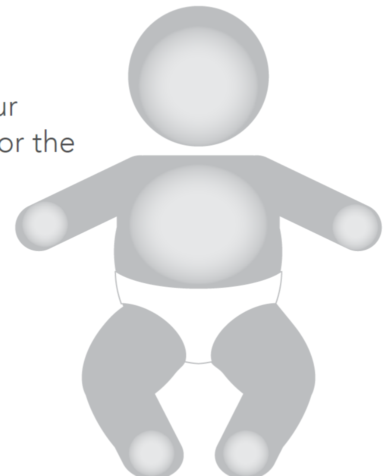
Contact your midwife if you notice any of these signs that your baby is having difficulty breathing:

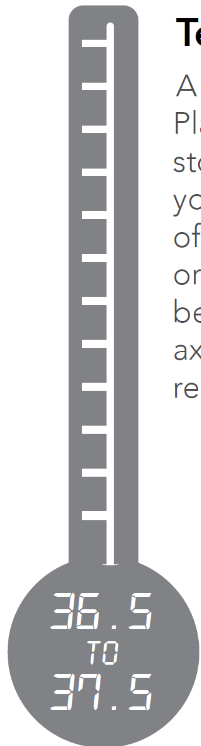
- ***Your baby's nostrils widen as he or she breathes (nasal flaring) for longer than a few minutes.***
- ***Your baby makes grunting sounds with each breath; this lasts longer than a few minutes.***
- ***The skin around your baby's ribs or at the base of the throat pulls in sharply with each breath.***
- ***Your baby's breathing stops for more than 10 seconds.***

Colour

A pink chest and face shows that your baby is getting enough oxygen. Your baby's hands and feet may be blue, purple or grey and cool to the touch for the first few days – this is normal. Your baby's skin may get blotchy and red after crying or when cold.

If the skin on your baby's face or chest becomes blue or grey please call 911 and contact your midwife immediately.





Normal temperature in °C

Temperature

A newborn should be dressed in one layer more than you are comfortable wearing. Placing your baby skin-to-skin (holding your bare baby against your bare chest or stomach), covered by a light blanket, will help them to regulate their temperature. If you want to know if your baby is too hot or too cold, feeling their chest or the back of their neck will give you a more accurate idea of their temperature than their hands or feet. It is normal for a baby's hands and feet to be cool for the first few days. The best way to take your baby's temperature is under the armpit (this is also known as an axillary temperature). Ear thermometers are not accurate for newborns and are not recommended. Normal armpit temperature is 36.5°C to 37.5°C (97.7°F to 99.5°F).

- If your baby's temperature is over 38.0°C (100.4°F), please contact your midwife.
- If your baby's temperature is over 37.5°C (99.5°F), remove a layer of clothing and take his or her temperature again after 30 minutes have passed.
- If your baby's temperature is over 37.5°C (99.5°F), and you have taken the above actions, please contact your midwife.
- If your baby seems cold or his or her temperature is less than 36.5°C (97.7°F), place your baby skin-to-skin and cover you and your baby with a blanket. Take his or her temperature again after 30 minutes have passed.

Feeding

If you are nursing, putting your baby to the nipple often gives your baby valuable nutrient-rich colostrum (thick, sticky and yellowish first milk), helps establish your milk supply, and helps both you and your baby learn how chest or breastfeeding works. Your baby will need to eat at least every two to four hours (sometimes much more often), usually for a minimum of 20 minutes at a time. It can sometimes take time for you and your baby to learn how to nurse. Spending time together skin-to-skin will help encourage your baby to latch and feed. Your baby may spit up after eating, usually small amounts of milk come out and dribble down his or her chin.

A good online resource is: www.breastfeedinginc.ca

Diapers

Your midwife may ask you to keep track of the number of wet and soiled diapers your baby produces. A disposable diaper feels heavier if it's wet. Many diaper brands today have a urine indicator that turns blue in the presence of a certain amount of urine. Not all diapers do, and some pees in the first few days may be too small to make this happen. If you have trouble telling when the diaper is wet, put a tissue in the bottom of the clean diaper. Sometimes babies will have what looks like "brick dust" in their diapers in the first few days, a pinkish or orange coloured spot. These are called urate crystals, and they are normal. A baby girl may have a small amount of bloody discharge from her vagina, this is a response to mother's hormones and it is normal.

Muscle Tone

A newborn needs to be supported when held, but newborn babies should not feel completely limp in your arms. A newborn should display strong, well-flexed movements of his or her arms and legs.

Umbilical Cord

As your baby's cord begins to fall off (anytime in the first 14 days) it may begin to look "goopy" and a small amount of blood or discharge may come off on your baby's diaper or clothing. Your baby's cord may also have a strong smell; this is normal. It is not normal for the skin around the base of the umbilical cord (on your baby's stomach) to become red and infected-looking. If it does, contact your midwife.

Contact your midwife if:

- Your baby is not feeding and seems lethargic (having trouble waking up) and you can't wake your baby to feed. One long sleep (4-6 hours) in every 24 hour period is ok.
- Your baby's armpit temperature is above 37.5°C (99.5°F) or below 36.5°C (97.7°F) and your baby is not wearing too much or too little clothing.
- Your baby breathes rapidly (more than 60 breaths every minute) for longer than 10 minutes (and your baby is not crying, being active or overdressed).
- Your baby has difficulty breathing, which may look like this:
    - » nasal flaring and grunting that lasts longer than a few minutes;
    - » your baby's skin seems to be pulling in sharply around the ribs or base of the throat when he or she breathes.
- Your baby is very irritable.
- Your baby is crying almost all the time and the crying is high-pitched.
- Your baby is limp and not interacting when awake.
- Your baby has repeated, projectile vomiting (more forceful than spitting up).
- You see a brick dust colour in your baby's diaper beyond the third day of life.
- Your baby has not had a wet diaper in a 24 hour period.
- You are worried about your baby for any other reason.

Call 911 and your midwife if:

- Your baby's skin colour changes to blue, grey or pale (blue hands and/or feet are normal in the initial days).
- Your baby's breathing stops for more than 10 seconds.

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Ontario

Sharing a bed with your baby

Sharing a bed with your baby

A guide for breastfeeding mothers

UNICEF UK Baby Friendly Initiative
with the Foundation for the Study of Infant Deaths

Breastfeeding is best for your baby's health and your own health. The longer you breastfeed, the greater the health benefits for you both.

It is recommended that your baby shares a room with you for at least the first 6 months, as this helps with breastfeeding and protects babies against cot death.

Bringing your baby into bed with you means that you can breastfeed in comfort. This may be why mothers who share a bed with their baby tend to breastfeed for longer than those who don't.

As it is easy to fall asleep while breastfeeding, especially when lying down, there are some important points to consider before taking your baby into bed with you.

In particular, adult beds are not designed with infant safety in mind. Babies can die if they get trapped or wedged in the bed or if a parent lies on them. So the safest place for a baby to sleep is in a cot by your bed.

However, you can reduce the risk of accidents and, because bed sharing helps with breastfeeding, you may find this leaflet useful.

Important - when not to sleep with your baby

Smoking increases the risk of cot death. You should make sure that you don't fall asleep with your baby in your bed if you (or any other person in the bed) are a smoker, even if you never smoke in bed.

Never sleep with your baby on a sofa or armchair.

Falling asleep with your baby is also dangerous if you (or any other person in the bed) might find it hard to respond to the baby, For example if you:

- have drunk alcohol
- have taken any drug (legal or illegal) which could make you extra sleepy
- have any illness or condition which affects your awareness of your baby
- are otherwise unusually tired to a point where you would find it difficult to respond to your baby.

It also may be safest not to bed share in the early months if your baby was born preterm, was small at birth or if he has a high temperature.

Sharing a bed with your baby

Reduce the risk of accidents and overheating

Sofas are very dangerous for babies as they can become trapped down the sides or in the cushions. Never lie down or fall asleep with your baby on a sofa or armchair.

Adult beds are not designed for babies. To prevent your baby overheating, suffocating or becoming trapped:

- The mattress must be firm and flat - waterbeds, bean bags and sagging mattresses are not suitable;
- Make sure that your baby can't fall out of bed or get stuck between the mattress and the wall;
- The room must not be too hot (16-18oC is ideal);
- Your baby should not be overdressed - he should not wear any more clothes than you would wear in bed yourself;
- The covers must not overheat the baby or cover the baby's head;
- Your baby must not be left alone in or on the bed as even very young babies can wriggle into dangerous positions;
- Your partner should know if your baby is in the bed;
- If an older child is also sharing your bed, you or your partner should sleep between the child and the baby;
- Pets should not share a bed with your baby

If you have any questions, your midwife or health visitor will be able to advise you.

Your sleeping position

If you are bed sharing, it is important to make sure that your baby cannot go under the covers or into the pillow.

Most mothers who are breastfeeding automatically sleep facing their baby with their body in a position which protects the baby by stopping him moving up or down the bed (see picture).

Your baby will usually lie on his side to breastfeed. When not actually feeding, he should be put on his back to sleep, never on his front or side.

If you are bottle feeding the safest place for your baby to sleep is in a cot by your bed.

Babywearing

by William Sears, pediatrician

New research proves what experienced parents have known for a long time: Caring for babies has positive effects for both parents and parents alike.

My interest in the art of carrying babies was born several years ago, while I was researching to write my book WHAT TO DO WHEN BABY IS CRYING? LIVE WITH A WITH A HIGH NEEDS BABY. I noticed that the more babies were worn, the less they cried. The mothers of difficult babies calmly said, 'As long as I'm wearing him/her, he/she is happy!' Based on these observations, I developed a scarf-like baby carrier and advised parents to wear their baby as much as possible, from birth. I then noticed a definite impact on the babies and their parents. Infants worn cried a lot less, had fewer episodes of colic and, in general, seemed more satisfied. As babies were happier, so were their parents. Parents who were carrying their baby also seemed to be better able to decode their baby's signals. Essentially, the parent and the baby seemed to be in harmony with each other.

The benefits of wearing your baby

It is natural for baby to be close to his mother. Babies are happiest when being held by mom. Babywearing is a great practice for keeping baby happy and to help build a stronger bond between mom and her baby. The benefits of babywearing help babies grow up smarter and happier.

1. Sling babies cry less.

Parents in my practice commonly report, "As long as I wear her, she's content!" Parents of fussy babies who try babywearing relate that their babies seem to forget to fuss. This is more than just my own impression. In 1986, a team of pediatricians in Montreal reported on a study of ninety-nine mother-infant pairs. The first group of parents were provided with a baby carrier and assigned to carry their babies for at least three extra hours a day. They were encouraged to carry their infants throughout the day, regardless of the state of the infant, not just in response to crying or fussing. In the control, or noncarried group, parents were not given any specific instructions about carrying. After six weeks, the infants who received supplemental carrying cried and fussed 43 percent less than the noncarried group.

Anthropologists who travel throughout the world studying infant-care practices in other cultures agree the benefits of babywearing cultures are that infants cry much less. In Western culture we measure a baby's crying in hours, but in other cultures, crying is measured in minutes. We have been led to believe that it is "normal" for babies to cry a lot, but in other cultures this is not accepted as the norm. In these cultures, babies are normally "up" in arms and are put down only to sleep – next to the mother. When the parent must attend to her own needs, the baby is in someone else's arms.

2. Sling babies learn more.
If infants spend less time crying and fussing, what do they do with their free time? They learn! Sling babies spend more time in the state of quiet alertness. This is the behavioral state in which an infant is most content and best able to interact with his environment. It may be called the optimal state of learning for a baby. Researchers have also reported that carried babies show enhanced visual and auditory alertness.

One of the great benefits of babywearing is when baby is in the behavioral state of quiet alertness, it gives parents a better opportunity to interact with their baby. Notice how mother and baby position their faces in order to achieve this optimal visually interactive plane. The human face, especially in this position, is a potent stimulator for interpersonal bonding. In the kangaroo carry, baby has a 180-degree view of her environment and is able to scan her world. She learns to choose, picking out what she wishes to look at and shutting out what she doesn't. This ability to make choices enhances learning. A sling baby learns a lot in the arms of a busy caregiver.

3. Sling babies are more organized.
It's easier to understand the benefits of babywearing when you think of a baby's gestation as lasting eighteen months – nine months inside the womb and at least nine more months outside. The womb environment automatically regulates baby's systems. Birth temporarily disrupts this organization. The more quickly, however, baby gets outside help with organizing these systems, the more easily he adapts to the puzzle of life outside the womb. By extending the womb experience, the babywearing mother (and father) provides an external regulating system that balances the irregular and disorganized tendencies of the baby. Picture how these regulating systems work. Mother's rhythmic walk, for example, (which baby has been feeling for nine months) reminds baby of the womb experience. This familiar rhythm, imprinted on baby's mind in the womb, now reappears in the "outside womb" and calms baby. As baby places her ear against her mother's chest, mother's heartbeat, beautifully regular and familiar, reminds baby of the sounds of the womb. As another biological regulator, baby senses mother's rhythmic breathing while worn tummy-to-tummy, chest-to-chest. Simply stated, regular parental rhythms have a balancing effect on the infant's irregular rhythms. The benefits of babywearing "remind" the baby of and continues the motion and balance he enjoyed in the womb.

SLING TIP:
The womb lasts eighteen months: Nine months inside mother, and nine months outside.

What may happen if the baby spends most of his time lying horizontally in a crib, attended to only for feeding and comforting, and then again separated from mother? A newborn has an inherent urge to become organized, to fit into his or her new environment. If left to his own resources, without the regulating presence of the mother, the infant may develop disorganized patterns of behavior: colicky cries, jerky movements, disorganized self-rocking behaviors, anxious

thumb sucking, irregular breathing, and disturbed sleep. The infant, who is forced to self-calm, wastes valuable energy he could have used to grow and develop.

While there are a variety of child-rearing theories, attachment researchers all agree on one thing: In order for a baby's emotional, intellectual, and physiological systems to function optimally, the continued presence of the mother, the most important benefits of babywearing, is a necessary regulatory influence.

4. The "humanizing" benefits of babywearing.
Another of the ways the benefits of babywearing improve learning is that baby is intimately involved in the caregiver's world. Baby sees what mother or father sees, hears what they hear, and in some ways feels what they feel. Carried babies become more aware of their parents' faces, walking rhythms, and scents. Baby becomes aware of, and learns from, all the subtle facial expressions, body language, voice inflections and tones, breathing patterns, and emotions of the caregiver. A parent will relate to the baby a lot more often, because baby is sitting right under her nose. Proximity increases interaction, and baby can constantly be learning how to be human. Carried babies are intimately involved in their parents' world because they participate in what mother and father are doing. A baby worn while a parent washes dishes, for example, hears, smells, sees, and experiences in depth the adult world. He is more exposed to and involved in what is going on around him. Baby learns much in the arms of a busy person.

5. Sling babies are smarter.
Environmental experiences stimulate nerves to branch out and connect with other nerves, which helps the brain grow and develop. The benefits of babywearing are that it helps the infant's developing brain make the right connections. Because baby is intimately involved in the mother and father's world, she is exposed to, and participates in, the environmental stimuli that mother selects and is protected from those stimuli that bombard or overload her developing nervous system. She so intimately participates in what mother is doing that her developing brain stores a myriad of experiences, called patterns of behavior. These experiences can be thought of as thousands of tiny short-run movies that are filed in the infant's neurological library to be rerun when baby is exposed to a similar situation that reminds her of the making of the original "movie." For example, mothers often tell me, "As soon as I pick up the sling and put it on, my baby lights up and raises his arms as if in anticipation that he will soon be in my arms and in my world."

I have noticed that sling babies seem more attentive, clicking into adult conversations as if they were part of it. Babywearing enhances speech development. Because baby is up at voice and eye level, he is more involved in conversations. He learns a valuable speech lesson – the ability to listen.

Normal ambient sounds, such as the noises of daily activities, may either have learning value for the infant or disturb him. If baby is alone, sounds may frighten him. If baby is worn, these sounds have learning value. The mother filters out what she perceives as unsuitable for the baby and gives the infant an "It's okay" feeling when he is exposed to unfamiliar sounds and experiences.

7 Post-Pregnancy Feelings No One Warns You About

By Maria Barillaro

Not sure what to expect after giving birth? Here are some post-pregnancy emotions we wish we'd known about!

Everyone has advice when it comes to what to expect during pregnancy, but few people take the time to prep preggos for the emotional roller coaster that ensues post-delivery. I myself went through a few ups and downs in the days after my children were born. When an item I ordered for my daughter's nursery was the wrong shade of purple, I cried for an entire day!

Here are a few feelings you may find yourself dealing with after giving birth. And trust us—they're totally normal.

1. Sadness

Your eyes could resemble a leaky faucet after delivery: the water just won't stop dripping out! Does this mean you're sad to be a mom? Of course not! It's normal to cry over little things, like not knowing how to change a diaper very well—or when you find out Netflix stopped airing your favorite series before you had the chance to see the finale. Susan Feingold, PsyD, a clinical psychologist and adjunct professor at the Illinois School of Professional Psychology, Chicago Campus of Argosy University, says feelings of intermittent sadness, weepiness, and emotional oversensitivity are not unusual. They're a common part of the baby blues, a temporary state of mood changes that last no more than a few days or weeks. «Baby blues are not to be confused with postpartum mood and anxiety disorders,» warns Dr. Feingold, who is also the author of Happy Endings, New Beginnings: Navigating Postpartum Disorders. Severe mood and/or anxiety symptoms combined with symptoms such as loss of motivation, sleep disturbances, disturbing thoughts, feelings of hopelessness, or thoughts of suicide should be addressed right away.

2. Fear

You'll quickly see that being a mother brings with it a whole set of new fears, even if you were never the worry-wart type before. From minor fears to more complex ones, the feeling of fear can be overwhelming for many mothers in the early stages of parenthood. You're not alone on this one, as new mom Francesca Chiarappa from Montreal, Quebec, Canada, can attest. «I was afraid of being alone with her,» she says of how she felt after her daughter was born. «Will I know what to do with her? How much to feed her? How to soothe her?» Being afraid that you won't do what's right for your child because you don't know the first thing about parenting is not a new feeling. It's just new to you. You're definitely not the first mother to battle with fears—even irrational ones—and you certainly won't be the last.

3. Joy

You know your baby will bring great joy into your life, but you don't really know how overwhelming that joy can be until your little one is born. Your positive emotions are exaggerated post-delivery just like your negative ones, and this overwhelming happiness usually finds its way into the mix, making you feel an incredible natural «high» at times. It's almost unbelievable that someone so tiny, who doesn't do much, can bring you so much joy that it moves you to tears. A yawn, a cough—these seemingly normal things

can actually be triggers for some of the happiest moments in your life. From weeping tears of joy to giggling uncontrollably over the silliest thing, the top of the roller coaster is pretty awesome. «After the births of two of my kids my husband and I settled in to watch a movie and it was just too funny—both times we had to turn it off because it was causing me to nearly hemorrhage!» says Elaine Zamonski, a mom of three in Dayton, Ohio. «The first time was Pootytang, the second time was Stepbrothers. I tried Stepbrothers again day two postpartum and was still driven to fits of painful laughter.»

4. Anger

Maybe no one admits it, but it's perfectly normal to have some feelings of anger in the days after delivery. Whether it's being angry at yourself for not knowing the first thing about breastfeeding, or being downright mad at the world because you don't know how to get your baby to stop crying, it's normal. Dr. Feingold explains this is not uncommon, especially in women who have high expectations or tend towards perfectionism. However, she warns about the severity of it. «Significant anger and irritability can be a symptom of postpartum mood disorders,» she says. If your symptoms prevent you from coping, Dr. Feingold recommends contacting your OBGYN or midwife to ask for names of mental health providers in your area. You can also visit postpartum.net for information and referrals.

5. The Jitters

You may find yourself on edge in the weeks after giving birth. You may be more easily startled, very tense, or even very anxious. This can be unsettling to someone who has never really felt this way in life before. Rest assured, this is not unusual. You aren't sleeping, you're worrying—oh yeah, and you just had a baby! During the first two weeks after delivering both of her sons, mom of two Nadia D'Addona from Montreal felt as though she was suffering from anxiety attacks. «Both times, I felt extremely overwhelmed,» she says. But as she adjusted to her new life, those feelings of anxiety disappeared.

6. Hypersensitivity

A very normal feeling after giving birth is that of sensitivity. You may feel deeply affected emotionally by everyone and everything. Watching the news could have you in tears, leaving you feeling deep sorrow for total strangers. Your emotions are all over the place, and your instinct to nurture everything may be coming into play. You don't necessarily have postpartum depression just because you can't seem to hold back the tears. «I cried nonstop for two weeks, not out of sadness but for stupid reasons like my husband hadn't vacuumed, or that my baby was so sweet and I couldn't stop hugging her,» Zamonski says. «I just cried and cried and cried, for literally every and no reason.» According to the American College of Obstetricians and Gynecologists, postpartum blues will usually get better in no more than two weeks without treatment. If it lasts longer, talk to your doctor.

7. Doubt

Not many mothers will admit to it, but the feeling of doubt—as in doubting whether you should have even had children or whether you're capable of doing the job—is actually normal. We tend to think that mothering is an instinct so we will know exactly what to do when our babies are born, but that isn't the case. When breastfeeding wasn't going as smoothly as planned, new mom Amanda Starnino from Montreal started to doubt whether she was right for motherhood. «I thought, this is the one thing I'm supposed to do for my baby as a mother, and I can't even do this,» she explains. Though these feelings are normal, try to remember not to be too hard on yourself. The post-delivery weeks are a learning process for both

you and your baby. Don't doubt yourself as a parent. You can do this!

Emotional Health in Pregnancy and After Birth

Low energy or changes in appetite or sleep can be normal in pregnancy and these symptoms may be confused with depression. However, symptoms in pregnancy can lead to postpartum depression or anxiety.

Up to 80% of mothers feel very teary, irritable and worried for up to 10 days after delivery. These "baby blues" are very common and do not usually need treatment other than understanding, rest and support.

Postpartum Depression and Anxiety

Depression and anxiety can occur anytime during pregnancy or after the birth of a baby. Feeling very depressed or anxious is not normal. Depression occurs in about 15% of women in pregnancy or after birth. Anxiety can be more common. Paternal depression affects 10% of men after the birth of a baby.

Partners can get depressed too.

You are more at risk for depression or anxiety with:

- a history (or family history) of depression or anxiety
- a pregnancy or delivery complication
- poor sleep
- few supports (family, friends)
- work or relationship stress
- stopped medication used to treat depression or anxiety
- early breastfeeding challenges

Symptoms to Watch for:

- depressed or irritable mood
- lack of interest in activities
- changes in sleep or appetite
- low energy or poor concentration
- feeling guilty or worthless
- worry that is difficult to control
- feeling panicky, restless or tense
- intrusive repetitive thoughts (e.g., fear of baby getting germs) or repeated rituals (e.g., hand washing, checking)
- flashbacks or nightmares of a trauma
- thoughts of suicide or harming yourself or your baby

You should seek help as soon as possible. Symptoms can last for many months and lead to:

- not taking care of yourself, your pregnancy or your baby
- effects on the physical health of your pregnancy
- trouble bonding with your baby
- difficulty in relationships or work
- using substances such as drugs or recreational alcohol
- suicide

Take Care of Yourself

- Take one day at a time.
- Ask for help from your health care provider.
- Share your feelings with your partner.
- Sleep when you can.
- Eat healthy foods and keep hydrated.
- Plan one thing to look forward to every day.
- Be active! Go outside for a walk.
- Go to a local support and parenting program.

Anxiety Disorder

Women commonly have signs of anxiety along with postpartum depression. Anxiety and depression can also happen on their own.

Tell your doctor or nurse if you are feeling any of following signs. It may be difficult to talk about your thoughts and feelings with your health care provi-

ders. But they can support you in getting the help you need. The sooner you get help, the better you will feel.

Anxiety is a normal human emotion that everyone experiences at times. Anxiety disorders, however, are different. They can cause such distress that it interferes with a person's ability to lead a normal life.

Common Symptoms of Anxiety

- excess worry
- scary or upsetting thoughts
- racing heart
- feeling on edge, restless or irritable
- avoiding people, places or activities
- difficulty concentrating
- trouble falling or staying asleep
- shortness of breath
- dizziness or light-headedness
- sweaty or clammy hands

Panic Disorder

A sudden feeling of intense fear or discomfort making you feel "out of control". Some women think they are having a heart attack or nervous breakdown.

Common Symptoms

- racing heart, chest pain
- sweating, hot or cold flashes
- shaking, loss of feeling or a tingling sensation
- shortness of breath, a feeling like you are choking
- stomach upset
- dizziness
- fear of dying

Obsessive Compulsive Disorder (OCD) – Scary Thoughts

Unwanted thoughts that can come and go involving harm to yourself or your baby. They can feel very real but when these thoughts happen after having a baby, mothers usually know that these thoughts are not real and will not act on them.

Common Symptoms

- unwanted, repetitive thoughts, impulses or images
- repetitive actions (e.g. washing hands over and over again, checking the baby all the time)
- scary thoughts or visions of the baby being harmed

Post Traumatic Stress Disorder (PTSD)

PTSD can happen after a distressing event such as a difficult or traumatic labour and birth, an accident, natural disasters, death of a loved one, abuse or sexual assault, or war.

Common Symptoms

- thoughts and dreams of the event
- feeling numb and detached from the world
- hard time sleeping
- lack of bonding with the baby
- sexual problems
- more likely to miss doctor visits
- avoiding further pregnancies
- avoiding places that remind you of the trauma

Postpartum Psychosis

Postpartum psychosis is rare, but a medical emergency.

Common Symptoms

- confusion
- feeling paranoid
- hearing voices
- having unusual thoughts of harming yourself or your baby

If you notice any of these signs in yourself, in a friend or partner, contact a doctor and go to a hospital emergency right away.

References:

https://www.parents.com/baby/new-parent/emotions/7-post-pregnancy-feelings-no-one-warns-you-about/

https://www.toronto.ca/community-people/children-parenting/pregnancy-and-parenting/postpartum-depression-and-anxiety/emotional-health-in-pregnancy-and-after-birth/

RESSOURCES AND SUPPORT

www.alternative-naissance.ca
514-274-1727
Alternative-naissance is a center of references and support for the humanization of birth.

www.centrepremierberceau.org
514-598-0677
Le centre Premier berceau is a prevention center for parents waiting for their first child.

www.ddm-mdd.org
514-937-5375
The Montreal Diet Dispensary provides nutritional and moral support to underprivileged individuals during pregnancy and the first months of life of their babies.

www.grossesse-secours.org
514-271-0554
Grossesse-Secours provides support services, postnatal home visits, drop-in daycare and shelter for pregnant individuals.

Le Groupe d'entraide maternelle de la Petite Patrie offers postnatal help in the Montreal area.
514-495-3494

Parent Line.
Telephone support for parents of children aged 0-18
514-288-5555 or 1-800-361-5085
Parents Help Line 1-888-603-9100

www.maisonbleue.info
514-509-0833
La Maison Bleue is a prevention center for families living in a context of vulnerability.

www.maisons-femmes.qc.ca
514-878-9134
Provincial group of shelters for women who are victims of domestic violence.

La Petite maison offre des services pour mère monoparentale 514-526-2639

www.postpartum.net et www.postpartum.org
English sites offer general information and resources. Postpartum.org has a section specifically for fathers. Do not hesitate to contact your local CLSC (or the CCPSC) for local resources and support groups.

http://www.reseaudescrp.org/
Le Réseau des Centres de ressources périnatales du Québec offers postnatal help and family oriented activities.

www.sosviolenceconjugale.ca
514-728-0023 ou 514-728-2353 ou 1-800-363-9010
SOS Violence offers a telephone support, évaluation and referral service for people who are victims of domestic violence. 24h/day, 7days/week

WOMEN'S HEALTH AND MATERNITY

www.aspq.org
514-528-5811
The **Quebec Public Health Association** contributes to improving the health of the Quebec population.

www.afar.info
The **Francophone Alliance for Respected Childbirth** offers a database on maternity.

fqpn.qc.ca
514-866-3721
The **Quebec Federation for Birth Planning** offers information on contraception and women's sexual health.

www.infocirc.org
Information and resource center on **circumcision**.

www.naissance-renaissance.qc.ca
514-392-0308
Naissance-Renaissance, a provincial feminist organization of autonomous community action.

www.motherfriendly.org (American website)
Coalition for Improving Maternity Services cares about the well being of mothers, babies and families.

www.osfq.org
514-286-1313
The Order of Quebec Midwives offers information on the midwifery profession in Quebec.

www.passeportsante.net
Health portal that has no lucrative purpose or commercial attachment.

www.cwhn.ca/indexfr.html
The Canadian Women's Health Network works to improve women's health. A good amount of information on pregnancy and childbirth is found there.

www.serena.ca
514-273-7531
Seréna is a non-profit organization whose mission is to **empower individuals and couples to manage their fertility** in a natural and effective way, by teaching them a better understanding of the female cycle. The organization specializes in the development and teaching of the symptothermal method.

www.sogc.org
The **Society of Obstetricians and Gynecologists of Canada** provides information and guidelines of medical practice on women's health.

BREASTFEEDING

www.allaitement.ca
1-866-allaité (255-2483)

La Leche League Canada (LLL)
Birth parent to birth parent support group that offers encouragement and personalized, up to date information to all parents that want to breastfeed their babies. Every month, the counselors conduct information and sharing meetings on breastfeeding. Instructors also provide telephone support. Welcome to pregnant individuals as well as breastfeeding parents and their spouses. For more information about our meetings, you can contact a counselor or consult the leaflets of some of our groups.
Meetings LLL at CLSC Métro in Montreal
1801 boulevard de Maisonneuve Ouest Montréal (Québec) H3H 1J9
Every Wednesday from 1:30 to 3pm, for more information: Linda 514 355-0772
www.LLLC.ca
514-842-4781

www.bfar.org
Breastfeeding after breast reduction
This site offers support and information to people who want to breastfeed after breast or nipple surgery. It is also a resource for health professionals who help mothers to breastfeed.

www.drjacknewman.com
videoclips and information on breastfeeding of the newborn

www.kellymom.com
Breastfeeding information only in English

www.ibclc.qc.ca
514-990-0262
Quebec Association of Lactation Consultants graduated from the IBLCE (AQC)
• Free service at the clinic with a referral
• Reduced price in pharmacies
• Private consultation (practice or home visit $$)

www.nourri-source.org
514-948-9877 ou 1-866-948-5160
Nourri-Source is a community help movement for breastfeeding, made up mostly of volunteers offering peer to peer support. Free personalized support is done by pairing. so you will always talk to the same person. Nourri-Source also offers breastfeeding parent meet-ups in the presence of a breastfeeding qualified nurse. Consult your local CLSC, or the CCPSC to find out about all the services offered near you.

www.mam.qc.ca
Support group located on the South shore
514-990-9626
MAM is a community organization in the field of perinatality. Its mission is to welcome, accompany and inform individuals and their families during the perinatal period (breastfeeding, information sessions, and activities). Our breastfeeding peer to peer counselors are there to offer peer to peer support.

ACTIVITIES

BABY MASSAGE
www.alternative-naissance.ca
514- 24-1727
6006, avenue Bordeaux

www.portersonbebe.com
Wearing your baby, making your scarf carrier and the knots.

www.cardiopleinair.ca
Cardio-stroller * Cardio-sled
1-877-327-5530

www.movies4mommies.com
Going out to the movies with your baby

PRENATAL YOGA, PRENATAL AQUA-FITNESS AND AQUA BABY
www.ymcamontreal.qc.ca

https://www.ydesfemmesmtl.org/en/
514-866-9941
1355, René-Lévesque boul. Ouest

www.luciebruneau.qc.ca
514-527-4527
2275, Laurier AV Est

POSTNATAL DEPRESSION

General information and resources.
www.Postpartum.orga specific section for fathers. Don't hesitate to contact your CLSC (or the CCPSC) for local resources and support groups.

PERINATALE RESOURCE CENTRES

www.carrefourperinaissance.org/ 450-472-2555

Le Carrefour péri-naissance et familial Région des Laurentides/St. Eustache

www.relevailles.com/
514-640-6741
Les Relevailles de Montréal
Perinatal resource center located in Pointe-aux-Trembles. The goal of Les Relevailles de Montréal is to promote harmonious adaptation to pregnancy and life with an infant. They support parents in enriching their skills and offer a range of services: classes, meetings, telephone support, breastfeeding, referrals, help at home and a library.

www.groupedentraidematernelle.org/
GEM Maternal support group of la Petite Patrie 514-495-3494
The maternal support group is defined as a community based family organization. Its mission is to welcome, enrich and enhance the parental experience.

OTHER RESOURCES

Parent-child mornings: Community sharing meetings of parents with their baby organized in several CLSCs. For more information contact your CLSC.

House cleaning service
La Grande vadrouille 514-341-0443
Services West-Nette 514-693-3749

Reading Suggestions

Pregnancy and Birth

- Mindful Birthing: Training the Mind, Body, and Heart for Childbirth and Beyond, Nancy Bardacke, 2012
- The Mindful Mother: A Practical and Spiritual Guide to Enjoying Pregnancy, Birth and Beyond with Mindfulness, Naomi Chunilal, 2015
- A Is for Advice (The Reassuring Kind): Wisdom for Pregnancy, Ilana Stanger-Ross, 2019
- All other books by Michel Odent
- The Birth Partner, Penny Simpkin, 2018
- Birthing normally, Hélène Vadeboncoeur, 2011
- Spiritual Midwifery, Ina May Gaskin, 1977
- Home Birth, Sheila Kitzinger, 1993
- Home Birth an Invitation and Guide, Alice Gilgoff, 1989
- Birthing from within, Pam England and Rob Horowitz
- Placenta the forgotten chakra, Robin Lim
- After baby's birth, Robin Lim
- Wise woman herbal childbearing year, susun weed
- Botanical medicine for women's health, Aviva Romm

Water Birth

- Choosing waterbirth, Lakshmi Bertram
- Water, Birth and Sexuality: Our Primeval Connection to Water and Its Use in Labour and Therapy, Michel Odent 2014
- Gentle Birth Choices: A Guide to Making Informed Decisions about Birthing
- Choosing Waterbirth: Reclaiming the Sacred Power of Birth

- Baby Massage Calm Power of Touch: The Calming Power of Touch, Alan Heath (Author), Nicki Bainbridge (Author), Diana Moore (Foreword), 2004
- What makes a baby, Cory Silverberg (Author), Fiona Smyth (Illustrator), 2013

Breastfeeding

- Dr. Jack Newman's Guide to Breastfeeding, Jack Newman and Teresa Pitman , 2015
- Ina May's Guide to Breastfeeding, Ina May Gaskin, 2009
- The Womanly Art of Breastfeeding: Completely Revised and Updated 8th Edition, Diane Wiessinger , Diana West , et al., 2010
- Latch: A Handbook for Breastfeeding with Confidence at Every Stage, Kaplan M.Ed. IBCLC, Robin and Abby Theuring, 2018
- Making more milk, Diana West and Lisa Marasco