

Having a baby

Having a baby

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SHPN (NKF) 110290

ISBN 978-1-74187-780-9

Further copies of this document can be downloaded from the NSW Health website www.health.nsw.gov.au

Disclaimer: Content within this publication was accurate at the time of publication.

September 2012

A revision of this document is due in 2017.

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Foreword

We are pleased to present the second edition of *Having a baby*. This resource is for all women who are pregnant or planning a pregnancy. It also provides valuable information for partners and families, helping them understand and participate in this significant phase of their lives. *Having a baby* has a strong focus on healthy pregnancies and normal birth, however, it also provides information and advice when things do not go to plan. Most importantly this resource explains the options for pregnancy and birth care in NSW and promotes informed choices for pregnant women.

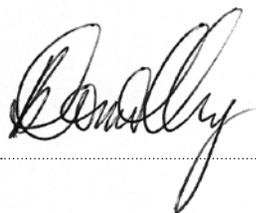
We would like to thank those women, health professionals and organisations who have contributed to the revision of this book. Their commitment, time and knowledge ensure that this publication provides current, evidence-based, best practice information about pregnancy, childbirth and the postnatal period.

The members of the NSW Maternal and Perinatal Health Priority Taskforce hope that *Having a baby* continues to be an important reference book for pregnant women and their families.



Emeritus Professor William AW Walters AM

Co-Chair, NSW Maternal and Perinatal Health Priority Taskforce



Natasha Donnelly

Co-Chair, NSW Maternal and Perinatal Health Priority Taskforce

*“There is nothing quite like finding out
you’re pregnant. You walk down the
street feeling like you have this fantastic
secret inside you” Kit*

Introduction

Congratulations on your pregnancy! You may have been planning your pregnancy for a long time, or perhaps you've unexpectedly found yourself pregnant. Either way, you're likely to have lots of questions.

This book gives you information about how to look after yourself and your baby in pregnancy and the busy weeks after the birth. It's about what to expect in labour and birth and how to make informed decisions about your care.

The book is also about your emotional wellbeing – this is part of a healthy pregnancy too. Like any big change in your life, having a baby can bring some anxiety and uncertainty. That's why *Having a baby* covers some of the concerns you may have in pregnancy and early parenthood and how to get help if you need it.

Along with good health care, support from people close to you can also help you through pregnancy, birth and life with your new baby. Share this book around so your partner, family and friends can learn more about pregnancy, how it affects you and what they can do to help.

As you read through this book, you'll find out about what is happening to you and your baby in each stage of your pregnancy along with good information about nutrition, exercise, taking care of yourself in pregnancy, getting good antenatal care, and getting ready for labour and birth. You'll also learn about the stages of labour and giving birth and what happens in the first days and weeks after your baby is born. It's also important that you know about some of the complications that can occur for mothers and their babies during pregnancy, labour and birth so there are sections dealing with these situations. We've also included some important information for you and your partner about how relationships change with pregnancy and the arrival of a baby, and about understanding your emotions as you adjust to all the changes in your life.

Information you can count on

There's lots of information around about pregnancy – some of it's good and some of it's not so good.

Having a baby has reliable (at the time of publication) information that's either based on research or that many women have found helpful. For further information, or to discuss any concerns you have, it is important to consult your health professional.



Telephone interpreters are available free of charge to anyone who wants to use health services in NSW. If you need an interpreter to contact any of the services listed in this document, you can ring the Translating and Interpreter Services (TIS) on 131 450.

When you ring TIS, you will first be asked by the operator for the language you require (e.g. Arabic, Korean etc). Depending on the language it may take a few minutes to connect you with an interpreter. Once the language interpreter is on line, you will then be asked for the service you want to contact. Have the contact details of the service ready. You will then have a three-way conversation using the telephone interpreter to communicate with the service.

What if you're not pregnant yet, but are planning to be?

This book is for you too. It has information on things you can do *before* you get pregnant to promote a healthy pregnancy.

Pre-conception advice is available from your General Practitioner (GP), women's health nurse or midwife.

See your GP for a full health check especially if you have any health problems. Some health problems can be affected by pregnancy e.g. diabetes, depression, high blood pressure and epilepsy. Also ask about any medications you are taking that could affect a developing baby. It's important not to stop any medications (prescription, over-the-counter and complementary medicines) until you have discussed it with your doctor.

Have a dental check-up. Bleeding gums happen when plaque builds up on teeth and irritates your gums. In pregnancy, hormonal changes can make your gums more easily irritated and inflamed. Keep your teeth clean, especially near the gum line. It will dramatically reduce or even prevent gum disease during pregnancy.

See your GP to check if you require vaccination or are protected against measles, mumps, rubella, varicella (chicken pox), diphtheria, tetanus and pertussis (whooping cough). Plan well ahead as you may need to have tests done to check your immunity against these diseases. You should avoid getting pregnant for 28 days following vaccination with the measles-mumps-rubella vaccine and varicella vaccines. Experts recommend that women planning to get pregnant and pregnant women get vaccinated against influenza (the flu). This vaccination can be safely given at any time in pregnancy.

Unless you've already been immunised against pertussis, you should have the pertussis vaccine soon after your baby is born. Your partner, the baby's grandparents and other regular carers of the baby should get vaccinated against pertussis before the baby is born. It is also important that your other children are vaccinated against whooping cough.

Talk to your GP about your family health history.

If you or your partner have a family history of a genetic problem like cystic fibrosis or thalassaemia, you might find genetic counselling helpful. For more information, see *Prenatal testing and genetic counselling* on page 114.

Start taking a folic acid supplement. Start it at least one month before you are pregnant. The usual dose is 0.5mg daily, though some women may be advised by their doctor to take a higher dose. For more information, see *Handle with care: looking after yourself in pregnancy* on page 11.

Change your habits. Cigarettes, alcohol, illicit and other drugs can harm unborn babies. If you need help to quit smoking or information about how alcohol and drugs can affect your pregnancy, see *Handle with care: looking after yourself in pregnancy* on page 11.

Lose weight if you are overweight or obese. It's best for you and your baby if you can get to a healthy weight before you get pregnant. Women who are a healthy weight before pregnancy may find it easier to become pregnant and are less likely to have serious complications like high blood pressure or diabetes during pregnancy. Check with your doctor or midwife if you're unsure what your ideal weight is.

For more information visit the Get Healthy website at www.gethealthynsw.com.au

Make sure your workplace is safe. Most workplaces are safe in pregnancy, but some people work with substances or equipment that can harm an unborn baby or damage male sperm. If you want to make sure the equipment and substances you work with are safe, ask your doctor, occupational health and safety officer, union representative or employer. For more information, see *Handle with care: looking after yourself in pregnancy* on page 11.

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Words to know

Abdomen Belly, tummy or stomach.

Afterbirth The placenta. It provides the baby with food and oxygen. It's attached to your baby by the umbilical cord.

Amniotic fluid The liquid the baby floats in inside the uterus. Sometimes called 'the waters'.

Amniotic sac The bag holding the fluid and the baby inside the uterus.

Amniotomy A midwife or doctor breaks the amniotic sac which holds the fluid and the baby inside the uterus.

Anaesthetist A doctor who specialises in providing pain relief.

Anaemia A deficiency in the number or quality of red blood cells.

Antenatal (Prenatal) The time during pregnancy, up until labour and birth.

Anus The back passage.

Areola The circular dark area around the nipple.

Apnoea The baby stops breathing and needs help to start again.

Augmentation Medical treatment which may help labour to progress.

Birth canal Vagina.

Birth plan A written plan which says what you would like to happen during labour and birth.

Birth weight The weight of the baby when it's first born. 'Low birth weight' means weighing less than 2500 grams.

Braxton Hicks contractions Contractions that some women feel in late pregnancy. They are not labour contractions – more like the body practising for labour.

Breech birth When the baby is born feet or bottom first.

Caesarean section operation An operation to deliver the baby. The doctor cuts the abdomen and uterus open to remove the baby.

Cervix The neck of the uterus.

Contraction When the muscles in the uterus (womb) tighten.

Diaphragm The muscle between your chest and your abdomen.

Deep Vein Thrombosis (DVT) A condition caused by a clot in one of the deep veins of the body.

Ectopic pregnancy When a fertilised egg attaches anywhere outside the uterus, most commonly in a fallopian tube.

EDB Short for estimated date of birth, which is the estimated date your baby is due.

Embryo The baby is known as an embryo until about the 12th week of pregnancy.

Epidural A type of anaesthetic that makes you numb below the waist.

Episiotomy A surgical cut in the area between the mother's vagina and anus that may be done during labour.

Fallopian tubes Tubes that lead from each ovary to the uterus.

Fetus The baby is known as a fetus after about the 12th week of pregnancy.

Folate/Folic Acid An important B vitamin found in green leafy vegetables, cereals, fruits and grains. It's also available in supplement form.

Forceps Surgical instruments that fit around the baby's head. They can be used to help the baby out of the vagina.

Genetic counsellor A health professional who provides information and support if there is a risk that your baby has a genetic condition.

General Practitioner (GP) A local medical practitioner (doctor) who treats acute and chronic illnesses and provides preventive care and health education.

Gestation The length of pregnancy usually measured in weeks.

Hypertension High blood pressure.

Induction An intervention to start the labour rather than waiting for it to happen naturally.

Internal examination The doctor or midwife puts two gloved fingers into the vagina to check on the progress of labour.

Intervention Using a medical treatment or instrument to help in labour or birth (e.g. forceps or an induction).

Jaundice A yellowness of the skin, sometimes seen in newborns.

Lactation consultant A health professional with extra training to support women experiencing breastfeeding challenges.

Lochia Bleeding from the vagina in the weeks after giving birth.

Mastitis Inflammation or infection of the breast.

Midwife Health professional who cares for women and their babies during pregnancy, labour, birthing and the postnatal period.

Miscarriage The loss of a baby before the 20th week of pregnancy.

Neonatal To do with the first 28 days after birth. 'Neonatal care' means care of newborn babies.

Neonatologist Doctor who specialises in caring for newborn babies especially if the baby is unwell.

Nuchal Translucency Test An ultrasound scan to screen for congenital conditions in a baby.

Obstetrician Doctor who specialises in caring for women during pregnancy, labour and birthing.

Ovary Ovary produces eggs (ova). Women have two ovaries.

Ovum Egg produced by the ovary.

Paediatrician Doctor who specialises in caring for babies and children.

Pap smear test A screening test for cervical cancer.

Pelvic floor A group of muscles which supports your uterus, bladder and bowel.

Perineum The area between the vagina and anus.

Placenta This provides the baby with food and oxygen while in the uterus. It's attached to the inside of your uterus at one end and at the other to the baby via its umbilical cord. It's also called the afterbirth.

Placenta praevia When the placenta is close to or covers the cervix.

Postnatal (Postpartum period) The first six weeks after the baby is born.

Postpartum haemorrhage Heavier than normal bleeding after giving birth.

Pre-eclampsia Serious condition with symptoms of very high blood pressure, headaches and visual disturbances.

Premature When a baby is born before the 37th week of pregnancy.

Quickening When the mother first feels the baby moving in pregnancy.

Show Passing the mucus 'plug' which seals the cervix.

Stillbirth When a baby dies in the uterus and is born after the 20th week of pregnancy.

Trimester Pregnancy is divided into three trimesters. The first trimester is from week one to week 12, the second trimester is from week 13 to week 26 and the third trimester is from week 27 to the birth of the baby.

Ultrasound A way of looking inside the body from the outside using sound waves. These tests are used in pregnancy to check on the size, growth and wellbeing of the baby.

Umbilical cord The cord that joins the placenta to the baby.

Uterus Womb. The part of the body where the baby grows.

Vacuum extraction A process to help the mother deliver the baby. A cup-like instrument is attached to the baby's head in the vagina using suction. The doctor then pulls gently while the mother pushes the baby out.

Vagina Birth canal.

VBAC Vaginal Birth After Caesarean section operation.

“You realise that everything in your life is going to change – but because the baby hasn’t been born yet, you don’t know exactly how it’s going to change. It’s a strange feeling, especially when you’re so used to having things under control. You feel as if you’re heading into some unknown place.” Carolyn

Antenatal care

Antenatal care

Even though you may feel really well, regular check-ups in pregnancy are important. These visits to a midwife or doctor make it easier to treat any problems early, so you're less likely to have complications with pregnancy and birth. They're also a good chance to:

- talk about how and where you'll have your baby
- ask questions
- talk about any concerns you may have.

Where do I go for antenatal care?

This depends on:

- where you plan to give birth – in a hospital, a birth centre or at home. For more information, see *Choices for care during pregnancy and birth* on page 6
- the services available in your area (ask at the antenatal clinic or maternity unit of your local hospital, your Local Health District or your GP, private obstetrician or privately practising midwife).

In NSW, maternity services are classified according to the level of care needed and type of service available. Some specialist services may only be available at larger hospitals. Ask your midwife or GP about your local maternity services, so you are aware of the range of services available, in the event that requirements for your care, or your baby's care, become more complex.

As soon as you're pregnant or think you are, see your GP or midwife. If you decide to have prenatal screening tests such as screening for Down Syndrome, you need to see your GP or obstetrician by the time you are 10 weeks pregnant so these tests can be coordinated. For more information, see *Prenatal testing and genetic counselling* on page 114.

We recommend that you book into the hospital as soon as your GP or midwife confirms your pregnancy. Most women who choose to have their babies in a public hospital or birth centre have their first antenatal visit between weeks 10 and 16, but don't wait until then to book into the hospital or birth centre.

After the first check-up, the number of visits with your midwife or doctor varies – probably every four to six weeks at the beginning of the pregnancy and more often later in the pregnancy. At these visits, the midwife or doctor will:

- talk with you about your pregnancy and health
- check your blood pressure
- check the baby's growth and wellbeing
- give you information about pregnancy, birth, breastfeeding and parenting
- answer your questions.

If you're worried about anything or have any questions, you can contact your midwife, hospital antenatal clinic, labour ward, birth unit or doctor between visits.

What happens at the first antenatal appointment?

Your midwife or doctor will ask you questions about your health such as any illnesses, medications, operations and other pregnancies and what happened. They will also ask about your family's medical history.

You might also be asked whether you smoke or use other drugs. This is not to judge you but because the more information your doctor or midwife has, the better they can support you and care for your health and your baby's health.

It's up to you whether you answer any of these questions you're asked – anything you say will be kept in confidence. The information will only be given with your permission to any health worker who needs to know as part of working with you.

You'll be offered some tests (to check for anything that may cause problems during pregnancy or after the birth). These tests will be discussed with you and you can choose whether you have them or not.

If you haven't already had a general health check-up, your midwife or GP might recommend:

- a check to make sure your heart, lungs and blood pressure are okay
- a urine test, to make sure your kidneys are healthy and check for signs of infection
- a Pap smear test
- a breast check.

Blood tests

Blood tests are used to check your health in a number of areas:

Anaemia Some women have anaemia in pregnancy. Anaemia makes you tired and less able to cope with any blood loss during labour and birth. It's most commonly caused by a decrease in your iron levels as your body uses more iron in pregnancy. Your midwife or doctor can tell you if you need iron tablets to prevent or treat anaemia. Your iron levels will be checked throughout your pregnancy.

Blood group and Rhesus (Rh) factor Your blood will be tested to find out your blood group, and to see if it's Rh positive or Rh negative.

Infections There are a number of infections that can affect pregnancy and the unborn baby. Tests may include:

- common childhood illnesses e.g. rubella (also called German measles)
- sexually transmitted infections (STIs) syphilis and hepatitis B
- bacteria that can normally live in the body but may affect the newborn baby e.g. group B streptococcus
- infections that can be passed on through blood-to-blood contact including sharing needles and other equipment for injecting drugs, e.g. hepatitis C and HIV (virus that leads to AIDS).

Rhesus (Rh) positive or Rhesus (Rh) negative – what does it mean?

Most people have a substance in their blood called the Rh factor. Their blood is called Rh positive. On average 17 people out of a 100 people don't have the Rh factor – so their blood is called Rh negative. If your blood is Rh negative, it isn't usually a problem, unless your baby happens to be Rh positive. If it is, there's a risk that your body will produce antibodies against your baby's blood.

Women with Rh negative blood group will be offered the Anti-D injection twice during the pregnancy (around 28 and 34 weeks) as a precaution.

During pregnancy you will have a blood test to see if you have developed these antibodies. After the birth, blood will be taken from the cord and you will be offered an Anti-D injection to prevent problems in future pregnancies if your baby is Rh positive.

Women who are Rh negative and whose pregnancy ends in miscarriage or termination will be offered Anti-D injection.

Some common STIs that affect pregnancy don't have symptoms. It's possible to have an infection without knowing it. You may be at greater risk of having an STI if you or your partner:

- have more than one sexual partner and don't use condoms
- have changed sexual partners in the last six months.

If you think you may have an STI, talk to your midwife or doctor about having a test.

If you have any questions about these tests, ask your midwife or doctor. It's important to have enough information beforehand so you understand what problems may be involved if there is a positive result. With some infections, midwives or doctors are required to notify medical authorities of a positive result. If this happens, your name and any identifying details won't be given to anyone. The authorities will just be told someone has tested positive to the infection. These test results are confidential.

For more information, *Handle with care: looking after yourself in pregnancy* on page 11.

Staying healthy

A healthy pregnancy is about more than just a healthy body. It's important that you are also emotionally well and getting good support from family and friends. Early in pregnancy, all women are asked some questions that will help to identify if there are any concerns they may have about their wellbeing. If there are problems, the sooner you get help to deal with them the better the outcome is likely to be for you, your family and your baby.

Even if everything is going well at your first visit, if things change for you or your family at any time during the pregnancy you can always discuss your concerns with your midwife or doctor. There are services available to help to get things back on track.

What about special tests for the baby?

Tests are available to every pregnant woman to check for some problems that may affect the baby. You don't have to have them – it's up to you. Your doctor or midwife will tell you about the tests and any costs of having them done. You'll be offered prenatal screening or diagnostic testing if you:

- are over 35 years of age
- have already had a baby with a genetic condition or inherited family health problem
- have a family history of a genetic condition.

For more about these tests and what to think about before you decide to have them, see *Prenatal testing and genetic counselling* on page 114.

I have mixed feelings about pregnancy...

Maybe you didn't plan to get pregnant right now – or maybe you didn't plan to get pregnant at all. If you're anxious about how you'll cope, don't be worried about telling your midwife or doctor. They may be able to refer you to services that can offer you practical and emotional support. If you're a teenager, there may be special services for you in your area.

Even if the baby is planned, it's still normal to feel anxious and uncertain sometimes. You may worry about giving birth or how you'll cope after the baby arrives. On top of all this, changes to your body may make you feel tired. Talk to your partner, your friends or family about how you are feeling. For more information, see *Your feelings in pregnancy and early parenthood: what all parents need to know* on page 136 and *Relationships in pregnancy and early parenthood* on page 144.

Pregnancy and stress

Pregnancy and early parenthood is an amazing time. However, it can be hard work even when everything is going well. Parenting can be a challenge, and this is particularly the case when there are other stresses in your life such as:

- domestic violence or emotional abuse
- depression, anxiety or other mental health issues
- financial worries
- having no family or friends close by to help
- sexual abuse (including sexual abuse in your past).

It is important to remember that you are not alone and that there are many services to help and support you. Don't be afraid to talk to your midwife or doctor about these or any other problems or concerns.

Some women have had experiences in the past – such as sexual abuse – which can cause difficulties for them in pregnancy and birth. A hospital social worker or counsellor may be able to help you plan ways to cope with this. They can listen to your concerns and talk with you about some of the things other women have found helpful in their birth plans.

So why are they asking me all these questions?

You may be surprised by some of the questions that come up at the first antenatal visit: Have you ever had problems with domestic violence? Are there family or friends around who can give support during pregnancy and afterwards? Have you ever had to cope with sexual abuse? Have you had any terminations or miscarriages?

All women in NSW (not just you) are asked these things. The questions help midwives and doctors to make sure you get help or support if you need it. Getting help early for any concerns you have may improve the health and wellbeing of both you and your developing baby and make parenting easier after your baby is born. You don't have to answer any questions you don't want to but remember that things you tell your midwife or doctor are confidential.

It's okay to ask questions

It's good to ask questions. Asking questions helps you understand more about your care. Remember that it's your right to:

- be fully informed about any tests or treatment you're asked to have
- refuse any tests or treatment you're offered.

You might want to ask your midwife or doctor:

- is this test/treatment routine in pregnancy
- how does it work
- why do I need it
- what are the benefits to me or my baby
- are there any risks to me or my baby
- do I have to have it
- what happens next if the results of a test are positive? What happens if they are negative
- what are the chances of the test result being wrong (a false negative or a false positive)?

Write your questions down and take to your next appointment.

Thinking ahead... how will I feed my baby?

Most women think about how they'll feed their baby very early in pregnancy. It's best not to have fixed ideas without getting all the information you need to make a decision.

Breastfeeding is important. It has great health benefits for you and your baby. Breastfeeding improves your baby's immune system so there is less chance that he or she will get sick. Breastmilk is the only food that most babies will need up to six months. Breastfeeding helps mothers get their bodies get back into shape after childbirth. It also reduces the risk of some cancers. In most circumstances and with the right support from health professionals and family members most women will be able to breastfeed their babies.

How you feed your baby is an important and personal decision that will be supported by all health professionals. For more information, see *Feeding your baby* on page 93.

*Choices for care
during pregnancy
and birth*

*Choices for care during pregnancy
and birth*

hospital to hospital and area to area so you might find a number of options open to you. These include:

The information in this section and in *Labour and birth*, which starts on page 70, can help you decide about where you want to give birth to your baby, and the sort of care you'd prefer during your pregnancy, labour and after your baby is born.

Pregnancy and childbirth are natural life events. It's most likely that you will have a normal pregnancy and birth. But while all women hope for a normal pregnancy and birth there is a chance of complications in pregnancy – for you, your baby or both of you. Some complications are found early while other problems may develop later in pregnancy or during birth. The purpose of your antenatal care is to identify any risks to you or your baby and manage them in the best possible way.

This section describes your main choices for pregnancy and birth care whether you choose to be cared for in the public health system or the private health system. For further information, talk with your midwife or your doctor.

Public health care choices

Pregnancy care choices

If you choose to receive your antenatal care and give birth in the public health system, you and your baby will receive your care through an antenatal clinic, a midwives' clinic or with your GP (in partnership with the antenatal clinic). The services offered vary from

An antenatal clinic in a public hospital The maternity unit at your local hospital usually has an antenatal clinic. Call the hospital to book in as soon as your pregnancy is confirmed. At the same time, you'll probably also arrange a date for your first antenatal visit to the clinic (sometime between 10 and 16 weeks). At your first visit to the clinic, a midwife will help you complete the booking process. This involves answering questions and filling in forms. If you or your midwife have identified any potential complications you might also see a doctor for a full medical examination. If you need specialist care, you might see one or several doctors (through the Doctor's Clinic at the hospital) during your pregnancy. If you need it, you can also be referred to other health workers (e.g. social workers, physiotherapists, dietitians) who can help you during your pregnancy.

Midwives clinic Most public hospitals also offer midwives' clinics. These clinics might be located at the hospital or birth centre, or in the community (for example, at your local Community Health Centre). Midwives care for women with normal pregnancies and during their labour and birth in birth centres or at home (if you've chosen to have a homebirth). Your midwife will refer you to a doctor if you develop any health concerns during your pregnancy. The doctor and midwife will work together with you to plan the best possible care. Birth centres and public homebirth services provided by public maternity services are very popular, so if you think you'd like one of these options, phone the hospital as early in your pregnancy as you can.

GP shared care If your GP offers shared care, you can choose to continue to see your GP for most of your antenatal care. You will see your GP for some appointments and attend the clinic for other check-ups. It's another option for women with normal pregnancies. Not all GPs do shared care. If your doctor doesn't offer shared care, ask at the hospital if it has a shared antenatal care program and they can offer you a list of GPs in your area who do offer shared

care. One of the benefits of GP shared care is that you develop a long-term relationship with a doctor who can continue to look after you and your baby once your baby arrives.

What is midwifery continuity-of-care?

Many public hospitals now offer midwifery continuity-of-care programs. You'll get to know the midwife or midwives who will look after you through your pregnancy, labour and birth and the postnatal period. You'll receive consistent information, support and advice from your midwife or midwives. This type of care has been shown to help you feel confident during this time. Your hospital may offer:

- **Caseload midwifery or midwifery group practice** If you're booked in for this kind of care, you'll have one midwife whom you'll get to know well over the course of your pregnancy, labour, birth and postnatal care. Your midwife will provide your midwifery care and will have one or two other midwives to back them up if they are not available. Your midwife will also coordinate your care and work in collaboration with the doctors in the maternity service if that's needed.
- **Team midwifery** In a team midwifery practice, a small team of midwives will care for you at a hospital antenatal clinic during your pregnancy, through your labour and after the birth. The midwives work with doctors in the maternity unit. You will usually get to know all the midwives on the team, and one of them will always be available for your labour and birth care.

Special services

Some hospital antenatal clinics may provide extra services to meet the need of:

- women who speak languages other than English
- women with specific cultural needs
- teenage women.

Ask your midwife about special services that may be available at the clinic.

The Aboriginal and Maternal Infant Health Service (AMIHS) is a culturally appropriate maternity service for Aboriginal mothers, babies and families. Ask your midwife or doctor if there is a local service near you.

Place of birth choices

In the public system, you can choose to have your baby in the hospital, at a birth centre (which may be located at a hospital) or at home.

Hospital care Choosing hospital care means you'll have your baby in the delivery/birthing unit of a public hospital. Midwives and/or doctors will provide care and support you through the birth. After the birth you'll be cared for in a postnatal ward by midwives, doctors and other health workers.

Birth centre Birth centres look and feel more like a home than a hospital. You'll be looked after in labour and birth by midwives. After giving birth at a birth centre, you're likely to go home within 24 hours and have follow-up care by midwives at home. Birth centres are an option for women with normal pregnancies, but aren't suitable for women with a higher risk of complications. This includes women who have heart or kidney disease, diabetes, high blood pressure or who have had complications in previous labours. The guidelines can vary from centre to centre so check with your birth centre. In a birth centre epidurals are generally not available. If a problem arises during your labour that requires medical attention you might be moved to the hospital delivery/birthing unit.

Home Some public hospitals provide homebirth services which you may be able to use if your pregnancy is progressing normally. You can find

out about these by asking your midwife, doctor or through your local hospital's birth centre. You can also choose a homebirth by hiring a privately practising midwife.

If you decide to have a homebirth, it is important to:

- have a registered midwife, GP or obstetrician care for you in labour and birth
- have regular antenatal care by a midwife or doctor in pregnancy
- have postnatal care provided by a midwife or doctor
- have your newborn baby checked by a midwife or a doctor in the first week after birth
- be sure your midwife or doctor offers tests for the baby after the birth or refers you to a service that does them
- be sure your baby is offered vitamin K and other treatments as required after birth
- book into your local hospital as a backup option if your birth does not go to plan.

To find out more about homebirth, contact the Australian College of Midwives (NSW) on (02) 9281 9522, or Homebirth Access Sydney on (02) 9501 0863 or visit www.homebirthsydney.org.au

What if I prefer a female doctor or midwife?

Some women prefer a female doctor or midwife. Hospital staff understand this, and try to provide female staff if they can. Most hospital midwives and

many doctors are female, and staff will try to provide a female practitioner.

However, it's also true that most hospitals have both male and female doctors and midwives and there may be times when it's not possible to see a female practitioner. In an emergency, the most important thing is that you and your baby receive the most skilled care available – this may mean that a male doctor, male midwife, or male nurse is involved.

All staff will respect women's preferences. If you're being treated by a male health professional, you can ask for a female staff member to be there if one is available.

If you choose to see a female obstetrician in private practice, she will usually attend the birth of your baby in hospital but, again, this may not be possible in an emergency.

In a public hospital, you might also receive care from midwifery and medical students and obstetricians and paediatricians who are in training under the supervision of practising midwives, obstetricians and paediatricians.

If you have any concerns or worries about the care you receive speak with your midwife or doctor. If you don't feel comfortable doing that, you can also speak to the manager, patient liaison officer or your GP.

Private health care choices

Some women choose their own care provider to look after them during their pregnancy and birth. This means you book in to see a private obstetrician, a

GP who does antenatal care, or a privately practising midwife. You can choose a private practitioner who practices in a private hospital, a public hospital or

conducts homebirth. You will have to pay for the cost of your care (which varies but can be high). Most women who choose these options have private health insurance to help cover the costs.

Check with your health fund to find out what aspects of your care and health care services are covered during your pregnancy, birth and postnatal period.

Private obstetrician and GP obstetrician With this option you receive care from a private obstetrician (Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists) and/ or a GP (Diploma of Royal Australian and New Zealand College of Obstetricians and Gynaecologists or equivalent post graduate training in obstetrics). You'll see them at their offices. Some obstetricians employ a midwife who may also be involved in your antenatal care.

Generally, private obstetricians or GP obstetricians deliver babies at a small number of hospitals so you may have to choose between a couple of hospitals. You will be cared for in labour by midwives employed by the hospital but your doctor will be closely involved and will normally be present at the birth of your baby. Some obstetricians and GP obstetricians may also offer pregnancy care in your home and support homebirth.

While you're in hospital, your postnatal care will be provided by the hospital midwives and your doctor. Your private obstetrician or GP obstetrician will provide ongoing care for up to six weeks postnatally.

Privately practising midwives Some women

choose to have a home birth with a privately practising midwife (registered with the Nursing and Midwifery Board of Australia). The midwife will care for you through your pregnancy, birth and after the baby is born.

Some private midwives ("eligible" midwives) now have a Medicare Provider Number, as doctors do. This means that the services they provide are covered by Medicare although, as with doctors, there may be a "gap". Ask your midwife for payment details and possible rebates for her services.

In the future, you may be able to book into your hospital under the care of your private midwife. Your midwife will provide midwifery care during your pregnancy; labour and birth care in hospital; and postnatal care in your home, and will be able to refer you to an obstetrician or GP obstetrician at any time in your pregnancy, labour or birth if the need arises.

*Handle with care:
looking after yourself
in pregnancy*

*Handle with care: looking after
yourself in pregnancy*

Exercise

It's great to be active and stay fit while you're pregnant, but check with your midwife or doctor first to make sure there are no health problems to prevent you from exercising. If there are no problems, try to do 30 minutes of moderate exercise, like walking or swimming, on most days of the week.

Regular exercise can:

- help you stay at a healthy weight
- help you relax
- help make you stronger and fitter – good for coping with pregnancy, labour and being a parent
- help decrease discomforts like back pain and varicose veins that affect some pregnant women

If you haven't been physically active before pregnancy, it's good to begin by doing gentle exercise. Walking, swimming and aqua classes (exercises in water) are good. Talk to your doctor or midwife first.

If you were active before pregnancy or if you play sport, talk to your midwife or doctor about your exercise routine. You need to make sure there are no health problems to prevent you from doing some activities, and that your exercise routine won't cause problems in pregnancy.

Be aware that pregnancy can increase your risk of injury. This is because your ligaments and joints loosen up to let your body grow bigger and to make it easier to give birth. Prevent injury in pregnancy by avoiding high-impact exercise (jumping up and down and repetitive bouncing movements) and any movements that over-stretch your hip, knee, ankle or elbow joints.

As well as keeping fit with moderate exercise, it is important to take special care of the muscles in your tummy, back and pelvic floor which are under more stress than usual in pregnancy. For more information about special exercises you can do throughout pregnancy see *Give me strength: pre- and post-natal exercises* on page 37.

Medications in pregnancy

Care with prescription and over-the-counter medications and herbal remedies

Some drugs (either prescription drugs or medication you buy from the chemists without a script) may be harmful in pregnancy. This includes common over-the-counter medications such as anti-inflammatories like Nurofen™, cold and flu medicines and remedies for nausea, vomiting and indigestion.

If you're thinking of taking any medication in pregnancy:

- paracetamol is considered the safest option for pain and fever
- check with your pharmacist, midwife or doctor first
- use the lowest effective dose
- avoid taking a variety of medications
- call MotherSafe on (02) 9382 6539 (Sydney metropolitan area) or 1800 647 848 (regional NSW).

Prescription drugs

If you take regular medication, it is very important to check with your doctor as soon as you know you are pregnant. Some medications may be harmful in pregnancy and can cause serious birth defects.

What if my doctor prescribes me a medication?

Make sure you tell your doctor if you're pregnant or trying to become pregnant.

What if I need to take medication regularly?

See your doctor and ask if your medication should be changed. If you have a chronic illness such as asthma, arthritis, depression, inflammatory bowel disease or epilepsy, you may need to keep taking medication. Talk to your midwife or doctor or contact MotherSafe to ask about the safest options in pregnancy or when breastfeeding.

Is the medication that I am taking for my mental health condition safe?

For some women with a mental health condition, it may be best to continue with your medication through pregnancy, rather than not treat the condition. Check with your doctor about the medication you are using.

Herbal remedies and aromatherapy

There's been very little research into the effects of herbal products on pregnancy, including the use of homeopathy and aromatherapy. Many people think that herbal products are safer because they're natural. But herbs can have very strong effects, so it's best to be as cautious with them as you are about other medicines.

Unlike medications made in a lab, herbs made by nature can vary a lot in their strength so it can be difficult to know for certain whether the dose you are taking is safe or not. The safest thing to do is to ask your doctor before you take anything, whether it's a herbal product or medication from the chemist.

Herbal remedies that should definitely be avoided when you're pregnant include aloe vera, angelica, arbor vitae, black cohosh, blue cohosh, cascara sagrada, comfrey, dong quai, feverfew, golden seal, juniper, passionflower, pennyroyal, pokeweed and slippery elm.

Health alert!

Do not stop taking your regular medications before checking with your doctor or pharmacist.



If you have a fever, tell your doctor as soon as possible. It's safer to take paracetamol to help reduce fever rather than have a high fever for too long, especially in the first few weeks of pregnancy.



It is really important that your midwife and doctor know if you have used any drugs before or during your pregnancy, as your baby may need special care when it is born.

What about St John's Wort?

If you're taking this herb for depression, tell your midwife or doctor. If you have depression there may be services and other therapies that can help.

Can I drink herbal tea in pregnancy?

Generally, if you drink them in normal amounts, most herbal teas are harmless.

Is raspberry leaf tea safe in pregnancy?

As with many traditional remedies, there isn't enough research to give a clear answer. There are claims that raspberry leaf tea can ease morning sickness. But there are also suggestions that it can cause nausea and may even contribute to miscarriage or premature labour by encouraging the uterus to contract. As to whether it helps make labour a little easier, that's not clear either. Australian research found that although raspberry leaf tea didn't shorten the first stage of labour, it did shorten the second stage slightly. It also lowered the rate of forceps or caesarean section operations a little.

The bottom line? We need more research. Until then, be guided by your midwife or doctor and – to be on the safe side – use other remedies for morning sickness. For more information, see *Common concerns in pregnancy* on page 43.

Alternative medicines and approaches

As with herbal remedies, there isn't a lot of research about the safety and effectiveness of many alternative medicines and treatment options. Some

treatment options, like acupuncture, massage, chiropractic and osteopathy, have been shown to be safe in pregnancy if the practitioner is fully qualified and experienced in treating pregnant women. However, some treatment options have not been properly evaluated, which means we can't say for certain whether there are any risks to you or your baby.

You should always talk with your doctor or midwife before beginning any new product or treatment while you're pregnant.

*Still smoking?
Now's the time to quit*

Quitting smoking is one of the best things that you can do for you and your baby. While quitting early in pregnancy produces the greatest benefits, quitting at any time during pregnancy reduces the

risk to the baby. Cigarettes can be a hard habit to break, but there's help and support available if you want to quit. It's good if your partner and other family members quit too. You all need to protect your baby from the effects of cigarette smoke.

Smoking in pregnancy is harmful because babies of smokers are more likely to:

- be at risk of stillbirth
- be premature (born before the end of the 37th week)
- be underweight. When you smoke harmful chemicals from cigarettes enter your baby's bloodstream. The baby then gets less oxygen and doesn't grow as well. Underweight babies are more likely to have health problems after birth
- have lung problems like asthma after they're born
- be at risk of SIDS.

Health Alert!

Stay away from other people's smoke

Passive smoking is breathing in other people's smoke. Every time someone smokes around you or your baby, you are all smoking too. Try to avoid other people's cigarette smoke while you're pregnant. Once the baby is born, don't let anyone smoke anywhere near your baby. Keep the baby away from places (e.g. beer gardens or parties) where people are smoking.

If you need help to quit

Call the Quitline (13 78 48). The Quitline is a confidential, telephone-based service designed to help people quit smoking. The Quitline is available 24 hours a day, 7 days a week, every day of the year. There are many programs available to help you quit. And there isn't a more important time to do it. Speak to your midwife or doctor about quitting.

Can I use nicotine gum or patches in pregnancy?

Nicotine replacement therapy (NRT) can help you quit smoking. These products include nicotine patches, gum, lozenges, tablets that dissolve under your tongue and inhalers. They give you a small amount of nicotine that helps reduce the craving for cigarettes. Although it's best to have no nicotine in your body at all, using NRT to help you quit is better than smoking cigarettes because:

- the nicotine dose is lower
- you don't take in other harmful chemicals that are present in cigarette smoke
- other people around you won't be breathing in smoke from your cigarettes.

If you want to try NRT, it's best to use the gum, dissolving tablets or inhaler. They only give you small doses of nicotine and you can control how much you have. Patches give a continuous dose of nicotine, and this is not ideal for the baby. But it's important to use these products in the right way. Ask your doctor or pharmacist what might work best for you.

If you're breastfeeding, nicotine gums, lozenges, tablets that dissolve under the tongue or an inhaler is better for you and the baby than smoking. You should feed your baby before you use these products. If you continue to smoke, you should feed your baby before you have a cigarette.

If I have a smaller baby because I smoke, won't that make it easier for me to give birth?

No! Having a smaller baby doesn't mean labour will be easier – but a baby who hasn't grown well in pregnancy and is underweight is more likely to have both short and long term health problems.

What if I just cut down and smoke fewer cigarettes? Isn't that better for the baby?

Many people who smoke less (or smoke lower tar cigarettes) make up for it by inhaling more smoke, causing more health problems for themselves. Not smoking at all is the safest option for you and your baby.

Alcohol – is there a safe amount to drink during pregnancy?

When you drink alcohol, the alcohol travels from your bloodstream into the baby's bloodstream and increases the risk of complications for both you and your baby. The safest option for pregnant women or women trying to get pregnant is to not drink any alcohol.

Heavy drinking of alcohol in pregnancy has been linked to a higher risk of miscarriage, stillbirth and premature birth.

Regular heavy drinking of alcohol (more than eight standard drinks a day) also increases the risk of fetal alcohol syndrome. Babies born with fetal alcohol syndrome have intellectual problems; problems with co-ordination and movement; defects to the face, heart and bones; and slow physical growth.

I had a few drinks before I found out I was pregnant...

Don't panic – current evidence seems to suggest that the risk of harm to the baby is likely to be low if the expectant mother has had small amounts of alcohol before she knew she was pregnant.

If you're worried, speak to your midwife or doctor or contact MotherSafe on (02) 9382 6539 (Sydney metropolitan area) or 1800 647 848 (a free call).

Illicit drugs

Most drugs taken during pregnancy will reach the baby through the placenta. It's difficult to know exactly what's in illicit drugs such as cannabis, speed, ice, cocaine, heroin, ecstasy or LSD. They may contain more than one type of drug and/or be mixed with other substances. This makes it hard to know what effect they may have on the pregnancy or the developing baby, but we know they increase the risk of complications for you and your baby.

Using more than one drug, as well as alcohol is another concern because the effects on the pregnancy or the baby are unknown. Regular use of some drugs, including cocaine, speed and heroin can also cause withdrawal symptoms in the baby after birth.

The table *Drugs in pregnancy – what we know* (on the following page) lists some of

the known effects of drug use on a mother and her developing baby.

The safest option for a pregnant woman is to not use any illicit drugs. People who inject illicit drugs or steroids can be at risk of catching viruses such as hepatitis C and hepatitis B. If you are using drugs, speak with your doctor or midwife as soon as possible to discuss your choices in pregnancy care.

What if I took drugs before I knew I was pregnant?

If you took drugs before you knew you were pregnant, it's important not to panic. Speak to your midwife, doctor or contact MotherSafe (02) 9382 6539 (Sydney) or 1800 647 848 (a free call).

Methadone and buprenorphine in pregnancy

If you use heroin or other opioid drugs, talk to your midwife or doctor about replacing them with a methadone program. Using methadone or buprenorphine rather than heroin can:

- improve the health of you and your baby
- reduce risks to your baby
- reduce the risk of complications in pregnancy
- help to stabilise drug use and lifestyle.

Drugs in pregnancy – what we know

Drug	How it affects pregnancy
Benzodiazepines (Valium, Normison, Serepax, Hypnodorm, Xanax, Temaze)	<ul style="list-style-type: none"> • These drugs cross the placental barrier and can affect the growth and development of the baby. • They can produce withdrawal symptoms in newborn babies. • If you have been prescribed benzodiazepine, it is important that you speak with your doctor if you are pregnant or planning to get pregnant. • These drugs can also be passed from mother to baby through breast milk. The baby's body cannot process these drugs quickly and they can build up in high doses.
Cannabis (pot, dope, ganja, grass, weed)	<ul style="list-style-type: none"> • Smoking cannabis with tobacco means you inhale carbon monoxide and other harmful chemicals that may cause problems for the baby. • It increases the risk that the baby will be born prematurely and with lower birth weight.
Cocaine	<ul style="list-style-type: none"> • Cocaine use increases the risk of miscarriage and stillbirth. • It can narrow the blood vessels in both the mother's uterus and in the baby which reduces the blood supply to the baby, causing growth problems, and can cause the placenta to detach from the uterus.
Methamphetamines (speed, ice, crystal meth)	<ul style="list-style-type: none"> • Methamphetamines increase the heart rate of mother and the developing baby. • Like cocaine, these drugs can narrow the baby's blood vessels causing growth problems and may also cause the placenta to detach from the uterus. • Smoking cigarettes can increase the effect of speed on the baby's blood vessels. • Using these drugs during pregnancy has been linked with bleeding, early labour, miscarriage and an increased risk of fetal abnormalities.
Ecstasy (E, XTC, X)	<ul style="list-style-type: none"> • Ecstasy causes a rise in blood pressure and body temperature which can cause complications in pregnancy and problems for the baby. • The use of these types of drugs during pregnancy has been associated with delayed development and subtle abnormalities.
Opioids (heroin, morphine, pethidine, codeine, oxycodone, methadone, tramadol)	<ul style="list-style-type: none"> • Opioid use in pregnancy increases the risk of miscarriage, premature birth, stillbirth, low birth weight, and Sudden Infant Death Syndrome (SIDS).

Infections that may affect you or your baby

Be careful with caffeine

Caffeine is a stimulant drug in coffee, tea, chocolate and other drinks (such as cola and energy drinks). There are concerns that too much caffeine may increase the risk of miscarriage and unsettled babies. Although some studies suggest low to moderate amounts of caffeine don't increase the risk, others say that more than 300mg of caffeine a day may be linked to a higher risk of miscarriage, especially in women who smoke or drink alcohol. To be on the safe side, have no more than 200mg of caffeine daily in pregnancy.

200mg is the same as:

- 2 cups ground coffee (100mg per 250ml cup) or
- 2½ cups instant coffee (75mg per 250ml cup) or
- 4 cups medium-strength tea (50mg per 250ml cup) or
- 4 cups cocoa or hot chocolate (50mg per 250ml cup) or
- 6 cups cola (35mg per 250ml).

The amount of caffeine in some soft drinks can vary so check the label. Some soft drinks also contain guarana, a plant extract containing caffeine. It's not known what the effects of guarana are in pregnancy.

Although many infections – like the common cold – cause no problems in pregnancy, some can be passed on to the baby and be harmful. Tell your midwife or doctor if there's a chance you have one of the infections on the chart on the following pages.

Some STIs can affect your pregnancy or your baby. It's possible to have an STI without knowing it – some infections don't have symptoms. If you need further information or help about STIs, contact the Sydney Sexual Health Centre which provides free and confidential services on 1800 451 624 (a free call) or visit them at www.sshc.org.au

Where to get more help and information about drugs and pregnancy:

MotherSafe on (02) 9382 6539 (Sydney Metropolitan Area) or 1800 647 848 (regional NSW). MotherSafe operates from 9am to 5pm, Monday to Friday (excluding public holidays). You can also visit MotherSafe online at www.mothersafe.org.au

ADIS (Alcohol and Drug Information Service): a 24-hour telephone line for anyone who wants help with a drug or alcohol problem, or information about drugs or alcohol. Tel: (02) 9361 8000 or 1800 422 599 (regional NSW).

Infections in pregnancy

Infection	How it's passed on	Symptoms
Pertussis (Whooping cough)	Close contact with an infected person – droplets spread by coughs or sneezes pass it on. These droplets can be in the air, on used handkerchiefs or on surfaces the person has touched.	May include mild fever, blocked or runny nose, tiredness and cough. The typical feature is coughing bouts taking a big gasping breath which causes a “whooping” sound.
Influenza (flu)	As above.	Typical symptoms include fever and chills, cough, sore throat, runny nose, feeling very tired, muscle aches, joint pains and headaches. Seek immediate medical advice if symptoms become worse or if you experience shortness of breath, chest pain, confusion, sudden dizziness or persistent vomiting.
Rubella (German measles)	As above.	May include faint rash, mild fever, runny nose, sore throat, swollen glands and joint pain.
Chickenpox (varicella)	As above.	Sudden onset of slight fever, runny nose, feeling generally unwell and a skin rash which begins as small lumps before becoming blisters and finally scabs.
Hepatitis B	Is caused by a virus that lives in blood and body fluids. Can be passed on through sexual intercourse, by sharing needles, unsterile body art (tattoos), or passed on to the baby during birth.	Many people who carry hepatitis B virus have no symptoms, but can still pass the disease onto other people. Symptoms include a yellow tinge to the skin and whites of the eyes (jaundice), dark urine and pale stools, fever, loss of appetite, feeling tired, joint pains.

	<i>Effect on baby</i>	<i>What you should know</i>
	<p>It can be a life-threatening infection in babies. Some newborns may not cough at all but can stop breathing and turn blue. Some babies have difficulties in feeding and can choke or gag.</p>	<p>Pertussis vaccines provide good protection from infection but a booster dose is always needed as the immunity fades away. Babies need to be vaccinated at 2, 4 and 6 months. Unless the mother has been immunised against pertussis, she should have the vaccine soon after her baby is born. Her partner, grandparents and regular carers of the baby should receive the vaccine before the baby is born. It is also important that your other children are vaccinated against pertussis.</p>
	<p>Can cause miscarriage or other complications in pregnancy like premature labour.</p>	<p>Flu is a highly contagious respiratory illness. It is important to get vaccinated each year before the flu season as a new vaccine is prepared every year to best match the strains predicted for the coming influenza season. The vaccination is free for all pregnant women and is considered safe for use anytime in pregnancy and while breastfeeding. However, women with an allergy or hypersensitivity to eggs should not receive the influenza vaccine. In immunised women, antibodies cross the placenta and babies are born with high levels which protect them in the newborn period.</p>
	<p>Can cause miscarriage and serious birth defects, including intellectual disability and problems with sight, hearing and the heart.</p>	<p>It's best to have your immunity checked before pregnancy (even if you've been immunised). You can be immunised against rubella before you get pregnant (but not when you're already pregnant). Tell your doctor or midwife if you have been in contact with someone with rubella.</p>
	<p>Can cause birth defects, as well as chickenpox infection in newborn babies.</p>	<p>Most women in Australia are immune to chickenpox. You can be immunised against chickenpox before you get pregnant (but not when you're already pregnant). Tell your doctor or midwife if you have been in contact with someone with chickenpox.</p>
	<p>Can pass the infection on to the baby during birth.</p>	<p>Women are offered testing for hepatitis B during pregnancy. All babies born in NSW are offered free hepatitis B immunisation in hospital after the birth. This helps protect the baby from hepatitis B generally. It also helps protect the baby from infection if the mother has hepatitis B. If a mother has hepatitis B, an extra injection will be given to the baby to help protect him or her.</p>

Infections in pregnancy continued

Infection	How it's passed on	Symptoms
Hepatitis C	Is a chronic liver disease caused by a virus in the blood. It mainly affects people who inject drugs. It's caught when blood from an infected person gets into the bloodstream of another person. This can happen through sharing needles and other equipment used for injecting drugs, or through unsterile body art (tattoos). Some people have caught the virus from blood transfusions or blood products before 1990.	As for hepatitis B.
HIV	Many people have no symptoms in the early stages. You may be at risk of HIV if: <ul style="list-style-type: none"> • you have had unprotected sex • you or your partner are from a country where HIV is more common, including some African and Asian countries • you have shared drug injecting equipment • you had a blood transfusion in Australia between 1980 and 1985 	May include persistent flu-like symptoms – fever, sore throat, swollen glands, rash. Also unexplained diarrhoea, weight loss, recurrent rashes, or AIDS-related illnesses such as pneumonia, skin cancers, brain infections and severe fungal infections.
Parvovirus, also known as slapped cheek disease or fifth disease	Close contact with an infected person. It's passed on by droplets from coughs and sneezes. Affects mostly preschoolers and schoolchildren.	Usually a mild illness with fever, lace-like rash (appearing first on the cheeks), sometimes joint pain.
Cytomegalovirus (CMV)	Infection that's picked up from close person-to-person contact through saliva, urine, and other bodily fluids. Can be passed on from children's nappies as well as by droplet infection.	Usually no symptoms in healthy adults. May cause symptoms similar to glandular fever.
Strep B (group B streptococcal infection)	Infection caused by bacteria (group B streptococcus). About 12-15 out of 100 women carry the bacteria in the vagina.	No symptoms in women.
Toxoplasmosis	Infection caused by a parasite found usually in cat faeces. Can also be caused by eating raw or undercooked meat.	Swollen lymph glands, muscle aches and pains, headaches, fever, generally feeling unwell.

	<i>Effect on baby</i>	<i>What you should know</i>
	<p>There is a small risk (5 out of every 100 babies born to a mother with hepatitis C) of passing the infection onto the baby during pregnancy or birth. The chances of passing it on to the baby in breastfeeding are very small, unless you have blood-to-blood contact with the baby (e.g. you have cracked nipples and the baby has scratches around the mouth).</p>	<p>If you are at risk of hepatitis C, get tested. For more information about hepatitis C in pregnancy, call the Hepatitis Helpline on (02) 9332 1599 or 1800 803 990. This is a free, confidential service.</p>
	<p>HIV can be passed on to a baby during pregnancy (although thought to be the least common way), birth or breastfeeding. The risk of mother-to-baby infection is as low as 2 out of every 100 babies if the mother has treatment, but risk increases if untreated. Baby has treatment after the birth. Breastfeeding is avoided.</p>	<p>Women are offered testing for HIV during pregnancy. If you have HIV or AIDS in pregnancy, you need specialist advice on treatments to improve your health and reduce the risk to the baby. For more information, contact ACON (AIDS Council of NSW) Tel: (02) 9206 2000.</p>
	<p>May cause miscarriage.</p>	<p>Most adults are immune, but healthcare and childcare workers and teachers may be at risk. Be aware of any outbreaks in schools or preschools that you're in contact with. Tell your doctor or midwife if you've been in contact with a child with the disease.</p>
	<p>Babies infected by CMV in pregnancy are at risk of disease of the liver or spleen, hearing loss, mental development and eyesight problems.</p>	<p>Careful hand washing (e.g. after contact with children or handling nappies) can lower the risk. If you think you have been exposed to CMV, talk to your doctor or midwife.</p>
	<p>Can be passed to the baby during birth and cause a serious infection. If infected the baby will need antibiotics and may need intensive care.</p>	<p>NSW Hospitals have two different ways of handling Strep B. In most hospitals you'll be checked for Strep B. If you're carrying Strep B you'll be given antibiotics in labour. In other hospitals, women with risk factors will be given antibiotics in labour. Risk factors include labour before 37 weeks or having a high temperature.</p>
	<p>Infection can be passed on in the uterus and potentially cause serious problems such as mental impairment and blindness in the baby.</p>	<p>Problems only occur if a woman becomes infected for the first time while pregnant. Precautionary measures include washing hands after handling raw meat, cooking meat thoroughly, and avoiding contact with cats – do not handle litter trays.</p>

Infections in pregnancy continued

<i>Infection</i>	<i>Symptoms</i>	<i>Effect on the baby</i>
Syphilis	Most women with syphilis have no symptoms. Symptoms may include painless sores in and around the vagina and rashes on the hands, feet or other parts of the body.	It can cause late miscarriage. If a pregnant woman has syphilis, she can pass it on to the baby. It can cause blindness in babies.
Chlamydia	<p>Women may have this without knowing it, but there may be symptoms like discharge or irritation when you pass urine, or deep abdominal pain during vaginal sex. Apart from symptoms, other good reasons to have a test are:</p> <ul style="list-style-type: none"> • being under 30 • if you or your partner have had a new sexual partner in the six months before you got pregnant • if you've been diagnosed with another STI <p>If untreated, chlamydia can also cause a serious infection (pelvic inflammatory disease) in the fallopian tubes or uterus. This can affect fertility.</p>	Can be passed on to the baby during birth, causing eye infection (conjunctivitis) or pneumonia.
Gonorrhoea	Extra vaginal discharge or irritation when you urinate; deep abdominal pain during vaginal sex.	If you're infected and not treated, the infection can be passed onto the baby causing eye infection (conjunctivitis) or upper respiratory tract problems
Genital herpes	Painful, tingling or itchy blisters in the genital area. Some people get flu-like symptoms. Sometimes there are no symptoms.	Tell your doctor or midwife if you or any of your partners have had or has genital herpes. The risk of infecting the baby is highest when you have your first outbreak of blisters, or when you're recovering from this first outbreak. Further outbreaks during pregnancy rarely affect your unborn baby. But if you think you may have an outbreak when labour begins, go to the hospital as soon as possible. You may need a caesarean section operation to prevent the baby getting sick. If you've had recurrent outbreaks before, the baby may have some immunity to genital herpes.
Genital warts	Genital warts are often painless. They may start as tiny painless swellings on the genitals, sometimes turning into little cauliflower-like lumps especially during pregnancy. But sometimes genital warts are flatter and harder to see.	Although common in pregnant women, genital warts rarely cause problems.

Work and pregnancy

	Treatment
	Antibiotics. Everyone should have a blood test in early pregnancy.
	Antibiotics. If you think you may have chlamydia talk to your doctor or midwife.
	Prompt treatment with antibiotics usually prevents harm to the baby.
	Medication can suppress outbreaks of herpes, and treat the symptoms. But because the virus stays in the system, symptoms can return.
	Warts can be removed but the virus, which causes them, stays in the system. Warts may reappear.

Unless your job involves heavy physical work or occupational hazards that may affect your baby, there's no reason why you can't work while you are pregnant. Some jobs bring you into contact with things that may harm an unborn baby. These are some examples, but it's not a full list of risks.

Infections Working in health care, child care or with animals, for instance, can increase the risk of infections that may affect the baby.

Chemicals Health care, dental care, veterinary care, manufacturing and pest control are just some areas that may involve risk.

Radiation Working around x-rays or radioactive material is not harmful if normal occupation, health and safety measures are taken. Radiation from electrical appliances is not harmful.

Other risks Jobs that involve heavy lifting or standing for long periods can pose risks.

If your job involves standing for long periods of time, make sure you take the chance to sit down during breaks (if possible, put your feet up on another chair). Standing for long periods may increase your chance of getting varicose veins in pregnancy. For more information, see *Common concerns in pregnancy* on page 43.

If you sit at a desk or computer most of the day, take a few minutes every hour to get up and walk around. Care for your back by:

- being aware of your posture – sit and stand tall
- using a chair that gives you good back support.

Avoid heavy lifting or climbing ladders and try to bend over carefully – especially in late pregnancy when body changes can make these things difficult.

To make sure your work is safe in pregnancy, ask your midwife, doctor, occupational health and safety officer, union representative or employer. You can also contact the WorkCover Authority of NSW, for assistance call 13 10 50 or go to www.workcover.nsw.gov.au for a copy of a free booklet, *Pregnancy and work*. WorkCover also has information on your rights as an employee, including your right to be able to do other work for your employer that is safe, or to have unpaid maternity leave.

Some hazards around the home

Sick children Be aware that you can also pick up infections that might affect your baby from other small children, such as chickenpox or parvovirus (slapped cheek syndrome). Always tell your midwife or doctor if you are worried.

Be cautious with pets Get someone else to clean up the cat litter tray or any cat faeces – but if you have to do it, wear gloves and wash your hands carefully with soap and hot water. This is to avoid the risk of an infection called toxoplasmosis. This infection is unlikely to make you ill, but can cause blindness and brain damage in an unborn baby. There's no need to get rid of the cat – just be careful with hygiene.

You can also pick up toxoplasmosis from soil and raw meat. If you're pregnant, remember to:

- wash fruit and vegetables prior to eating
- avoid raw or undercooked meat
- wash your hands
 - > after petting animals
 - > after contact with bodily fluids
 - > before you eat, and before and after you prepare food
- avoid contact with cat faeces
- wear gloves for gardening.

Another infection called cytomegalovirus (CMV) can also harm the development of your unborn baby and, in some cases, can cause miscarriage. You can pick up CMV from contact with bodily secretions such as urine or saliva. To avoid infection, wash your hands with soap and water or use an alcohol rub particularly after changing a nappy.

Avoid lead in pregnancy We can't avoid lead completely because it's in the air and soil. We all absorb small amounts of it. But children and pregnant women have a higher risk of problems caused by too much lead.

Children absorb more lead than adults. In pregnancy, low levels of lead can pass through the placenta and affect the baby's intellectual development. It may also cause problems with growth, hearing and behaviour.

We don't know if these effects are reversible.

Renovating houses can increase your exposure to lead. If your house was built before 1971 (when lead-based paint was still available), get advice before doing anything that disturbs the paint. Disturbing lead-based paint can spread lead dust into the air and around the house. ***It's important that pregnant women and children aren't around during renovations that disturb lead-based paint.***

Other sources of lead include lead industries (such as vehicle battery recyclers); clothes and dust on lead workers' clothes; hobbies which use lead (leadlighting, fishing and pottery) some traditional medicines such as pay-loo-ah, bali goli, rueda and azarcon; lead crystal glassware; and crockery from developing countries (lead can leach from the glaze).

In areas near lead smelters or mines, lead contamination in the environment and the house will be higher than in most urban areas.

Pregnant women who are at risk of having an elevated lead level should discuss this with their doctor.

Cleaning products, paints and other household chemicals

Check the labels of these products to make sure there are no safety warnings for pregnant women. If the labels make a product sound very toxic, it may be better to avoid using it at this time. If you use cleaning products, glues, paint or any other household chemicals, follow the safety directions on the label. Make sure there's plenty of fresh air.

Naphthalene in moth balls and toilet deodorant cakes

Some moth balls and toilet deodorant cakes contain a substance called naphthalene. Exposure to very large amounts of naphthalene can cause damage to blood cells, leading to a condition called haemolytic anaemia. Some of the symptoms that may occur after exposure to large quantities of naphthalene are fatigue, loss of appetite, nausea, vomiting, and diarrhoea. Newborn babies are particularly at risk of damaging their blood cells if they are exposed to naphthalene.

Further advice concerning the health risks of naphthalene can be obtained 24 hours a day, 7 days a week Australia wide from the NSW Poisons Information Centre on 13 11 26, or from local Public Health Units.

How do I know what's safe and what isn't?

MotherSafe is a free telephone service for women in NSW. It provides a comprehensive counselling service for women and their healthcare providers who need to know about

medications or who are concerned about exposures during pregnancy and breastfeeding. MotherSafe can give you information about the safety and likely effects of:

- prescription drugs
- over-the-counter medications
- street drugs
- infections
- radiation
- occupational exposures.

MotherSafe runs an outpatient clinic for women who need face-to-face counselling with a doctor about medications in pregnancy. It also runs the MotherSafe PLaN clinic for women who are thinking about getting pregnant. Women can discuss pregnancy, lifestyle and nutrition with an experienced midwife.

Call MotherSafe on (02) 9382 6539 (Sydney Metropolitan Area) or 1800 647 848 (regional NSW).

MotherSafe operates from 9am to 5pm, Monday to Friday (excluding public holidays).

You can also visit MotherSafe online at www.mothersafe.org.au

Healthy eating for pregnancy

Why is healthy eating so important in pregnancy?

- it helps the baby grow and develop
- it helps keep you healthy while you're pregnant
- it helps achieve a healthy weight gain.

All you have to do is eat foods from each of the following food groups every day and drink plenty of water.

Eat foods from each of these food groups every day:

- bread, rice, pasta, noodles and other grain foods
- vegetables and legumes (legumes means dried beans and peas, lentils and soy foods such as tofu)
- fruit
- milk, yoghurt, semi-hard or hard cheeses (reduced fat)
- freshly cooked meat, fish, poultry and eggs
- nuts.

Drink water Drink water according to thirst – usually more in hot weather or during exercise. All drinks (except alcohol) can count towards your fluid intake, but water is the best thirst quencher. When it comes to cost and convenience, nothing beats tap water, especially if it's fluoridated (fluoride is a chemical that helps teeth become stronger). If you are concerned about the quality of your water supply, boil the water before drinking it. Pregnant women should minimise their intake of drinks like cola and coffee because of the caffeine and sugar they contain. If you can't do without these drinks, try decaffeinated alternatives.

Food groups and recommended serves in pregnancy

Food group	How many serves per day?
Bread, cereals, rice, pasta, noodles.	4-6 serves, where a serve is: <ul style="list-style-type: none"> • 2 x 60g slices of bread • 1 medium bread roll • 1 cup cooked pasta, rice, or noodles • ½ cup untoasted muesli • 1 cup cooked porridge • 1 ⅓ cups breakfast cereal
Vegetables, legumes.	5 serves, where a serve is: <ul style="list-style-type: none"> • ½ cup cooked vegetables or cooked dried beans • 1 cup raw salad vegetables • 1 small potato
Fruit.	4 serves, where a serve is: <ul style="list-style-type: none"> • 1 whole medium fruit (e.g. 1 medium apple or banana) • 2 small fruits (e.g. plums or kiwi fruit) • 1 cup canned fruit • 1½ tablespoons sultanas • 4 dried apricots
Milk, yoghurt, cheese and dairy alternatives.	At least 2 serves, where a serve is: <ul style="list-style-type: none"> • 1 cup milk (full fat, reduced or skim) • 2 slices of semi-hard or hard cheese (reduced fat) • 200g yoghurt (plain or flavored) • ½ cup evaporated milk • 1 cup soy milk (with added calcium) • 1 cup custard • ½ cup salmon or sardines, including bones
Lean meat, fish, poultry, eggs, legumes.	1½ serves, where a serve is: <ul style="list-style-type: none"> • ½ cup lean mince • piece of lean meat or chicken the size of the palm of your hand • 2 small chops • 1 small fish fillet • ½ cup salmon • 2 small eggs • ⅓ cup nuts • ¼ cup seeds • ½ cup cooked lentils, beans or chickpeas

If you eat foods that are high in fat, sugar and salt...eat just small amounts or eat them now and then, not every day. Too many of these foods (e.g. chips, cakes, lollies, pies or soft drinks) mean less room for the healthy foods you and your baby need. They can also cause weight problems.

Are takeaway foods ok?

Many takeaway foods are high in saturated fat, sugar, salt and kilojoules and low in important nutrients.

Healthier takeaway choices are freshly prepared wholemeal sandwiches, rolls, wraps or bagels, foccacia or Turkish bread with a healthy filling, barbecued chicken (skin removed), and Asian stir-fried or steamed dishes.

You do need to be cautious with takeaway foods because of the risk of food-borne bacteria. In general, it's best to avoid pre-prepared foods and eat food that is freshly prepared.

How much should I eat?

If you already have a healthy diet, then you won't need to make many changes to the way you eat when you are pregnant – just add an extra serve of vegetables, two extra serves of fruit and half a serve of meat each day. This table shows how much to eat from each food group every day.

Health alert!
You don't need to eat for two during pregnancy.

Menu ideas for healthy eating in pregnancy

	<i>Menu</i>
Breakfast	Wholegrain breakfast cereal, or porridge with low-fat milk and fresh or dried fruit OR Egg, reduced fat cheese or baked beans with wholegrain toast OR Yoghurt, fruit and wholegrain toast with vegemite
Morning snack	Banana smoothie made with reduced fat milk or yoghurt OR Fruit and yoghurt OR A piece of fruit
Lunch	Sandwich, wrap or roll filled with lean meat, fish, egg, reduced fat cheese or hummus, and salad OR Stir-fried vegetables with noodles, beef, fish, tofu or nuts, with a piece of fruit OR Bean and vegetable soup with wholegrain bread and reduced fat cheese
Afternoon snack	Wholegrain biscuits and vegemite OR Dried fruit and nuts OR Pitta bread with hummus
Dinner	Vegetable curry with chickpeas or lentils and rice, with a fruit salad OR Home-made pizza with reduced fat cheese and side salad OR Pasta with lean beef and vegetable or lentil sauce and a side salad, followed by banana custard

Eating fish when you're pregnant

Fish is rich in protein and minerals, low in saturated fat and contains omega-3 fatty acids. Omega-3 fatty acids are important for the development of the nervous system in babies, before and after they are born. However, some fish contain mercury levels that may harm an unborn baby or young child's developing nervous system.

Recommended safe amounts and types of fish for pregnant women.

Pregnant and breastfeeding women and women planning pregnancy

1 serve equals 150g

Eat 2-3 serves per week of small fish. Fish should be small enough to fit on a dinner plate. Examples include: mackerel, silver warehou, bream, snapper, trevally, whiting, flathead, kingfish, canned tuna and salmon, herrings, sardines, shellfish, lobster, octopus OR

Eat 1 serve per fortnight of shark (flake), or billfish (broadbill, swordfish and marlin) and no other fish that fortnight OR

Eat 1 serve per week of catfish or orange roughy (deep sea perch) and no other fish that week.

Common food concerns during pregnancy

There are several nutrients that are particularly important for you to eat while you are pregnant.

Iron

Too little iron in your diet means that you won't have enough oxygen-carrying red blood cells and you may feel tired, weak, breathless or mentally exhausted. Studies show that when mothers don't have enough iron, they may have more complications in pregnancy or their babies may arrive early.

The best sources of iron are lean red meats, nuts and legumes such as soy beans or chickpeas.

You'll help your body to absorb more of the iron in your food if you have a vitamin C-rich food or drink with your meals. This can be as simple as having a glass of orange juice with breakfast; or tomatoes, red capsicum, broccoli or peas with lunch or dinner. It's also best to drink coffee or tea in between meals rather than with them, as these drinks make it harder for your body to absorb the iron in food.

Calcium

Eating plenty of calcium-rich foods during pregnancy helps make your baby's bones and teeth strong. If your diet doesn't have enough calcium, the growing baby will try to meet its needs by taking calcium from your bones. This may increase your risk of weak bones, which could fracture easily later in life.

Remember that low-fat or reduced fat dairy products usually have as much (if not more) calcium than full-cream dairy foods (but cottage cheese doesn't contain much calcium). If you don't eat any of the dairy products or alternatives listed in the table *Food groups and recommended serves in pregnancy* on page 28, you may need a calcium supplement. Check with your midwife or doctor.

Vitamin D

You may have your vitamin D level checked during pregnancy. It is very important to correct this if your level is low, either by limited exposure to natural sunlight or taking a tablet containing vitamin D in the correct dose.

Do I need extra vitamins or minerals in pregnancy?

All women of childbearing age need to have a balanced diet and take a multivitamin which contains recommended dose of folic acid before trying to conceive and throughout pregnancy. It is important that women take multivitamins that are designed for pre-conception, pregnancy and breastfeeding as these preparations are more likely to contain the correct amounts (recommended daily intake or RDI) of various vitamins and minerals in pregnancy. This includes iodine, which is important for healthy brain development. Experts recommend a supplement of 150microgram of iodine per day for all women who are pregnant, breastfeeding or considering pregnancy. If you have a pre-existing thyroid condition, talk to your doctor before taking an iodine supplement. For more information visit www.nhmrc.gov.au

What about fats and oils?

You only need small amounts – a little butter or margarine spread thinly on bread, and a little oil for cooking and salad dressing. Canola, olive, sunflower, safflower, corn and soya bean oils are healthier choices. You get plenty of fats and oils from the amount used with cereal foods and from meat, eggs, cheese, peanut butter, and margarine.

MotherSafe has a factsheet on vitamins and minerals in pregnancy. Visit the MotherSafe website at www.mothersafe.org.au and click on 'Factsheets'.



It is a myth that calcium is lost from the mother's teeth during pregnancy. If you don't get enough calcium in your diet, though, your body will provide this mineral to your baby from stores in your bones.



Health alert!

Raw fish and seafood such as oysters, sashimi, smoked salmon or smoked oysters should be avoided all together by pregnant women. To find out why, see *Keeping food safe* on page 35.

Folate is important for you and your baby

Folate (or folic acid) is a B vitamin. It's important to get plenty of folate before you get pregnant, (at least one month prior) and in the early stages of pregnancy (the first 3 months). It may help prevent health problems for your baby. If you haven't taken extra folate before pregnancy, don't worry. Just make sure you're getting enough as soon as you know you're pregnant.

You can get enough folate by:

- eating folate-rich foods – e.g. wholegrain bread, wholegrain breakfast cereals with extra folate, dark green leafy vegetables, dried beans, chickpeas and lentils, oranges, orange juice, bananas, strawberries, avocado and yeast spreads like Marmite or Vegemite. Aim to eat two servings of fruit on the above list, as well as five servings of vegetables and four to six servings of bread or cereals each day
- having a low-dose folic acid tablet (0.5mg), or taking a pregnancy-specific multivitamin which contains 0.5mg of folic acid each day as well as high-folate foods. If you don't want to take a multivitamin, you can buy folic acid tablets at the supermarket, chemist or health food shop.

Health problems linked to not having enough folate early in pregnancy are called neural tube defects (spina bifida and anencephaly). They can affect the baby's spinal cord or brain and will cause serious problems. For more information, see *Prenatal testing and genetic counselling* on page 114.

If you or one of your relatives has already had a baby with a neural tube defect, you have a higher risk of having a baby with this problem. Talk to your doctor or midwife. He or she may:

- recommend a higher dose folic acid tablet
- suggest genetic counselling and tests to check for neural tube defects in pregnancy.

Easy and delicious ways to get more folate include:

- eating wholegrain breakfast cereal with added folate, sliced banana and a glass of orange juice
- helping yourself to big serves of steamed or stir-fried vegetables
- snacking on bananas, raw unsalted nuts or wholegrain toast with yeast spreads (e.g. Marmite or Vegemite)
- using mashed avocado on bread instead of margarine or butter.

Talk to your doctor and midwife to find out how much folic acid you should be taking, if you:

- have epilepsy
- take anti-convulsant medication
- have a deficiency of vitamin B12
- have diabetes
- are overweight.

I'm a vegetarian. Do I need to change my diet?

A balanced vegetarian diet can be very healthy. Use the table *Food groups and recommended serves in pregnancy* on page 28 to check that you're getting enough servings from each of the food groups.

Sometimes, vegetarian diets can be low in important nutrients:

- **Iron and zinc** Eat plenty of plant foods which have iron and zinc (legumes and nuts). Have food containing vitamin C at the same meal
- **Vitamin B12** Fortified breakfast cereals are an excellent source of vitamin B12 for vegetarians. If you don't eat dairy foods or eggs, you may need a supplement
- **Calcium** See the table *Food groups and recommended serves in pregnancy* on page 28 for a list of non-dairy calcium foods. If you are not eating plenty of these, you may need a calcium supplement
- **Protein** Make sure you get enough plant protein from legumes, nuts and seeds.

If you'd like help planning your diet, talk to your midwife, doctor or dietitian.

I'm a teenager. Do I need anything extra?

If you're under 17, you're still growing. This means your body needs extra nutrients – be sure to get three healthy meals each day. You need extra calcium too – have three serves of dairy products (or four if you don't eat much cereal). If you need help to plan your meals, talk to your midwife or doctor.

Can changing my diet in pregnancy or while I'm breastfeeding prevent my baby having allergies?

Changing your diet is not recommended. Research has found that avoiding foods like egg, peanut, soy, fish or cow milk (foods that may cause allergies in some people) has no effect on the baby's risk of allergy.



Smart snacking

Try to resist the urge to snack constantly. When you need to snack, choose foods that are nutritious for you and your baby such as vegetables, dairy products, fresh or dried fruit, yoghurt, unsalted nuts, wholegrain fruit bread, cheese (reduced fat) and tomato on toast, or pita bread and fresh hummus. These are better for you and your baby than cakes, biscuits or salty snack foods – though it's okay to treat yourself sometimes!

How much weight should I gain in pregnancy?

It is important for all women to eat healthily and stay active during pregnancy to minimise the risk of gaining too much weight. Although you might feel hungrier, you don't need to "eat for two".

About half of all Australians are above their recommended weight range. Women who are overweight may have special needs during their pregnancy, because they have an increased risk of:

- gaining too much weight during pregnancy and having difficulty losing it after the baby is born
- having an unhealthily large or small baby
- high blood pressure
- gestational (pregnancy) diabetes
- caesarean section operation
- blood clots in the veins of the legs or pelvis
- stillbirth.

Some women who are very overweight will need to give birth in a hospital that provides a higher level of care.

Even if you are already pregnant, managing your weight gain can help to reduce the risk of complications during pregnancy. As a guide, the heavier you are at the start of your pregnancy, the less weight you should gain during pregnancy.

Body mass index (BMI) is used to estimate your total body fat and helps to determine if your weight is within the normal range or if you are underweight, overweight or obese. BMI is calculated by dividing your weight in kilograms by your height in metres – squared (m^2). The following link has a BMI calculator that you can use to work out your BMI <http://www.gethealthynsw.com.au/bmi-calculator>

Women who have BMI less than 18.5 or more than 35 should consider seeking professional dietary advice about healthy weight gain. Some ethnic groups have different cut off points for the BMI obesity range of figures. Check with your doctor or midwife for more information.

The table below shows how your height and pre-pregnancy weight are used to work out your BMI and the recommended weight gain during pregnancy. You should not go on a diet while you are pregnant unless it is recommended by your midwife or doctor.

Recommended weight gains in pregnancy

<i>Pre-pregnancy BMI (kg/m²)</i>	<i>Rate of gain 2nd and 3rd trimester (kg/week)*</i>	<i>Recommended total gain range (kg)</i>
Less than 18.5	0.45	12.5 to 18
18.5 to 24.9	0.45	11.5 to 16
25.0 to 29.9	0.28	7 to 11.5
Greater than or equal to 30.0	0.22	5 to 9

* Calculations assume only a 0.5-2 kg weight gain in the first 3 months

Source: Queensland Health (2010) Statewide Maternity and Neonatal Clinical Guideline: Obesity

Keeping food safe

When you are pregnant, your immune system is lowered making you more at risk of becoming ill, including from food poisoning. Some germs may cause more severe illness to you than they might if you weren't pregnant and they can also harm your unborn baby. Here are some tips to help you avoid poisoning.

Keep it cold

- Keep the fridge at 5°C or below.
- Put any food that needs to be kept cold in the fridge straight away.
- Don't eat food that's meant to be in the fridge if it's been left out for two hours or more.
- Defrost and marinate foods – especially meats – in the fridge.
- Shop with a cooler bag and picnic with an esky.

Keep it clean

- Wash and dry hands thoroughly before starting to prepare or eat any food, even a snack.
- Keep benches, kitchen equipment and tableware clean.
- Separate raw and cooked food and use different cutting boards and knives for each.
- Don't let raw meat juices drip onto other foods.
- Avoid making food for others if you're sick with something like diarrhoea.

Keep it hot

- Cook foods until they're steaming hot .
- Reheat foods until they're steaming hot.
- Make sure there's no pink left in cooked meats such as mince or sausages.
- Look for clear juices before serving chicken or pork.
- Heat to boiling all marinades containing raw meat juices before serving.

Check the label

- Don't eat food if it is past the 'use by' date.
- Note a 'best before' date and follow this.
- Follow storage and cooking instructions.
- Ask for information about unpackaged foods.

Health Alert!

Avoid infection – wash your hands

Some infections can harm the development of your unborn baby and in some cases can result in miscarriage. To avoid infection, wash your hands with soap and water or use an alcohol rub. Wash your hands:

- after contact with body fluids such as saliva, nasal secretions, blood or vomit
- after changing nappies or going to the toilet
- before and after you prepare food and before you eat
- after gardening or touching animals and animal stools (kitty litter)
- whenever your hands look dirty.

Listeria

Listeria is a food-borne bacteria (germ) that can cause a type of food poisoning called listeriosis. It doesn't usually cause a problem for healthy people, but people with a lowered immune system, including pregnant women, may be more vulnerable to the bacteria. In rare circumstances, pregnant women can pass the infection on to their unborn baby which can result in miscarriage, stillbirth or premature birth and can make a newborn very sick. Antibiotics can often prevent an unborn or newborn baby becoming infected if the mother has listeriosis.

In adults, listeriosis may have no symptoms at all, or you may develop a fever and feel tired (but these can be symptoms of other things as well). Always tell your doctor or midwife if you have a fever in pregnancy.

Listeria is commonly found in the environment including on plants and in animal faeces, soil and water. Listeria can grow even when foods are kept in the refrigerator, but is killed by cooking or reheating food to steaming hot.

You can also reduce the risk of getting listeriosis by avoiding certain foods that are known to be at higher risk of carrying the bacteria:

- unpasteurised dairy products, e.g. soft or semi-soft cheese (they're ok if they're in a cooked dish)
- cold cooked chicken
- cold processed meats
- pre-prepared salads
- raw seafood
- soft serve ice cream
- paté.

Some higher-risk foods are more likely to cause food poisoning. Always cook eggs thoroughly and avoid raw meat and chicken, store-bought sushi, fried ice cream, raw or lightly cooked sprouts, and foods that may contain raw eggs, such as home-made mayonnaise, mousse or aioli.

*Give me strength:
pre- and post-natal
exercises*

*Give me strength:
pre- and post-natal exercises*

Exercises for pregnancy and afterwards

As well as keeping fit with walking, swimming or other activities, you need to take special care of the muscles in your tummy, back and pelvic floor. These muscles are under more stress than usual in pregnancy and are easily weakened. Exercise will help to:

- keep muscles strong
- prevent and relieve back pain (a common problem in pregnancy)
- control your bladder
- get you back into shape after your baby is born.

Do these exercises throughout your pregnancy, as long as you feel comfortable. You can start doing them again as soon as day two after a vaginal birth. If you've had a caesarean section operation, wait until day five. Do the tummy and back exercises for at least six weeks after the birth – and keep up the pelvic floor exercises for the rest of your life.

Remember:

- breathe normally while you do them (don't hold your breath)
- if you have any pain or discomfort, especially in your back, tummy or pelvic area, stop the exercise. Ask a physiotherapist for advice.

Mind your back

Strong abdominal muscles do more than flatten your tummy – they also help to protect your back. Avoid strong abdominal exercises until six weeks after the baby is born – gentle exercises are OK.

Gentle abdominal exercises will help keep your spine flexible.

Pelvic rotation

- Stand with your feet comfortably apart.
- Bend your knees slightly.
- Put your hands on your hips.
- Rotate your pelvis clockwise (as if you're belly dancing).
- Now rotate your pelvis anti-clockwise.
- Repeat 5-10 times.

Pelvic tilt (helps relieve back pain, too)

- Stand with your feet comfortably apart.
- Bend your knees slightly.
- Place one hand on your tummy and the other on your lower back.
- Imagine your pelvis is a basin or bowl and tip it slowly backwards and forwards.
- Repeat 5-10 times.
- If it's comfortable, repeat this exercise on your hands and knees.

Pelvic tilt on your hands and knees

- Keep your hands on the floor, and tip your pelvis backwards and forwards.
- This position is particularly good if you have backache.
- Repeat 5-10 times.

If you want to make this exercise a little harder:

- Hold your body as still as possible.
- Lift one arm up level with your shoulder.
- Lift the opposite leg at the same time.
- Hold for a few seconds, then lower your arm and leg.
- Relax the tummy muscles.
- Repeat with the other arm and leg.
- Repeat 5-10 times on each side.

Check your tummy muscles after the baby is born

During pregnancy, it's normal for tummy muscles to separate. It's easy to check:

- lie on your back with your knees bent and your feet flat on the floor
- press the fingers of one hand gently into the area around your navel
- breathe out and raise your head and shoulders a little

- if there is a separation, you'll feel a 'gap' and the two separate edges of the muscle.

Keeping up the exercises (either standing up or on all fours) will help to close the gap after your baby is born (though sometimes the gap may not close completely).

If the gap is wider than two fingers, you may have lower back pain. As well as keeping up your exercises, wearing an abdominal support may help. Ask a midwife or physiotherapist for advice.

Stretches to ease back aches and pains

For low backache:

- Sit with your bottom on your heels with your knees apart.
- Lean forward towards the floor, resting your elbows on the ground in front of you.
- Slowly stretch your arms forward.
- Hold for few seconds.



For middle back:

- Go down on your hands and knees.
- Draw in lower tummy.
- Tuck your tail under.
- Hold for a few seconds.
- Gently lower the back down as far as feels comfortable.

For pain in shoulder blades and upper back:

- Sit on a firm chair.
- Brace your tummy muscles.
- Interlock your fingers and lift your arms overhead.
- Straighten your elbows and turn your palms upwards.
- Hold for few seconds.

Other ways to care for your back in pregnancy and after the birth

- Avoid standing on one leg or heavy lifting.
- Work at benches or tables that are at waist height.
- Keep nappy buckets and washing baskets at waist height.
- Carry the baby in a safe baby carrier or put them in a pram rather than carrying them in a capsule. Several different types of wearable baby carriers

are available. Fabric wrap, pouch or bag slings and framed carriers are some examples. Parents and carers should take care when using slings and pouches to carry babies. Babies are at risk of suffocation if placed incorrectly in a sling. For important information on safely using baby carriers go to <https://www.productsafety.gov.au/content/index.phtml/itemId/971550>

- Kneel down rather than bending to clean the bath or make beds.
- Go for a swim (after birthing, wait until your bleeding has stopped before you start swimming again).
- If walking causes pain in one buttock; you have pain in the pubic, groin or lower back area; or if you notice the pain the day after a walk, shorten your stride, avoid stairs, and avoid any activity (e.g. vacuuming) where you might put more weight on one leg.
- If back pain is severe or persistent, see a doctor who may refer you to a physiotherapist.

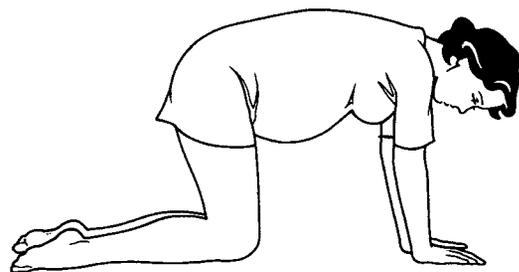
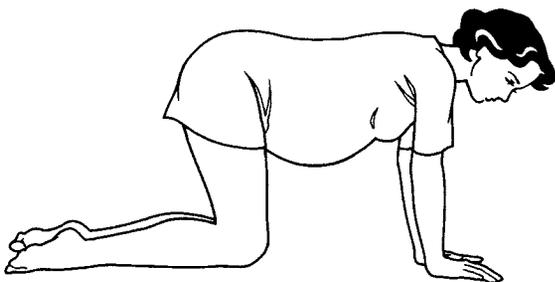
Caring for your pelvic floor

Being pregnant and having a baby means you're almost three times more likely to leak urine and wet yourself than women who haven't had a baby. One in three women who have had a baby wet themselves...but you don't have to be one of them.

What causes it?

Being pregnant and giving birth stretches the

Pelvic tilt



muscles of your pelvic floor – the muscles that keep your bladder shut. Weakened muscles can't stop your bladder from leaking. This leaking happens mostly when you cough, sneeze, lift or exercise. You may also find that you can't wait when you want to pass urine.

Will it go away by itself?

No. You'll need to help your pelvic floor muscles get strong again. If you don't strengthen the muscles after each baby, you're likely to wet yourself more often when you reach middle age. Pelvic floor muscles tend to weaken with age. Menopause can make incontinence worse.

How can I prevent this happening to me?

- Always squeeze and hold your pelvic floor muscles before you sneeze, cough or lift.
- Don't go to the toilet "just in case" – this trains your bladder to want to empty more often.
- Empty your bladder completely when you go to the toilet.
- Avoid constipation by drinking plenty of fluids (preferably water) and fibre rich foods.
- When sitting on the toilet, lean forward. Your knees should be slightly higher than your hips (you could use a small stool or step to rest your feet on). Rest your elbows on your knees or thighs so that your back is straight. Gently bulge your abdomen. Relax your pelvic floor and avoid pushing.

D

o pelvic floor squeezes every day. Here's how:

- Squeeze, lift and hold your pelvic floor upwards and forwards towards your pubic bone tightening around the anus, vagina and urethra.
- Start by holding for 3 seconds or more (build up to 10 seconds) and rest for the equal length of hold time.
- Repeat the squeezes 8-12 times (one set).
- Keep breathing during the squeezes.
- Congratulations – you've done one set. Try to do three sets every day, gradually holding your squeeze for longer. As your pelvic muscles get stronger, you can aim to hold for longer.

You can start the pelvic floor exercises lying on your back or side and you may practise this sitting and then standing when it gets easier for you.

Do these squeezes three times a day for the rest of your life.

Want to know more about how you can strengthen your pelvic floor and keep your abdominals and back in good shape?

For more information on exercise in pregnancy Sports Medicine Australia provide a brochure at http://sma.org.au/wp-content/uploads/2014/10/SMA_AWiS_Pregnancy_-_Exercise.pdf. Information is also available from the NSW Office of Sport visit http://www.dsr.nsw.gov.au/active/tips_pregnancy.asp

The National Continence Management Strategy has a series of brochures about continence including publications specifically for women who are pregnant and women who have had a baby. They have also produced factsheets with exercises to help you strengthen your pelvic floor. Visit www.bladderbowel.gov.au where you'll find links to these publications and also to versions of the brochures in many community languages.

For more advice about exercises that will help you through pregnancy and becoming a parent, see a hospital physiotherapist. To contact a women's health physiotherapist in your area, call the NSW Branch of the Australian Physiotherapy Association on (02) 8748 1555.



Where can I get help?

The Continence Foundation of Australia provides a free National Continence Helpline on 1800 33 00 66 or visit <http://www.continence.org.au/> for more information about bladder and bowel health. How can I remember to do my pelvic floor squeezes?

It's easier to remember if you do them at the same time as you do something else. Pick something from this list. Each time you do it, do a set of squeezes too.

- After going to the toilet.
- Washing your hands.
- Having a drink.
- Feeding the baby.
- Standing in line at the supermarket checkout.

Weaker pelvic floor muscles can make you break wind more

Just in case you need another reason to get serious about strengthening your pelvic floor muscles – these muscles also help close off the back passage (anus). Many women find that following the birth of their baby they have less control, and find it harder to control wind, or to hold when they need to open their bowel. If you do experience problems speak to your midwife or doctor as early treatment can be simple yet effective in improving muscle tone.

Common concerns in pregnancy

Common concerns in pregnancy

All the changes that occur in your body to support your baby's development can cause you some physical discomfort. This section deals with some of the more common symptoms and concerns that women might experience in pregnancy. If you are worried at any time about how you are feeling, speak with your midwife or doctor.

Abdominal ache

Abdominal ache is common in the second and third trimesters. It's called round ligament pain. Round ligaments are supports on each side of the uterus. The growing uterus tugs on these ligaments, causing pain. It's harmless but it can hurt. Changing position can help ease the strain on the ligaments. Tell your midwife or doctor if pain becomes severe or persistent.

Backache

Backache is common in later pregnancy. It's probably caused by the softening of ligaments in your lower back and pelvis, as well as by the extra weight of the growing uterus. Sometimes the pain can be enough to interfere with normal activities including work and sleep.

Some things that may help include:

- aquarobics (gentle exercise in water)
- hot packs
- regular exercise, including walking
- alternate standing and sitting activities, but don't stand when you can sit
- resting each day (lie down if you can or try resting, tummy first, on a beanbag)
- wearing flat shoes instead of high heels
- circling your elbows, which helps to relieve pain in the upper back. Put your fingers on your shoulders and make circles backwards with your elbows
- acupuncture.

Tell your midwife or doctor if backache is severe or persistent.

For more information, see *Give me strength: pre- and post-natal exercises* on page 37.

Bleeding gums and tooth problems

During pregnancy, hormonal changes can make your gums more easily irritated and inflamed. If you develop red, puffy or tender gums that bleed when you brush, you're experiencing an exaggerated response to plaque that builds up on your teeth. Careful and gentle brushing and flossing will help prevent this. Have a dental check-up before you get pregnant or early in pregnancy to make sure your teeth and gums are in good shape. See your dentist if bleeding gums persist. It's safe to have dental treatment when you are pregnant.

If gum disease is not treated, it can cause problems for both you and your baby. Poor maternal oral health after birth increases the risk of infants developing tooth problems early through the direct transmission of bacteria from mothers to their children. It can also make it harder for you to eat the good diet you need to eat during pregnancy and breastfeeding.

If you crave sugary foods while you're pregnant, or are eating small amounts of food frequently due to morning sickness, good dental care is even more important. Keep your teeth and gums healthy by:

- brushing your teeth with fluoride toothpaste, before breakfast and last thing at night before bed
- using a toothbrush with soft bristles and a small head
- cleaning between teeth daily with dental floss
- don't smoke – it increases the risk of gum disease and tooth loss
- seeing your dentist, if you haven't had your teeth checked in the previous 12 months
- visiting your dentist if you have any signs of tooth decay and/or gum disease.

Breathlessness

Most pregnant women feel short of breath in early and late pregnancy. It's generally harmless and doesn't affect the baby. Talk to your midwife or doctor if your breathlessness becomes severe or comes on suddenly or if it occurs when you lie down.

If you have a bad cough or cold with sudden attacks of breathlessness or breathing problems, tell your midwife or doctor.

Burning or stinging when urinating

Burning or stinging when you're urinating can be a sign of a urinary tract infection (cystitis). These infections are more common in pregnancy. Tell your midwife or doctor if you have these symptoms: early treatment is important.

Constipation

Hormonal changes can slow your bowels down. Move them along with regular exercise, plenty of fluids and fibre-rich foods (wholegrain bread and cereals, unprocessed bran, vegetables, fresh and dried fruit, nuts, dried beans and dried peas). It's safe to use a mild laxative or a fibre supplement until diet and exercise take effect, but avoid harsh laxatives. Iron tablets can sometimes cause constipation – if you take them, ask your midwife or doctor about changing to a different type.

Cramps

Muscle cramps in the foot, leg or thigh are common, especially in late pregnancy and at night. Some tips:

- try rubbing the muscle firmly, or stretching it by walking around for a while
- relieve a foot cramp by bending your foot upwards with your hand
- try not to stretch with your toes pointed.

A magnesium supplement might help – talk to your doctor. Calcium is often suggested as a remedy, but there's no evidence that it really works.

Feeling faint

Pregnancy affects the circulation system. Standing for too long, especially when it's hot, can make you feel faint or you may feel dizzy if you get up quickly after lying down. Lie or sit down at the first sign of faintness and put your head between your legs until you feel better. Drinking plenty of fluids also helps. In pregnancy, your blood sugar levels can go up and down more significantly and low blood sugar may make you feel faint, so eat regularly to keep your blood sugar levels even.

Frequent dizziness or fainting early in pregnancy (especially if there is vaginal bleeding or abdominal pain) could mean an ectopic pregnancy. See your doctor straight away if you experience these symptoms.

Food cravings

Sudden urges for sweet foods, fruit or cereals, and cravings for unusual foods or foods you don't usually eat are probably caused by hormonal changes. It's okay to indulge these cravings occasionally, as long as your diet is healthy and balanced.

Frequently passing urine

In early pregnancy, needing to pass urine frequently is possibly caused by hormonal changes. In later pregnancy, it's more likely to be caused by the weight of the uterus pressing on the bladder. If you're having twins, this may be even more of a problem. In the later stages of pregnancy, you may find it harder to empty your bladder, and may also 'leak' a little urine when you sneeze, cough or lift something. Doing your pelvic floor exercise each day will help prevent this. For more information, see *Give me strength: pre- and post-natal exercises* on page 37. If passing urine causes stinging or burning, let your midwife or doctor know, as it may be a sign of an infection.

Headaches

Headaches are more likely in the early months. Rest and relaxation are the best treatments. Make sure you're drinking enough water as headaches can be caused by dehydration, especially in warm weather. Headaches can also be a sign of eye strain which can happen due to relaxation of your eye muscles (remember, all your ligaments and muscles go through changes in pregnancy) so it can be useful to get your eyes checked. If headaches are frequent and severe, tell your doctor or midwife. In later pregnancy, headaches could be a sign of high blood pressure.

Heartburn

Heartburn causes a burning feeling in your chest, sometimes with a taste of bitter fluid in your mouth. It is possibly caused by hormonal changes and the growing uterus pressing the stomach. It's common in the second half of pregnancy and the best remedy is to sit up for a while and drink some milk – this neutralises the stomach acid, which spills into the oesophagus (food passage), causing heartburn.

Ways to prevent heartburn include:

- eating slowly, and eating frequent, small meals instead of one large one
- avoiding large amounts of food close to bedtime
- eating and drinking at separate times
- sleeping in a semi-upright position, supported by pillows.

If these things don't help, your midwife or doctor may suggest an antacid.

Itching

As your baby grows, the skin of your abdomen gets tighter and may feel itchy. A moisturising cream may help. The itching may also be a sign of an uncommon condition called cholestasis, which is a liver disorder. Cholestasis can cause complications and is associated with premature birth, so it is important to mention the itchiness to your midwife or doctor. Itchy genitals may mean a thrush infection. Check with your midwife or doctor.

Morning sickness

There are lots of things that may help you to feel better during the early months. Here are a few ideas some women have found helpful. Not all things work for everyone, so keep experimenting to find something that helps you.

- Try to avoid triggers (like certain smells or even looking at certain things) that make you feel sick.
- Drink plenty of fluids. It's best to drink small amounts often instead of a lot at once. You may find it's best to drink between meals rather than with them, but avoid caffeinated drinks e.g. coffee, cola etc.
- Avoid an empty stomach. Have frequent small, dry snacks like unbuttered toast, crackers or fruit.
- Avoid fatty food.
- Eat small meals often rather than eating a lot of food at once.
- Try to eat when you feel least nauseous. Try eating fresh cold foods like salads if the smell of cooking makes you feel sick.
- Eat something before you get out of bed in the morning (keep some water and crackers beside the bed). Get out of bed slowly and take your time in the morning rather than rushing.
- Rest when you can – fatigue can make nausea worse.
- Try taking vitamin B6.
- Acupressure wristbands for travel sickness (available from pharmacies) can help.

- Try ginger tablets, dry ginger ale, peppermint tea or ginger tea (put three or four slices of fresh ginger in hot water for five minutes).
- Don't brush teeth straight after vomiting – rinse your mouth with water and wipe a smear of fluoride toothpaste over your teeth.

These are just a few ideas. Other cultures have other remedies that are popular. If nothing helps, talk to your midwife or doctor. Prescription medications are available if symptoms are severe. If your morning sickness is particularly severe, you may need to be hospitalised.

MotherSafe has a factsheet on nausea and vomiting in pregnancy and remedies that are safe for you and your baby. Visit www.mothersafe.org.au and click on 'Factsheets'.

Nose bleeds

Nose bleeds can happen because of the extra supply of blood to the lining of your nose in pregnancy. Blowing your nose gently helps prevent them. If you get a nosebleed, try applying pressure to the bridge of the nose. If this doesn't stop the bleeding, see a doctor as soon as possible.

Piles (haemorrhoids)

Piles are varicose veins in the anus that cause soreness, itching and slight bleeding. The cause can be constipation and/or pressure from the baby's head. The best remedy is to avoid straining (squatting rather than sitting on the toilet may help). Look at the section on constipation for helpful hints. Ask your doctor or midwife to suggest a soothing ointment.

Saliva

You may produce extra saliva (and even dribble in your sleep!). It's normal during pregnancy.

Skin

Some women develop acne for the first time during pregnancy. Or, if you already have acne, you might find it's worse than usual. You might also get patches of darker skin on your face. These are called chloasma and will fade after the baby is born.

Sleeping problems

Insomnia can become a problem in late pregnancy. Your sleep is easily disturbed by visits to the toilet, heartburn, a busy baby or difficulty getting comfortable. Perhaps you're feeling anxious about the birth or parenthood – that's normal too. Some women also have vivid, disturbing dreams at this time – again, possibly a result of anxiety.

Things that may help include:

- avoiding caffeine (particularly in the later part of the day)
- a warm shower or bath before bed
- relaxing music or relaxation techniques (see *Getting ready for labour and birth* on page 67) to help you go to sleep
- sleeping with one pillow under your tummy and another under your legs
- reading for a while with a drink of warm milk.

If nothing works and you feel exhausted, see your doctor or midwife.

Stretch marks

Not everyone gets stretch marks – fine, red lines that usually appear on the abdomen, breasts and thighs – but they're more likely if you put on weight rapidly. They don't disappear completely after pregnancy, but they do fade to a faint, silvery-white. Although studies show that massaging the skin with oils or creams won't prevent stretch marks, it may help to keep your skin soft.

Swollen ankles

Swelling in your ankles and feet in pregnancy can be normal. It's caused by extra fluid in your body, some of which collects in your legs. If you stand for long periods, especially in hot weather, this fluid can make your ankles and feet swell. The swelling tends to get worse towards the end of the day and usually goes down at night while you sleep. It's more common towards the end of pregnancy.

Things that may help include:

- wearing comfortable shoes
- gentle leg and ankle exercise
- putting your feet up as often as possible
- using less salt and eating fewer salty foods.

You should also tell your midwife or doctor as soon as possible if the swelling is there early in the day and doesn't go down at night, or if you notice swelling in other parts of your body (like your hands, fingers and face).

Vaginal discharge

During pregnancy, there's usually an increase in normal white vaginal discharge. Tell your midwife or doctor about any discharge that smells unpleasant, causes soreness, itching or irritation, or is greenish or brownish in colour.

Varicose veins

When the uterus grows in pregnancy it presses on the veins of the pelvis. This can slow down the return of blood flowing back from the legs to the upper body. Hormonal changes can also affect the valves in your veins, which help the blood flow back up the legs, also contributing to the development of varicose veins. A family history of varicose veins makes you more likely to get them in pregnancy. Help prevent them by:

- avoiding tight underpants or anything that fits tightly around the top of the leg – these can restrict circulation
- changing weight frequently from foot to foot when you stand for long periods
- putting your feet up whenever you can, with your legs supported
- speeding up circulation with foot exercises – move feet up and down at the ankles and around in circles a few times
- putting on support pantyhose before you get up in the morning and wearing them throughout the day
- ice or cool packs against sore swollen veins can provide relief.

Varicose veins can also appear in the vulva (external genitals), making it sore and swollen. Tell your doctor or midwife – they may suggest wearing a sanitary pad firmly against the swollen part as a support. You can also try the suggestions above to get some relief.

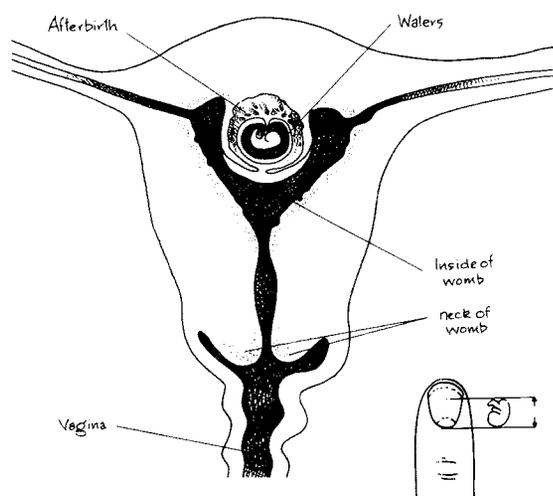
Stages of pregnancy

Stages of pregnancy

The first trimester: from conception to week 12

This section will help you understand the changes that are happening in your body and to your baby as it grows and develops.

The fetus at 6 weeks



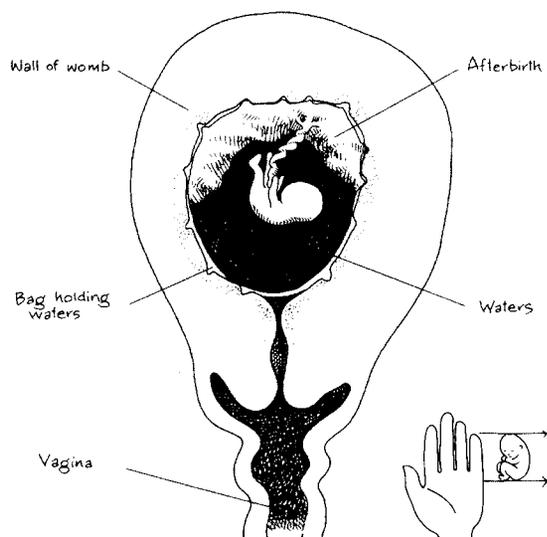
How your baby grows

Your pregnancy began when your egg (ovum) was fertilised by male sperm. The egg split into two cells. These cells kept on splitting until there were enough to make a little ball of cells. This ball of cells then moved down the fallopian tube to the uterus (womb), where it settled into the lining. It then grew and became:

- the **baby** – called an embryo at this stage
- the **placenta** – this feeds the growing baby with nutrients and oxygen from your blood
- the **cord** – this links the baby to the placenta (it's like a highway taking food and oxygen to the baby and carrying waste material away)
- the **amniotic sac** – the soft 'bag of water' that protects your baby in the womb.

By 8 weeks from your last period, your baby is about 13-16mm long. Its heart is starting to beat. Its brain, stomach and intestines are developing. There are little bumps or buds where arms and legs are starting to grow.

The fetus at 12 weeks



What's happening to me?

You don't look pregnant on the outside, but on the inside your baby is growing fast. You're now looking after your baby as well as yourself. Eat the right food to help you and your baby and get to know the things that may harm your baby's health.

Now's the time to see your midwife or doctor to begin antenatal care. Starting regular health checks early:

- helps find and prevent problems in pregnancy
- helps you get to know the health professionals who will care for you in pregnancy
- helps you find out what to expect in pregnancy and birth.

A few things to expect

Most women feel well in pregnancy, but there are big changes happening in your body. These changes can make you feel uncomfortable, especially in the first three months. A few things to be prepared for:

Feeling nauseated Nausea is common in early pregnancy, but it doesn't happen to everyone. Although it's called 'morning sickness', it can happen at any time of the day or night during pregnancy. It usually lasts from around week six to week 14. It is believed that the nausea is caused by the extra hormones your body produces in the early weeks to help keep your pregnancy going. By 12 to 14 weeks, your placenta has grown enough to take over and support the baby. The hormone levels decrease and you usually start to feel better.

An altered sense of smell Certain smells that never bothered you before may make you feel nauseous.

Feeling tired and less energetic Tiredness is common in the first 12 weeks or so, but it doesn't usually last. You'll most likely feel better around 14 weeks (though you may feel tired again in the last few weeks of pregnancy). Rest as much as you can during these tired times – especially if you're working and/or have other children. It helps to put your feet up during the day if you can – try to do this in your lunch hour at work. You may need to go to bed earlier than usual. Resting more or asking for help with cooking and other chores doesn't mean you're not coping. It's what your body needs.

Feeling moody Don't be surprised if you feel irritable sometimes. There's a lot happening in both your body and your life that can affect your mood. Hormone changes in the early months can make you moody. Feeling tired and nauseous can make you irritable. Knowing your life is about to change can affect you, especially if there are problems with your partner or worries about money. These feelings are normal. Don't keep them to yourself – talk to your partner or a friend. If you feel down or anxious a lot of the time, tell your midwife or doctor.

Only pregnant for nine months? That's what you think!

The average length of a pregnancy is 280 days from the last period – and if you do the maths, this works out to be closer to 10 months than nine. Here's a way to work out when your baby is due, but remember it's a guide not a guarantee. Most babies don't arrive on the estimated date of birth. Most arrive sometime between 37 and 42 weeks from the last period.

- Write down the date of the first day of your last period (for example, February 7).
- Add seven days to the date (adding seven days gives you February 14).
- Count back three months (January 14, December 14, November 14).
- Your baby's estimated due date is around November 14.

Feeling down or worried before the baby

is born There's nothing unusual about feeling down, overwhelmed or having different and scary thoughts when you are expecting a new baby. If you feel depressed or worried, or find yourself having concerning thoughts about yourself or your baby for more than two weeks, talk to your midwife or doctor as soon as possible. You may have antenatal depression or a related mental health problem. If you have experienced a mental health problem in the past, it's common for a relapse or a different kind of problem to occur around the time of childbirth so it is important to find and talk with someone that may be able to help as soon as possible.

Going to the loo...again! In the first three months of pregnancy, you may need to pass urine more often. This is caused by hormonal changes and your uterus pressing on your bladder. See your doctor or midwife if there's any burning or irritation when you pass urine, or if you have to pass urine very frequently, as these could be signs of an infection.

Your breasts get bigger and may feel sore and

tender Wear a bra with plenty of support. After the third month of pregnancy you may need maternity bras. But if you can't afford them, don't worry. It's best not to wear underwire bras as they may damage the breast ducts. The main thing with any bra in pregnancy is that it's comfortable, gives good support and doesn't put pressure on any part of your breast. If you buy a new bra, get one that fits on the tightest fastening. It gives you room to grow. Front fastening bras make breastfeeding easier later on. If your breasts feel uncomfortable at night, try a sports bra without wire (crop top).

Is it okay to have sex during pregnancy?

Yes, unless your midwife or doctor advises against it. The penis can't harm the baby. But don't worry if you or your partner don't feel like sex at some stage in the pregnancy. This is normal. You may prefer just to be held, touched or massaged by your partner. At other times you may enjoy sex as much as usual – or even more. Everyone is different.

“I was surprised at how difficult the first three months were. I didn't expect to be so tired at that stage of the pregnancy. I coped by getting help from my partner and family with housework.”

Carolyn

Ultrasound test

Most women will be offered at least one ultrasound before they are 20 weeks pregnant. The times when you may be offered an ultrasound are:

1st trimester:

- If you're not sure when you became pregnant, your GP or midwife might recommend an early ultrasound to confirm your estimated date of birth.
- For the nuchal translucency ultrasound at around 12 weeks. This test can tell if a baby has an increased risk of certain physical and/or intellectual conditions. For more information, see *Prenatal testing and genetic counselling* on page 114.

2nd trimester:

Your midwife or doctor will offer you an ultrasound test at about 18-20 weeks. It's up to you whether you want to have it. As with any test in pregnancy, it's good to ask why you should have it and whether there are any risks you need to know about.

This ultrasound can check important aspects of your baby's physical development. It can:

- check for some structural problems with the baby (but ultrasound can't detect all problems)
- see if there's more than one baby
- see where the placenta is growing
- measure how much fluid is around the baby.

“It was great when the first three months were up and I could say I was pregnant. I didn’t want to tell anyone at first just in case I had a miscarriage. It was difficult at work when I was feeling tired and always going to the loo, but trying to make out everything was normal.” Ellen

The second trimester: from week 13 to week 26

How your baby grows

By 14 weeks, your baby is about 11cm long and weighs about 45g. Its organs have formed, including ovaries or testicles. Although you can't feel it yet, your baby is moving around.

At 18 weeks, your baby is about 18cm long and weighs about 200g. In the next four weeks, you may feel the baby move (it feels like fluttering). This is sometimes called "quickenings". If you could see your baby now, you could tell his or her sex. Your baby is gaining weight fast, and has eyebrows, hair and fingernails.

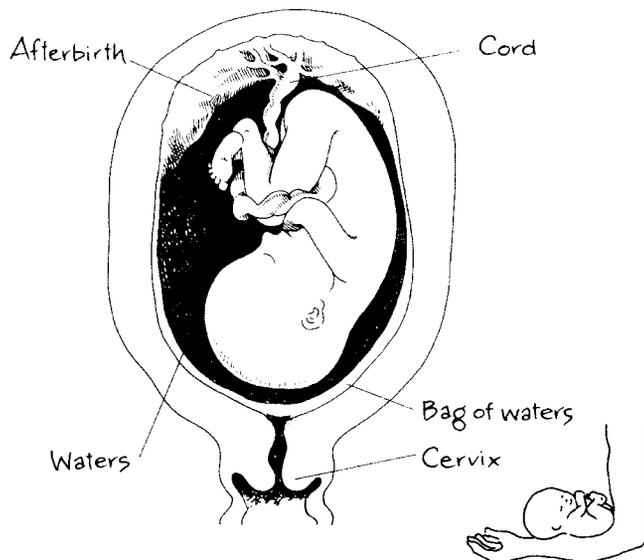
By 24 weeks, your baby is now about 30cm long and weighs about 650g. Its skin is covered in fine hair and protected with a waxy coating. The top of your uterus is just above the level of your navel. A baby born now has about a one in two chance of survival, but

this depends very much on where the baby is born, if there is expert care available and how well your pregnancy has progressed. Babies who do survive at this stage have a high risk of a serious disability such as blindness or cerebral palsy.

What's happening to me?

You're into the middle part of your pregnancy. It's the 'second trimester', which goes from week 13 to week 26. By 16 weeks you may be gaining weight and beginning to look pregnant. Although the baby only weighs a few hundred grams, other things are adding to your weight. There's extra blood and fluid, as well as your growing breasts, uterus and placenta. Your breasts and legs might look a bit different as the increased blood supply and pregnancy hormones can make your veins stand out more.

Baby at 24 weeks



Health alert!

Have you seen your midwife or doctor for your first antenatal appointment yet?

No? Make an appointment now. Appropriate antenatal care is very important to promote good health for you and your baby.

Could you be having twins or more? If so, you're likely to find out at this ultrasound. Having two or more babies (a multiple birth) means:

- you may have more problems because there is a risk of complication with more than one baby
- you will need more tests in pregnancy (including more ultrasounds)
- you will need extra care from doctors during pregnancy and birth to provide specialist advice or treatment
- you will be recommended to have your labour and birth in a hospital with specialist care available in case it's needed
- you may need more midwifery support in the postnatal period to establish breastfeeding and you'll need extra support from friends, family and Early Childhood Health Services to establish parenting routines.

These extra precautions don't mean that you and your babies aren't healthy. But because there's an increased risk of complications with more than one baby, you need to take extra care. For more information, see *Multiple pregnancy: when it's twins or more* on page 122.

A few things to expect

You're probably feeling better. You're likely to feel less tired and nauseated in this part of your pregnancy. Your uterus has moved up and isn't pressing on your bladder so much. This means fewer trips to the toilet – at least for now.

You'll soon be struggling to do up your jeans.

This doesn't mean spending big on maternity clothes. Chances are there are clothes in your wardrobe you can still wear – and maybe some in your partner's too. Friends may be happy to lend you clothes, and there's always your local second-hand clothes shop. Some women use an 'expander' – a big stretchy band that fits across the opening of normal pants and skirts so they can keep on wearing them through pregnancy.

Are you feeling warmer? Many women do. It's caused by the extra blood in your body. This extra warmth can be a bonus in mid-winter, but not in summer. Loose, cotton clothes are cooler than synthetic fabrics.

As you get bigger it can be harder to find a comfy position to sleep in. Some women find it helps to try lying on their side, with a pillow between their legs as well as under the head.

As your baby gets bigger, your balance can be affected. Let someone else do the heavy lifting or perching on ladders. Be careful when bending – remember your joints are softer in pregnancy and you're more likely to injure yourself.

Sometime around 20 weeks, your baby may be kicking enough for your partner to feel the movements. It's not always easy for partners to feel as if they are part of the pregnancy – but this is a great way for them to share the experience and get to know the baby.

Antenatal education

Many women and their families find education sessions provide valuable information and help them prepare for labour, birth and parenthood. They can also give you the chance to ask questions and discuss your feelings about pregnancy and parenthood. Your partner and other support people are welcome to attend with you. Antenatal education is also a good way to meet other parents-to-be.

Courses will generally include information about:

- what to expect in labour and birth (some courses will offer tours of the delivery/birthing unit)
- relaxation techniques and other skills to help you during pregnancy and birth
- pain relief in labour
- exercises for pregnancy, birth and back care
- breastfeeding
- caring for your new baby at home.

You may be asked to pay a fee.

Ask your midwife or doctor about antenatal education available in your area. They are available:

- from your midwife
- at some hospitals or Community Health Centres (some areas have programs for teenage mothers and mothers from culturally and linguistically diverse backgrounds)
- through private organisations/practitioners which can be found in the *Yellow Pages* or searching online for child birth educators.

Health alert!

Mind your back

Did you know that back pain is common in pregnancy and after the birth? Help prevent it now with:

- good posture (try to stand 'tall', instead of slumping; pull your abdominal muscles in towards your spine and try to keep this 'tucked in' feeling)
- bending and lifting correctly
- simple exercises to keep your back strong.

For more information, see *Give me strength: pre- and post-natal exercises*, on page 37.

“The classes were good and most women had their partners with them. I’m not the sort of person to sit down and read a book, so I really found the classes helpful. I felt I had a better understanding of what birth was going to be like.” Mark

Things you might be wondering about

Can I still wear my high heels?

If you wear high heels, it's time to come down to earth – just for a few months. You'll be more comfortable, have less back ache and feel less tired in heels lower than 5cm high.

How do I fasten my seatbelt?

Worn properly, a seatbelt can protect you and the baby if there's an accident. Wear the lap part of the seatbelt under your bump. It should be fastened as tightly as possible, but you should still feel comfortable. For more information, visit <http://roadsafety.transport.nsw.gov.au/stayingsafe/children/childcarseats/>

Is it safe to fly?

In a normal, healthy pregnancy there's usually no health-related reasons why you can't fly, but generally it's not recommended after 32 weeks. Some airlines also have their own policies about travel during pregnancy which may mean you can't get travel insurance so check with your airline.

To reduce the risk of Deep Vein Thrombosis (a condition which can be life-threatening), ask for an aisle seat so you can move around a bit more easily. Take regular walks every 30 mins up and down the plane, drink plenty of fluids and avoid coffee so you stay hydrated. For medium to long-haul flights lasting more than 4 hours, wear properly fitted graduated compression stockings. If you have additional risk factors for thrombosis discuss your plans with your midwife or doctor.

Is it okay to use aromatherapy oils in pregnancy?

Some women like to use essential oils for massage or in an oil burner during pregnancy or labour. Some oils such as chamomile and lavender are thought to be calming. Check with your hospital to find out if an electric oil burner is available in the delivery/birthing unit as hospitals don't allow open flame burners near their emergency oxygen outlet.

Some oils may not be safe in pregnancy when massaged over a large area of the body or swallowed. Check with your midwife, doctor or a qualified aromatherapy practitioner. Some oils to avoid include basil, cedarwood, cypress, fennel, jasmine, juniper, sweet marjoram, myrrh, peppermint, rosemary, sage and thyme.

Now that I'm pregnant, can I still wear my navel ring?

Usually a navel ring is only a problem when your belly expands and the ring catches on your clothes – otherwise it can stay put if you want. As for nipple rings or rings in your genital area, these will need to come out at some stage – ask your midwife or doctor for advice.

Countdown to parenthood

Ready for parenthood yet? Start planning ahead for the chaotic early weeks after the baby is born.

- Can your partner take some time off to help in the first weeks? It's good for all of you. It means you have support and your partner has more time to get to know the baby.
- If your partner can't be around, can someone else help?
- Who will look after your other children if you are in hospital or busy caring for your new baby?
- Talk to your partner about how you'll share the workload once the baby is born.
- Find out what practical support you can get from family and friends.
- Can someone help with babysitting or minding any other children to give you a break? People often want to help and like to be asked.
- If you're single and have little support, ask your midwife or doctor about services in your area that may help.
- Get to know other women in your area. If you spend most of the week at work, you may not have friends close by. Being at home with a new baby can make you feel isolated. Having friends in the area can help.
- Being a parent is a job that needs to be learned. Getting to know other parents who are experienced with young children helps you learn.
- If possible, don't plan any big life changes (like moving house, major renovations or changing jobs) in the first few months after the baby is born.

Thinking about getting to the hospital

Talk with your partner about how you will get in contact with the hospital when labour begins, and how you will get to the hospital when it's time to go. It's a good idea to have a plan about what you'll do if you can't reach your partner, or if things seem to be happening quickly. Don't plan to drive yourself to the hospital. Have a backup plan in case your partner can't be reached or is delayed in getting home to you.

Thinking about a birth plan

A birth plan is a list of what you'd like to happen when you are in labour and give birth. It's a good way to:

- let your midwife or doctor know what kind of care you'd like in labour, birth and afterwards
- be more involved in decisions about your care
- help you get ready for labour and birth.

A birth plan includes things like who you'd like to be with you in labour, and what position you'd like to give birth in. But before you make a plan, you need to know more about what birth is like and what choices you have. You can find out more by:

- having antenatal education
- talking to your midwife or doctor about any issues or concerns you have about labour and birth and early parenting
- asking about who will be involved in your care, how many people will be involved and who will have access to your medical records
- reading about birth – re-read *Choices for care during pregnancy and birth* on page 6 and read *Labour and birth* on page 70
- reading about breastfeeding – see *Feeding your baby* on page 93
- talking to other mothers
- talking to your partner or other relatives or friends who'll be there to support you at the birth.

These questions will help you think about what to put in your birth plan:

- where do I want to give birth to my baby?
- who do I want with me in labour e.g. my partner, my children, another family member or a friend? Support in labour is important.
- what do I want to bring with me to my labour e.g. music?
- what birthing aids am I likely to need in labour e.g. a beanbag, squatting bar or birth stool?
- do I want pain relief? If so, what kind?
- how will the type of pain relief I choose affect the labour or the baby?
- what position do I want to try and give birth in?
- what if I need a caesarean section operation? Would I prefer to have a caesarean section operation with an epidural anaesthetic so I can stay awake? Do I want my partner to be with me – and will my partner be able to cope?
- what is the usual practice for an induction of labour?
- what procedures may be recommended and why?
- what equipment may be used in my pregnancy care and for the birth of my baby and why?
- do I have any cultural or religious needs around giving birth?
- do I want to hold my baby skin-to-skin after he/she is born?

It's important to stay flexible. Remember that things may not go according to plan. There may be complications or you may change your mind about something.

Who will support you?

Studies show that women who have someone with them right through labour have a more positive experience of labour and are less likely to need medication for pain relief to help them to labour and have a shorter length of labour.

It can be helpful to have people around you who can provide both emotional and physical support during labour. This might be your partner, mother, sibling or a close friend. You can have more than one person with you. Some women choose to hire a doula or birth attendant to support them during labour. A doula is not a member of your maternity team but is experienced in supporting women and their partners during labour. Check with your midwife or doctor as some hospitals have policies about support persons.

When you decide about any kind of treatment it's important to make decisions based on good information. Talk to your midwife or doctor about the pros and cons of different interventions before you're likely to need them. Think of your own safety and wellbeing and that of your baby when you make these decisions.

*“I thought being pregnant meant you’d
have this bump growing out of your body.
I thought that was it – I’d no idea there’d
be other changes like feeling breathless or
feeling so warm when everyone was else was
freezing.” Emma*

The third trimester: from week 27 to week 40

How your baby grows

By week 28, your baby is now about 36cm long and weighs about 1100g. Its eyelids have opened and its lungs have grown enough that your baby would be able to breathe outside the uterus – though it would probably need help to breathe if it were born now. A baby born at 28 weeks has a good chance of surviving, but there's still a high risk of a disability.

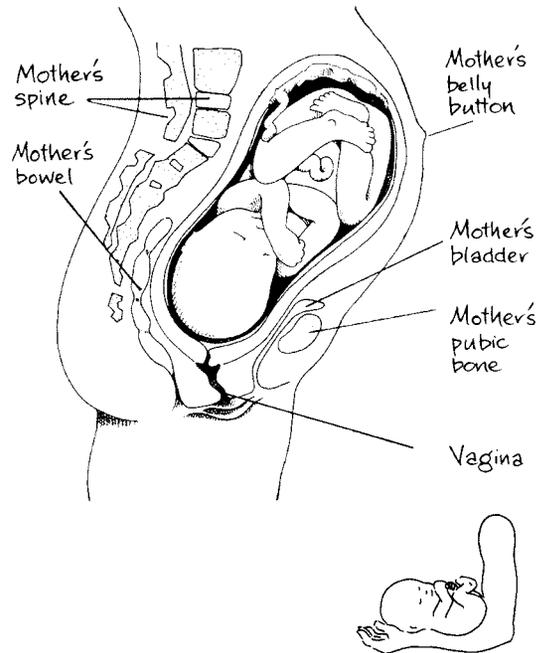
By 32 weeks, your baby is about 41cm and weighs about 1800g. A baby born at this time will have to learn to suck. For more information, see *Early arrival: when a baby comes too soon* on page 131.

By 36 weeks, your baby is about 47.5cm and weighs about 2600g. By 40 weeks, it's grown to about 50cm and weighs about 3400g. The brain can now control the baby's temperature, and the growing body has now caught up with the size of the head. Your baby is ready to be born.

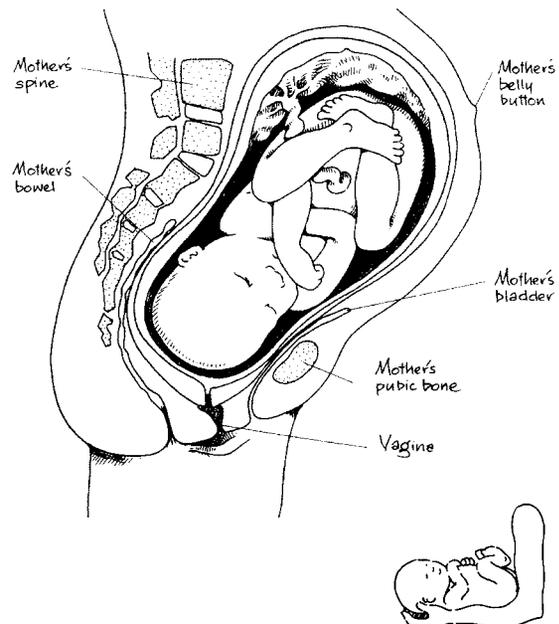
What's happening to me?

- **You're on the home stretch!** This is the first week of the last part of your pregnancy.
- **In some ways, these final three months are a bit like the first three.** You may be more tired and more emotional. Aches and pains in your belly and back are more common. Try to rest as much as you can.
- **You might develop heartburn.** For some helpful tips, see *Common concerns in pregnancy* on page 43.
- **You may be feeling physically uncomfortable.** You may have pains at the top of your legs or your pelvis and lower back. This is caused by the ligaments in your pelvis stretching. Talk with your midwife or doctor if the pain is severe. Rest and gentle exercise is important. You'll cope better in labour if you are rested and stay fit. Sleeping problems are more common from now on. You can try some of the tips in *Common concerns in pregnancy* on page 43.

Fetus at 32 weeks



Fetus at 40 weeks



- **In the last month:**

- **you may feel breathless.** This is because your baby is growing so well. It's pressing against your diaphragm, the muscle between your chest and your abdomen.
- **by now it may seem like you've been pregnant forever.** Many women have given up work by this stage. It's normal to slow down, but you may also get a bonus burst of energy. It's all part of 'nesting' – the urge some women have to get things ready before the baby comes.
- **the baby may have dropped down into your pelvis.** This may make it easier to breathe but the extra pressure on your bladder means you'll want to go to the toilet more often. If you're not sure what the signs of labour are and when to go to hospital, ask your midwife or doctor.
- **Your baby may arrive anywhere between 37 and 42 weeks** (only 5 out of 100 babies arrive on their estimated date of birth).

Tests you'll be offered in this trimester

You might have some extra blood tests in this trimester if you haven't already had them. One will be for gestational diabetes – a type of diabetes that affects some women during their pregnancy (see *Complications in pregnancy* on page 124). In the last three months of pregnancy, your midwife or doctor may also offer a test to check for bacteria in your vagina called Strep B. The test is done by taking a low vaginal swab. Although Strep B won't cause problems for you, it can infect your baby during birth and cause serious problems. If you do have Strep B, your midwife or doctor will recommend you have antibiotics in labour to protect the baby.

Things you might be wondering about

I'm getting stretchmarks on my breasts and tummy – can anything prevent them?

Stretch marks look like thin stripes on your skin (red, purple, pink or brown depending on your skin type). They happen when your body grows rapidly (bodybuilders get them too!). In pregnancy they're common on breasts, abdomen and thighs and sometimes the upper arms. Some products claim to prevent them and some people say vitamin E or other oils massaged into the skin help too. There's no harm in trying, but there's no real evidence that anything helps except time. They do fade to a faint silvery-white and become less noticeable.

Why are my breasts leaking?

Breastmilk is produced by the body from about 16 weeks of pregnancy. Some women will find their breasts leak a little milk in the last few weeks. Breast pads available from supermarkets and pharmacies will help you feel more comfortable.

Will perineal massage help prevent tearing?

Your midwife or doctor may suggest you try massaging the perineum during late pregnancy (and labour) to help reduce the need for episiotomy. They can explain and show you how to practise this during pregnancy. There's some evidence that it works. You may want to try it as some women have found it helpful.

40 weeks has come and gone! Now what?

As long as you have a normal pregnancy with no complications, it may be ok to wait for the baby to arrive in its own time. Your midwife or doctor will talk with you about waiting while making sure that you and your baby are well. You may have some extra tests such as fetal monitoring or ultrasound. For information about induction of labour, see the section *When help is needed: Medical interventions* on page 78.

Find out about tests and injections for your baby after birth

Before leaving hospital, all women are offered the following tests and injections for their babies:

- newborn screening test (heel prick blood test) to check for a number of rare health problems that are more easily treated if they're found early
- injections – a vitamin K injection and immunisation to protect the baby against hepatitis B
- hearing test.

You'll be given information about these tests and injections during pregnancy. At one of your antenatal visits, you may be asked to give your consent for the baby to have them. For more information see *After your baby is born* on page 86.



Health alert! Headaches and other changes late in pregnancy

Tell your midwife or doctor if you have any problems such as headache, blurred vision, sudden swelling in the feet, hands and face, or any change in vaginal discharge.

How much should my baby be moving?

Take time to become familiar with your baby's pattern of movements. All babies have sleep/awake cycles in the womb but some babies move more than others. Is he or she busier at night and quieter in the morning? Is there usually a burst of activity at a particular time? You might find it harder to feel your baby moving if you have excess tummy fat or if the placenta is on the front wall of your uterus. If you think your baby is moving less, or you haven't felt your baby move in a while, contact your midwife or doctor straight away. It's far better to get your baby checked than to worry about it.

My baby's in the breech position. What happens now?

A breech position means the baby presents bottom or feet first rather than head first. In Australia about three to four out of every hundred babies are in a breech position by the time labour starts. If your baby is breech by the time you're around 37 or 38 weeks, you may be offered a procedure called an 'external cephalic version'. A doctor tries to turn the baby by placing his or her hands on your tummy and gently coaxing the baby around so it can be born head first. Ultrasound is used to help the doctor see the baby, cord and placenta. The baby and the mother are monitored during the procedure to make sure everything is okay.

Many breech pregnancies are delivered by caesarean section operation. If you are keen to have vaginal birth, please discuss it with your midwife or doctor. If a vaginal breech birth is not available at your local hospital you can ask to be referred to another maternity service where it is offered.

Can my other children be with me in labour?

Talk to your partner and your midwife about the pros and cons of having your children with you in labour. You and your partner know your children best, and will have an idea of how they'll cope. If you want your children with you, think about who can look after them in the birthing room. Your partner and the midwives will be busy looking after you. If there are complications, or if the children want to leave, that person can care for them outside or take them home.

Plan what you'll need to take to the hospital or birth centre

You'll need:

- nightdresses or large t-shirts and a dressing gown
- some loose, comfortable day clothes
- comfortable footwear
- several pairs of comfortable underpants (some women use disposable briefs)
- maternity bras and/or maternity singlets
- breast pads
- toiletries
- sanitary pads – either 'super' size or maternity size (you can buy maternity pads in supermarkets)
- something to wear while you're in labour if you choose to wear clothes – a big T-shirt or an old nightdress, warm socks
- clothes for you to wear when you're going home (you won't be back to your normal shape yet and may still be in maternity clothes)
- a wheat pack or hot pack for pain relief in labour (ask the hospital if you can use these in labour – some hospitals don't allow them in case of burns to your skin)
- anything you want with you in labour (e.g. music, massage oil, snack food).

For your baby:

- disposable nappies (if you plan to use them) as some hospitals do not supply these
- nappies and clothes for the baby to wear home
- cleaning products for baby, nappy wipes or cotton wool for baby's nappy changes and soap or non-detergent wash for baby's bath
- if you have a long distance to travel, you should also pack a change of clothes for the baby
- baby blanket
- baby capsule in your car.

Your partner or birth support person may also need to have a bag ready. Think about:

- food and drinks for them during labour, as well as for you. This may include juices or other drinks, soup, and foods that are easy to heat or ready to eat so they don't have to leave you for long
- swimmers and towel (if you're going to a hospital with a large bath, and you want support in the water while you're in labour)
- camera.

Check with your midwife, doctor or hospital about other requirements.

Before the baby arrives ...

If this is your first baby, you'll be amazed at how one tiny person can turn your life upside down.

New babies demand a lot of time – and if there's any time left over, you'll be too tired to do much. Having twins will mean even less time. Do anything you can now to make life easier after the birth. You can:

- prepare and freeze meals
- stock up on groceries and other supplies (don't forget sanitary pads)
- organise a baby capsule.

All babies must travel in a baby capsule or restraint in the car. You can hire a capsule or restraint or you can buy one. The maternity unit can give you details of organisations that provide capsule hire and fitting. For more information about baby capsules and car restraints for children, contact the Roads and Maritime Services on 13 22 13 or go to www.rta.nsw.gov.au



Have your bag packed and ready to go to hospital – just in case. Pack a bag even if you're having a homebirth – there's still a chance you may need to go to hospital.

If you're having a homebirth

Your midwives will bring most of the equipment they need including any emergency equipment. This list is a guide to some extra things you might like to prepare. Keep your list of phone numbers handy.

- Old, freshly laundered linen e.g. several towels, sheets and baby blankets.
- A large plastic sheet to cover the birthing area (disposable plastic drop sheets used for painting can be used).
- Light snacks for during labour as well as supplies for the support people.
- A few bottles of drinks for rehydration such as fruit juice, cordial or sports drinks.
- Pillows and cushions.
- A portable heater to warm the room.

*Getting ready for
labour and birth*

Getting ready for labour and birth

Relaxation and breath awareness

Being as relaxed as possible during labour will help to reduce pain by relieving tension; help your uterus to work better; and help you save energy (feeling stressed uses up energy!). You can learn to relax in labour using two simple techniques.

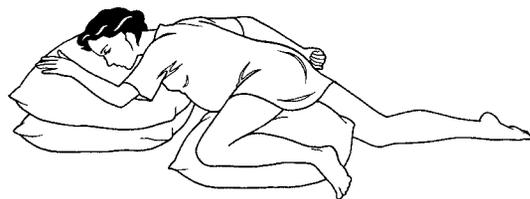
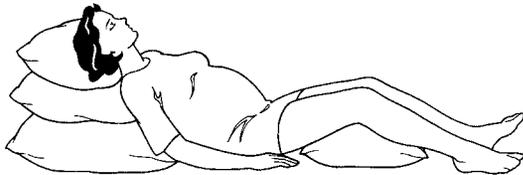
Basic relaxation technique

You don't need to be pregnant to benefit from this. It can help you cope with stress (and help you sleep) at any time in your life. Practise this technique at home once or twice a day for at least 10 minutes if you can. It's good if your partner or other support person understands the technique as well.

Find a comfortable position – sit or lie down on your side. Use pillows to support all the curves of your body. Play some relaxing music if you like.

Clench your right hand. Tense the arm muscles up to your shoulder. Now let go of the tension. Give a long, sighing, outward breath as you let go and relax. Feel your arm go loose. Be aware of how breathing out helps you relax. Relax more with each outward breath.

Find a comfortable position



Repeat this with your:

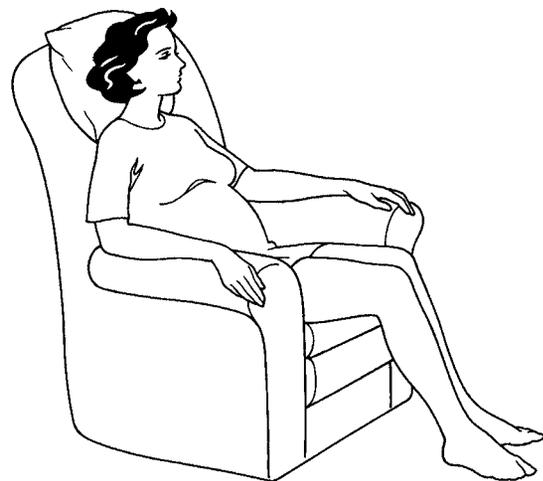
- left hand and arm
- right foot and leg
- left foot and left leg.

Bunch your shoulders up towards your ears. Feel how tense it makes you – now relax your shoulders as you breathe out.

Tighten the muscles around your genitals and anus (these muscles are part of your pelvic floor). Squeeze your buttocks together. Then let go as you breathe out.

Clench your jaw and frown, tightening your face and scalp muscles. Now breathe out and relax.

Once you've learned the difference between a tense muscle and a relaxed one, you can follow these steps without tensing your muscles first. Just release the tension from all the muscles of your body – from your face (including the jaw), arms and legs, buttocks and pelvis. Let go and allow them to rest completely.



Breath awareness technique

People often take quick, shallow breaths when they're anxious or stressed. Doing the opposite – taking long, slow deep breaths – can help you feel calmer and more relaxed.

Being aware of your breathing in labour and slowing it down can:

- help release tension and help your body relax
- help you 'flow' with contractions rather than tense up against them
- help you fight any urge to push which you may feel at the end of the first stage of labour before the cervix is fully opened (your midwife or doctor will guide you so that you push at the right time)
- increase oxygen to the baby during labour
- help prevent rapid, shallow breathing (hyperventilation) which can give you 'pins and needles'.

Health alert! *Labour is important for your baby*

Babies benefit from both labour and vaginal birth for the preparation of their lungs for breathing. The contractions of your uterus help the baby prepare to take their first breaths.

Practising breath awareness

Try to breathe as slowly and deeply as is comfortable for you.

As you breathe out, try to let any tension flow out of your body, along with the air from your lungs. It may help to make a steady noise, sigh or a groan ('ahhh' or 'hmm') as you do this.

Practising positions for labour

Changing positions in labour can really help you manage your contractions and pain. But if you're not used to some of these positions (like squatting or rocking on your hands and knees) it's good to practise them during the pregnancy.

Stretches

Stretches can help you hold different positions in labour without getting too uncomfortable, relax tired muscles and keep you supple.

You can do stretches at any time in pregnancy. Hold each stretch for as long as possible (just a few seconds is fine). Gradually increase the time until you can hold the stretch for up to a minute.

Calf stretch

Stand facing a wall, about 30cm away. Put one foot about one metre in front of the other. Stretch your arms out to touch the wall, leaning your upper body forward. Bend your front knee, putting your weight onto the front leg. Hold the stretch and breathe into it. Repeat with the other leg.

Shoulder rotation

You can do this either standing or sitting comfortably on a chair. Put your fingers on each shoulder and make circles backwards with your elbows. Stretch your arms over your head to smooth out tightness in the shoulders and upper back. This helps ease pressure under the rib cage too.

Labour and birth

Labour and birth

In early first stage of labour, your uterus is working to make your cervix shorter and thinner. For your first

labour, this shortening and thinning of the cervix can be hard work and can make you really tired so it's important to rest when you can. This process may take up to a few days.

Every labour and birth is different and varies depending when it starts and how long it takes. Your midwife or doctor can answer any questions you might have about your labour and birth and what you and your partner can do to prepare. There are three main stages of labour. The time taken for each stage will vary from woman to woman. Everyone's different.

How will you know if you're going into labour? Most women experience one or more of these signs when labour's beginning:

- contractions
- a 'show'
- waters breaking.

As the first stage progresses, your uterus begins contracting to open up your cervix (the neck of your womb). These contractions build until the cervix is about 10cm open, enough to let the baby through.

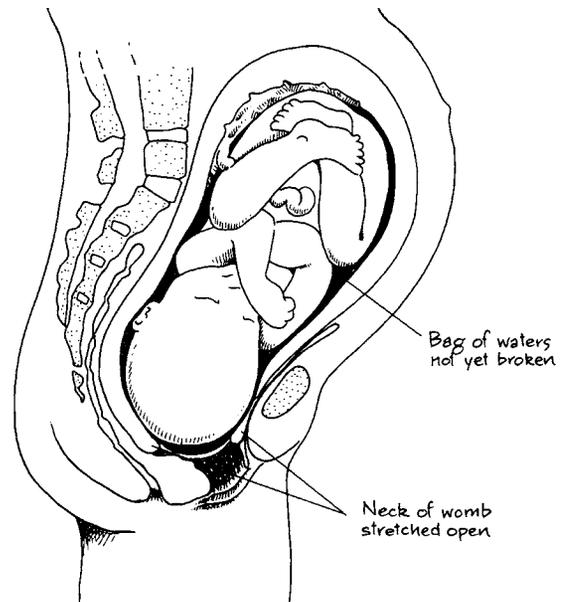
labour, this shortening and thinning of the cervix can be hard work and can make you really tired so it's important to rest when you can. This process may take up to a few days.

How long does it last?

On average, this first stage lasts from 10 to 14 hours for a first baby, and about eight hours for a second baby.

First stage

Position of baby at first stage



Remember your breath awareness technique!

When you're having early contractions in the first part of labour, try to relax with normal breathing. It's best to try to ignore contractions at this early stage and get on with your normal routine, moving about as much as possible.

When it gets hard to relax using normal breathing during first stage contractions, keep breathing deeply and slowly for as long as possible. Your breathing will become a little faster as the contractions get stronger, but try to slow your breathing down to your normal rate or a little slower.

At the beginning and end of each contraction take a deep breath in and out (like a big sigh) and relax your shoulders as you breathe out. This will help to cue your body to relax.

Remember to return to normal breathing as soon as you can after each contraction.

Contractions

Women describe and experience contractions in different ways. These may feel like:

- lower abdominal cramps that feel like a period
- persistent dull lower backache
- inner thigh pain that may run down your legs.

At first these contractions are short and may be far apart – sometimes they're as much as 30 minutes apart. But they get longer, stronger and closer together.

The contractions will gradually get closer together, become more painful and last longer until they're about a minute long and coming faster – about every two or three minutes.

You may feel anxious or even out of control when contractions become stronger and closer together. It helps to take a deep breath when the contraction starts then breathe rhythmically concentrating on the out breath. It may help to sigh or moan or make rhythmic noise. Try to concentrate on each contraction, one at a time. When the contraction has finished, take a deep breath and blow it away. This helps you relax in between the contractions. Many women say it helps to move around and find comfortable positions – during the contractions this may mean leaning on something and swaying your hips or rocking on all fours. A deep bath or shower can also be really helpful in easing labour pain and helping you feel more in control. Your midwife will suggest different things to help you as you progress through labour but it's worth remembering that your body will tell you what to do in terms of how to move and breathe.

A 'show'

You may also pass some bloodstained or pink-coloured mucus. This is the plug that's been sealing up the cervix. It means your cervix is starting to stretch. A show can appear hours or even days before contractions start.

Waters breaking

'Waters breaking' means that the bag or amniotic sac that holds your baby breaks and the amniotic fluid leaks or gushes out. The fluid that comes out is the amniotic fluid that's been surrounding and protecting your baby while he or she grows inside you. The fluid will usually be clear but can be yellow or straw coloured. If it is green or red in colour, there may be a problem. Whatever the colour, you should put a pad on and ring your midwife, maternity unit or doctor, as you will probably need to go to your birthing centre or hospital so they can check you, your baby and your baby's position.

If your waters have broken and you still are not having regular contractions after 24 hours you may need your labour to be induced, as there is a risk of infection. Your midwife or doctor will talk to you about this.

How your partner or support person can help

There are lots of things your partner or support person can do to make labour more comfortable. But don't forget that they need to be prepared too. Make sure they understand what the birth will involve. Talk to them about your birth plan and about how they can help you in labour.

They can:

- stay with you and keep you company. (It can be good to have more than one support person. One can stay with you while the other has a break)
- hold your hand, talk to you, encourage you and remind you that the pain will pass
- bring you drinks of water and ice
- remind you to use relaxation techniques
- give you a massage
- help you change position
- get the attention of hospital staff if you need them
- help you make decisions about any treatment.

Some women, however, don't want to be touched or talked to when labour is strong. That's OK. Feeling supported and not fearful in labour is important. It helps your body to have a natural response that will help you manage the pain from contractions. You may feel yourself withdraw mentally into your body as you concentrate on each contraction but words of encouragement from your supporters are important throughout labour.

Should I go to hospital straight away?

Don't panic. It's a good idea to call your midwife or doctor and talk to them about your contractions and how you are feeling. Make sure you tell them if your waters break. It's usually best to try and rest at home for a while if you:

- are in the early stages of labour
- feel comfortable
- have had a healthy normal pregnancy.

During this time, it's helpful to:

- walk and move around between contractions
- get on with things around the house (easy things – no heavy lifting)
- have a shower or a bath.

It's okay to eat or drink normally. It's important to stay well-hydrated so drink regularly.

During your pregnancy, your midwife or doctor will have discussed with you when you should go to hospital, and who to contact when the time comes.

Generally you will need to call your midwife, doctor or maternity unit and go to hospital if:

- you pass any bright bloodstained fluid from the vagina
- you pass a gush or trickle of watery fluid (this may be amniotic fluid)
- the pains become more regular
- you or your partner have any concerns.

Let the midwife, doctor or maternity unit know you're on your way before you leave for the hospital. If you have a support person don't forget to call them if they are not already with you.

What happens when I get to hospital?

This depends on the hospital, but generally a midwife will:

- put an ID bracelet on your wrist
- talk about what's happening to you
- check your temperature, pulse and blood pressure
- check the baby's position by feeling your abdomen
- measure the baby's heart rate
- time your contractions
- test your urine
- perhaps do an internal examination (if the midwife thinks you are in labour) to see how much your cervix has opened, and to check the baby's position.

The midwife will continue to regularly check your progress and your baby's condition from time to time during the first stage. You may feel like changing positions frequently, using hot packs on your back or belly, a back rub, warm showers or hopping in the bath/spa/birth pool.

Ask your midwife and your support person to help you find a position that is comfortable for you and experiment e.g. standing, squatting or on hands and knees.

Helping your labour along

How quickly your labour progresses depends on a few things, including the baby descending or going down through the pelvis, and the cervix or neck of the womb opening up (dilating) with strong regular contractions. There are many ways that you can help your labour along.

Feeling as relaxed as possible

Things that may help include:

- music
- aromatherapy
- relaxation and breathing techniques.

Hot packs placed on the lower abdomen or back can feel good. Some hospitals don't allow them in case of burns, so check first with your midwife. Hot showers and baths can help too.

Keeping active

Walk around the room or up and down corridors while you can. Being active can help keep your mind off the pain. Lean on your partner or support person if it helps.

Changing positions

Try:

- standing
- squatting
- rocking on your hands and knees
- sitting back to back with your support person.

Massage

Massage can help ease muscle tension in labour, and help you relax. Your partner or other support person can use long, flowing strokes, or large circular strokes. For low back pain, they can try smaller movements with firm pressure. Keep the hands touching the body all the time.

Groaning or grunting

There are no prizes for keeping quiet in labour (if athletes and weightlifters can grunt when they push themselves, so can you). Trying to keep quiet may only make you tense.



“Walking around when I was having contractions helped me to handle the pain a lot more than when I was lying down.” Lynette

Why water?

Being in the water during labour can be very effective for comfort and pain relief during labour. Water provides support and buoyancy that helps you to relax.

Lying in warm water during labour can reduce stress hormones and pain by helping your body to produce natural pain relievers (endorphins). It can ease muscular tension and help you to relax between contractions. Labouring in water may:

- provide significant pain relief
- reduce the need for drugs and interventions, particularly epidurals
- help you feel more in control in labour and happier about how you're coping
- provide a feeling of weightlessness-relieving tired muscles and stress
- speed up labour
- promote relaxation and conserve energy.

Pain relief in labour

Everyone is different when it comes to how they feel pain and how they handle it. There are many things that can help you cope with pain in labour. But until you're dealing with the pain of childbirth, you don't know how you'll cope or what works best – so be prepared to try different ways.

Other things can also affect how you cope with pain including:

- how long labour lasts and whether you're labouring in the day or night. If you're tired from a long overnight labour, it can be harder to cope with pain
- feeling anxious. Anxiety makes you tense – and that makes any kind of pain or discomfort worse. Knowing what to expect in labour, having people with you to encourage and reassure you and being in an environment that makes you comfortable can help you relax and feel more confident.

Many of the suggestions above, such as staying active and changing positions, will help you to cope with pain. But sometimes you may need medication. Here's a summary of the common types of medication available. For more information about different options and side effects, talk to your midwife or doctor.

“I was able to rest in a warm bath, pulling myself upright as each contraction hit. Between pains I lay back in the warm water. I think my pregnancy yoga classes helped me to work with each contraction, rather than fighting the pain.” Karen



Pain relief in labour

Drug	Description	Main advantages	Main disadvantages	Effect on baby
Paracetamol	Tablets or capsules.	<ul style="list-style-type: none"> You can take them at home. Safe to use in pregnancy. 	<ul style="list-style-type: none"> Only mild analgesic effect. 	No known effect.
Nitrous Oxide (Gas)	Mixture of nitrous and oxygen gas, which you breathe through a mouthpiece or mask.	<ul style="list-style-type: none"> You control how much you use. Short-term effect. Only works when inhaling the gas. 	<ul style="list-style-type: none"> Takes edge off pain, rather than blotting it out. May make you feel nauseous, drowsy or confused. 	No known effect.
Morphine	An injectable narcotic drug.	<ul style="list-style-type: none"> Provides good pain relief in early labour. Starts to work after about 20 minutes and the effect lasts for 2-4 hours. 	<ul style="list-style-type: none"> May make you feel nauseous or drowsy. 	Occasionally, the baby may be a little sleepy and slow to breathe when it is first born which may affect his/her ability to start breastfeeding.
Epidural	Anaesthetic, which numbs you from the waist down. A small tube is inserted into your lower back and the epidural is 'topped up' when needed.	<ul style="list-style-type: none"> Gives more long-lasting pain relief. Most reliable and effective form of pain relief especially in second stage of labour. 	<ul style="list-style-type: none"> You won't be able to move around during labour. Can make it harder for you to push the baby out during labour. Increases the likelihood of other interventions, e.g. oxytocin to progress labour; forceps delivery or vacuum extraction. May leave your legs numb for a while after the birth. 	Effect depends on other interventions related to baby's birth. Some drugs used in the epidural may cross the placenta and may affect the baby's breastfeeding in the first few days.

When help is needed: medical interventions

An 'intervention' is an action taken by a midwife or doctor that literally intervenes in the birthing process. There is some concern that interventions are used too often in childbirth in Australia. Again, there are different opinions. Some people say using interventions make childbirth safer. Others say that having one intervention can mean you end up needing extra interventions. For example, induction of labour may make it harder to cope with contractions because they start quickly and strongly. This means you may need stronger pain relief than if you went into labour naturally.

If you're healthy and your pregnancy and labour are normal, you may not need any intervention.

This section discusses some of the more common interventions used in labour and birth. Talk to your midwife or doctor about them while you're pregnant. You might want to ask some of the following questions:

- why would I need this intervention
- what are the risks and benefits to me and my baby
- are there any alternatives
- is it likely to increase my need for more interventions
- can I do anything while I'm pregnant to decrease my chances of needing the intervention
- what is the hospital's policy on this intervention and the evidence to support this
- will it hurt
- will it affect my recovery
- will it affect my ability to breastfeed
- will it affect any future pregnancies?

Your midwife or doctor should discuss the pros and cons of any intervention with you before you agree to it.

Induction of labour

Sometimes, your doctor may recommend inducing labour – bringing it on artificially instead of waiting for it to begin. The reasons for inducing a baby may include a multiple birth, diabetes, kidney problems, high blood pressure or when a pregnancy is past 41 weeks.

If your labour is being induced it is important that you discuss this procedure with your doctor or midwife. The benefit of being induced must outweigh the risks. An induction of labour has some risks, for example there is a higher risk of forceps or vacuum delivery and caesarean section operation.

Ways to induce labour and start contractions:

- **Sweeping the membranes is a relatively simple technique.** During a vaginal examination, the midwife or doctor makes a circular movement with a finger to disturb the membranes. The evidence suggests that sweeping does promote the onset of labour and reduces the need for other methods of induction.
- **Prostaglandin is a hormone your body produces.** It helps your cervix soften. Prostin® and Cirvidil® are two synthetic forms of prostaglandin. They are inserted in the vagina near the cervix to soften it. This may also start contractions. They can take 6 to 18 hours to take effect. One of the risks is that this method of induction can over-stimulate your uterus and create difficulties for the baby.
- **Mechanical cervical ripening** uses a small plastic catheter to help soften and open the cervix.
- **Breaking the waters** (called an amniotomy) involves a doctor or midwife inserting an instrument into the vagina and through the open cervix, to gently puncture the membrane holding the amniotic fluid. This allows the baby's head to press down on the cervix more, increasing the hormones and contractions.

- **Oxytocin is a hormone your body produces naturally in labour.** It makes the uterus contract. Giving synthetic oxytocin (Syntocinon®) through an intravenous (IV) drip helps contractions start. The downside of oxytocin is that it can make contractions harder to cope with. This may mean you're more likely to need pain relief. Ask to have the drip attached to a mobile stand so you can move around if you want. The risks of oxytocin are similar to prostaglandin except that the effect is more pronounced and more immediate, but also more reversible, than prostaglandins. You and your baby will need to be continuously monitored during labour to check for side effects.

A combination of these medical interventions may be needed to start labour.

Augmentation

This means making the labour move along more quickly. It may be done when labour has begun naturally, but is progressing slowly. It is usually done by your midwife or doctor breaking your waters or by inserting an IV drip with oxytocin (a medication to increase contractions). The risks are the same as those when oxytocin is used for induction of labour.

Monitoring the baby in labour

It's important to check the baby's heartbeat in labour to make sure the baby is coping. A change in the baby's heartbeat can be a sign the baby isn't getting enough oxygen. This is called 'fetal distress'.

The heartbeat can be monitored by:

- **Listening** The midwife does regular checks (every 15-30 minutes) by pressing an ear trumpet (Pinard's) or doppler to your abdomen to listen to the baby's heartbeat. This monitoring is recommended if your pregnancy has been healthy and normal and you are well.
- **Continuous external fetal monitoring** Using an electronic monitor attached to a belt around your abdomen. This continuously records the baby's heartbeat and your contractions on a paper printout. External monitoring is used if there are complications or there are risks of complications. Some monitors restrict your movements. If you are advised to have continuous monitoring, ask if there's one available that lets you move around.
- **Internal fetal monitoring** This uses an electronic monitor that attaches a probe through the vagina to the baby's head. It should only be used if the external monitoring is problematic, the quality of the recording is poor, or in a twin pregnancy. It should not be used if you are HIV positive or hepatitis C positive.
- **Fetal scalp blood sampling** A few drops of blood are taken from your baby's scalp (like a pin prick). This kind of monitoring gives an immediate report on the baby's condition in labour. This test would be done if the doctors need more information than continuous monitoring provides. Sometimes this test needs to be repeated. The result will indicate if the baby needs to be born immediately.

What's the best position for giving birth?

The best position is the one *you* find most comfortable. Positions that use gravity, such as sitting, squatting, straddling a chair or standing, are better than lying down on your back. Gravity helps you push and helps the baby's head to come through the birth canal. You might prefer to be on your hands and knees. This position can help with pain relief as it takes the pressure off your back. Compared to giving birth lying down, these positions may make labour a little shorter and less painful. Lying on your back can be especially uncomfortable if you have lower back pain with the contractions.

Transition period

This is a changeover time near the end of the first stage. Your cervix is nearly fully opened. Soon, the baby will start to move down into the vagina.

Some women say this is the hardest part of labour. Strong contractions can last for 60 to 90 seconds and come one to two minutes apart. You may feel:

- shaky
- hot and cold
- nauseous (you may even throw up)
- irritable or anxious
- as if you can't cope any more
- out of control.

These are all normal feelings, but you may not experience any of these symptoms.

How long does this last?

Transition can take from five minutes to more than an hour.

Second stage

In the second stage, you help to push your baby out. You'll probably feel a strong urge to push as if you need to go to the toilet. There may be a stretching, burning feeling as the baby's head gets to the entrance of the vagina.

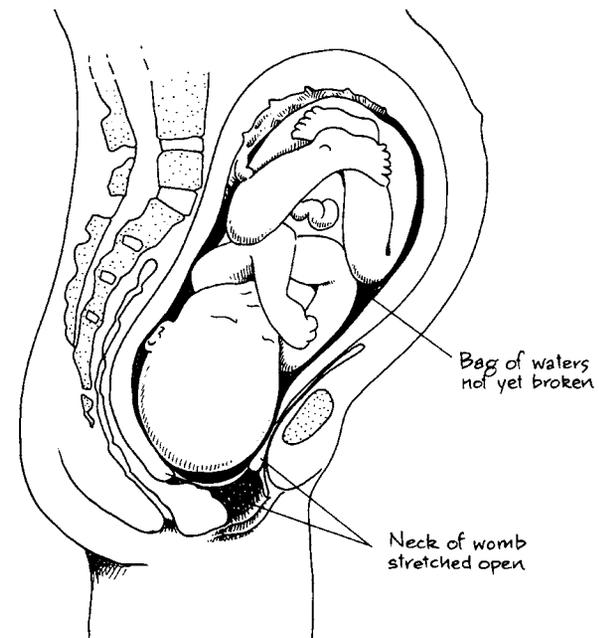
How long does it last?

The second stage usually lasts up to 2 hours for a first labour and up to an hour in a second labour, but an epidural can lengthen this stage.

Episiotomy – the pros and cons

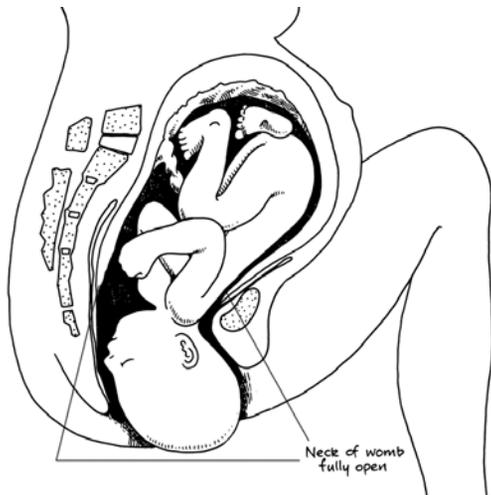
An episiotomy is a surgical cut in the woman's

Position of baby at transisition



perineum (area between the vagina and anus). During the birth, there's a chance that your

perineum may tear when the baby's head comes through. This is more likely to occur when forceps are used. Research has shown that the selective use of episiotomy may reduce more severe vaginal or perineal tear. Perineal tears are more likely to occur with a forceps birth. Women who have an episiotomy or a tear that involves muscles will require stitches. Talk to your midwife or doctor about this before labour.



"I liked labour. The pain was really bad, but I felt fantastic knowing that I could get through it." Katrina

Delivery using forceps or vacuum extraction (instrumental delivery)

Sometimes babies need to be delivered with the help of forceps or vacuum extraction. This may be because:

- the mother is having difficulty pushing the baby out
- the baby is in an awkward position
- the baby isn't getting enough oxygen and needs to be delivered quickly.

There are two methods of instrumental delivery:

- **Forceps** are like tongs that fit around the baby's head. They are used to help the baby out of the vagina. If you need a forceps delivery, you will usually need an episiotomy too.
- **Vacuum extraction (ventouse)** is an instrument like a cup attached to a pump. The cup is put into the vagina and onto the baby's head. The pump creates a vacuum effect. This holds the baby's head to the cup so the doctor can then gently pull the baby out, usually when you are having contractions and pushing.

Your doctor will choose the method depending on what's happening during the birth – sometimes forceps are best, and at other times it's better to use vacuum extraction. It's often a decision that needs to be made at the time, rather than something you can plan for. Before any of these procedures, your midwife or doctor will explain what will happen and any possible side effects.

Caesarean section operation

When a caesarean section operation is performed, the baby is born through a cut made through the abdomen into the uterus. The caesarean section operation is usually done with a low horizontal cut two or three finger breadths above the pubic bone so the scar is hidden by pubic hair. Some caesarean section operations are 'elective' (this means they're planned), others are emergencies.

Elective caesarean section operations are done before labour begins. They should not be scheduled before 39 weeks unless there's a medical reason as it may create problems for the baby.

Caesarean section operations may be necessary because:

- the baby is in an awkward position – bottom or feet first, or lying sideways
- it's a multiple birth (in some cases)
- the baby is distressed during labour
- you or your baby are at risk for some reason, and birthing needs to be quick
- the placenta is in the way of the baby's exit
- labour is not progressing.

A caesarean section operation is usually done with an epidural or spinal anaesthetic, or sometimes under general anaesthetic. If you need a caesarean section operation, you'll find it helpful to have information about the procedure including anaesthetic options.

A caesarean section operation performed with an epidural anaesthetic means you'll be awake when your baby is born. Your partner or support person should be able to be present in the operating theatre so you can both see the baby when it's born. The epidural also provides excellent post-operative pain relief.

You can ask to have skin-to-skin contact with your baby immediately after birth in the operating theatre or in the recovery room. This improves mother baby bonding, keeps your baby warm and helps him or her to begin breastfeeding. If you are not able to hold your baby skin-to-skin at first, ask that your partner does, and then place the baby to your chest as soon as you are able.

Third stage

After a caesarean section operation, your baby may need extra care and you may need a longer time in hospital. You'll usually have an IV drip and a catheter (a tube to drain urine) for one or two days. Once you are at home you'll need extra time to recover as a caesarean section operation is a significant surgical operation. Recovery can take up to six weeks and may make it difficult to care for your baby. Exercises are very important after a caesarean section operation to get your muscles working again. Your midwife, doctor or physiotherapist will advise you when to start.

Breastfeeding in the first few days after birth is very important for mother and baby. If you have had a caesarean section operation, or are very tired or sleepy after the birth, you'll need to take extra care to ensure you can safely breastfeed your baby.

The third and final stage of labour starts when your baby is born and lasts until the uterus pushes out the placenta. This stage is usually much shorter and less painful than the other two. However, it is a very important stage and must be completed before everyone can relax.

How long does this last?

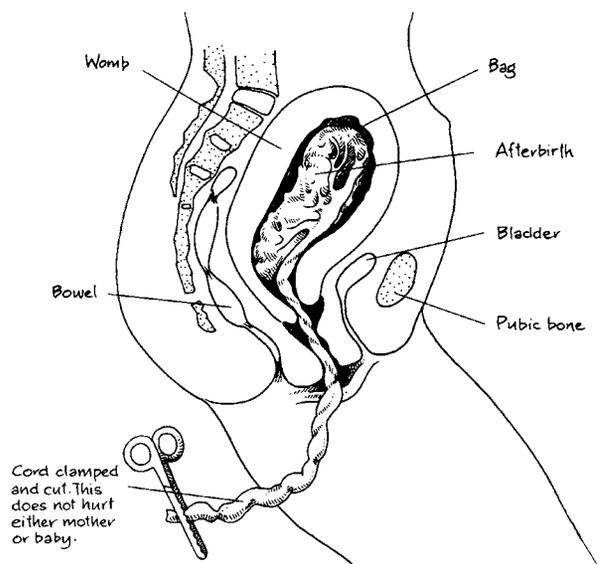
Most women have an injection of synthetic oxytocin (Syntocinon®) to help the uterus push out the placenta more quickly. This is called active management and is the best way to prevent excessive postpartum bleeding. Following the injection, this stage often takes about 5-10 minutes.

Some women prefer to wait and let the placenta come out naturally without an injection (called a natural third stage). A natural third stage can take up to an hour or so. Talk to your midwife or doctor when you are pregnant about which option is best for you. This will help you make an informed decision.

What happens after my baby

Health alert!

There are increased respiratory problems in babies when caesarean section operations are carried out before 39 weeks and where there is no labour. Therefore, planned caesarean section operation should not routinely be carried out before 39 weeks.



is born?

All being well, your baby will be given to you and you can have skin-to-skin contact, touch and stroke the baby's skin, and be close. Skin-to-skin contact means that the baby is naked and lying on your naked chest. This is good for you and the baby because it:

- promotes bonding
- keeps the baby warm
- lets the baby feel your heartbeat and smell your skin. This tells the baby you're there and helps him or her adjust to life outside your body
- encourages the baby to breastfeed (but this early skin-to-skin contact is important even if you're not breastfeeding)
- encourages your body to produce oxytocin which keeps your uterus contracted, to minimising blood loss.

Around the same time, the cord is clamped and cut (this doesn't hurt you or the baby). Usually, your partner will be asked if they would like to cut the cord. If you plan a natural third stage, discuss this with your midwife or doctor in the pregnancy or early labour as the cord is not cut until it stops pulsating and the placenta is out.

When should I feed my baby?

If you and the baby are well, help your baby find the breast soon after the birth. This helps:

- get breastfeeding off to a good start
- your uterus contract and push the placenta out
- reduce your bleeding
- keep your baby's blood sugar levels normal.

But don't worry if the baby doesn't want to breastfeed or if there's a medical reason you can't feed straight away – you can still breastfeed successfully without this early feed.

Checks after your baby is born

While you are cuddling your baby, your midwife or doctor will do a check called an Apgar score. It will be done twice (at one minute and five minutes after birth). It tells the midwife or doctor if your baby needs any special help adjusting to life. The Apgar score is based on the baby's:

- breathing rate
- heart rate
- skin colour
- muscle tone
- reflexes.

You probably won't even notice it's being done as the midwife or doctor can do it without disturbing the baby very much. You and your partner will be given time with your baby so that you can get to know one another. It's important that you and your baby stay together if you are both healthy.

After a while, your baby will be examined, weighed, measured and given identification bracelet/s. If you consent, he or she will also be given vitamin K and hepatitis B injections. The baby will be dressed and wrapped in a blanket. If there are concerns about your baby keeping warm even after prolonged skin-to-skin contact then he or she may be put on a warmer (a little bed with a heat lamp).

Bathing your baby

It is recommended that newborn babies are not routinely bathed immediately after birth.

However, bathing of the newborn baby is recommended when the baby's mother has active hepatitis B/C or HIV.

Injections to protect your baby

Experts recommend that newborns have two injections soon after they are born. These are a vitamin K injection, and vaccination against hepatitis B. It's up to you whether the baby has these injections – but they're strongly recommended to protect your baby. These injections will be provided free to your baby. You will usually receive information about these injections – vitamin K and immunisation against hepatitis B – during your pregnancy.

Why is vitamin K important?

Vitamin K helps prevent a rare but serious disorder called Haemorrhagic Disease of the Newborn (HDN), which can cause serious bleeding and may affect the brain. Newborn babies may not have enough vitamin K in their bodies to prevent HDN. By six months of age, they have usually built up their own supply. It's particularly important for babies to have a vitamin K injection if:

- they are premature or sick
- they have bruising from the birth or caesarean section operation
- their mothers took medication in pregnancy for epilepsy, blood clots or tuberculosis. Tell your doctor or midwife if you take any of these medications.

Vitamin K can be given by mouth or by injection. An injection is the preferred method, because it lasts for months and is a single dose. Vitamin K given by mouth doesn't protect for as long. If you want your baby to have vitamin K by mouth, your baby will need three separate doses – at birth, at 3 or 5 days old and at 4 weeks of age. The third dose is very important for parents to remember! Without it, the baby may not be fully protected.

Does vitamin K have side effects?

Vitamin K has been given to babies in Australia since 1980 and Australian health authorities believe vitamin K injections are safe. Parents who decide against vitamin K should look out for any symptoms of HDN. These include:

- unexplained bleeding or bruising
- any yellowing of the skin or whites of the eyes after three weeks of age.

Babies with these symptoms should see a doctor, even if they've had vitamin K.

Why does my baby need to be vaccinated against hepatitis B?

Hepatitis B is an infection of the liver caused by a virus. Some people with this virus may have no symptoms or only mild symptoms. But up to 25 out of a 100 people who are affected may get serious liver disease later in life, especially if they caught hepatitis B as a child. Immunisation helps prevent this.

It's important to start hepatitis B vaccination as soon as possible after birth to make sure it's as effective as possible. Babies need three more hepatitis B vaccinations at two months, four months and six months of age.

If you are a hepatitis B carrier, your baby is at high risk of being infected with hepatitis B. To prevent transmission from you to your baby, your baby should be given the usual hepatitis B vaccination and one dose of hepatitis B immunoglobulin (HBIG), preferably within 12 hours of birth and definitely within 7 days. After this, your baby will also need the usual three further hepatitis B injections at two, four and six months of age.

Are there side effects from hepatitis B immunisation?

Serious side effects are very rare. The most common problems are soreness where the injection was given, mild fever and joint pain. See your doctor if you're concerned.

*After your
baby is born*

After your baby is born

Looking after yourself

Your uterus takes a few weeks to get back to normal. It happens faster when you breastfeed. You may feel some cramps as your uterus contracts down to its normal size. They can be more noticeable when the baby is sucking. Some women who have given birth find that the 'after pains' are more painful with the next birth. Don't expect to have a flat tummy for a while.

Bleeding from the vagina is normal for up to three to four weeks. This bleeding is called lochia (it's not your period). For the first 12 to 24 hours after birth, it can be heavier than a normal period. Eventually it will lessen to a brownish discharge. The bleeding may be heavier during a breastfeed. Use pads, not tampons.

Your vagina and perineum If you had a vaginal birth, sitting down can be uncomfortable, especially if you have stitches. Stitches that dissolve are used, so you don't need to have them removed. The midwives will check the area to make sure it's healing normally. Keep the area clean and dry by washing two or three times a day and after a bowel movement. Change your pads frequently. The best remedies for pain relief are lying down and resting to take pressure off the perineum. Use non-prescription painkillers such as paracetamol if you need them.

Your breasts All women produce breastmilk. Production usually starts around week 16 of pregnancy and some women find they leak a little milk in the last few weeks. For the first few days after birth, the breasts are soft because your baby only needs a very small amount of breastmilk. Once babies start to get hungry and feed more frequently, the breasts respond by producing more milk. Your breasts may feel fuller and heavier as your milk 'comes in'. Breastfeeding according to the baby's needs and letting one breast drip while feeding on the other side will help stop your breasts from becoming overfull. Paracetamol (taken according to the directions on the pack), cold compresses (on your chest) and cool showers will help relieve any swelling and tenderness.

If you have decided not to breastfeed, you will still feel some breast discomfort in the first few days after birth because your breasts will still produce milk. This will ease over a few days. You can get some relief by wearing a supportive, comfortable bra with breast pads, limiting the touching of your breast/nipples, using a cold compress and taking paracetamol (according to the directions on the pack).

Your caesarean section operation scar is usually a low horizontal cut on your tummy, below your bikini line. Dissolving stitches are generally used these days which means the stitches don't need to be removed. The scar can be sore and uncomfortable for a few weeks. You'll be given pain killers in the first few days to help ease the pain as you gently and slowly move around and care for your baby. The midwife or physiotherapist will show you exercises you can do without putting a strain on the scar. The midwives will help you care for your baby.

Having your baby stay with you in your hospital room will help you and your baby get to know each other!

Your feelings Even though you feel tired, you may be on a high for the first day or so after the birth. This is sometimes called the postnatal pinks – and they can soon be replaced by the blues. You may feel sensitive, weepy and irritable. Most women go through this for a few days after the birth or even up to two weeks. If these feelings last longer than this, talk to your midwife or doctor. For more information, see *The first few weeks of parenthood* on page 104 and *Your feelings in pregnancy and early parenthood: what all parents need to know* on page 136.

Things you may be wondering

Do I need immunising against rubella or pertussis (whooping cough)?

If the blood tests you had early in pregnancy showed you had little or no immunity to rubella, it's a good idea to be immunised before you leave hospital. This is a triple vaccine (MMR) which also immunises against measles and mumps. It's important not to get pregnant for a month after vaccination.

If you haven't been immunised against whooping cough, you should have the pertussis vaccine soon after your baby is born. Your partner, the baby's grandparents and any other regular visitors or carers should receive the pertussis vaccine before baby is born. Make sure your other children are immunised against whooping cough.

When can I go home?

You may be able to go home as early as four to six hours after birth. Almost all hospitals now offer mothers and their babies, who are well, the opportunity to go home shortly after birth. Planning to go home soon after the birth of your baby means that you get to share your new baby with friends and family in the comfort and privacy of your own home. Going home soon after the birth means your family life is less disrupted and you're back with your other children more quickly. A midwife will visit you at home to provide postnatal care for you and your baby including breastfeeding advice. Midwives may provide postnatal support until your baby is 14 days old.

A longer postnatal stay in hospital may be required if you had a forceps or vacuum birth, a caesarean section operation, or if you or your baby are unwell. On average, hospital stays range from 24-48 hours for women who have had a vaginal birth to three or four days for women who have had caesarean section operations. When you go home from hospital after a long stay, you might be offered postnatal care and support at home from the midwives. The midwives can provide postnatal support until your baby is 14 days old; however, the availability of this service varies from hospital to hospital so check with your midwife or doctor.

After you return home you are also likely to be offered a visit by a child and family health nurse to provide 1-4 week baby checks as well as link you to other services. Please see page 92 for more information.

Routine checks for newborn babies

In the days following your baby's birth, he or she will be examined by a doctor or midwife specially trained to perform a check-up called the **newborn examination**. The doctor or midwife will take a head-to-toe look at your baby to check for any problems.

All parents in NSW are offered the opportunity to have their baby screened for a number of rare disorders. This test is called the **Newborn Screening**. You might also hear it called the "heel prick" test. The test involves taking a few drops of blood from your baby's heel. The drops are put onto special paper and sent to a lab for testing.

The conditions that the Newborn Screening tests for are not common but they are serious and it's best to know early if your baby has one of them. That way, treatment can start as soon as possible. The test looks for:

- **Congenital Hypothyroidism** which is caused by problems with the thyroid gland. Early treatment means children develop normally.
- **Phenylketonuria** means the baby can't properly use a substance in milk and food (called phenylalanine) which helps make protein in the body. If the problem isn't treated, phenylalanine builds up in the blood and causes brain damage. Treatment will help the baby develop normally.
- **Galactosaemia** is caused when a type of sugar (galactose) found in both breast and cow's milk builds up in the blood. Prompt treatment with special galactose-free milk will prevent serious illness. Without treatment, a baby may become very sick and die.
- **Cystic Fibrosis** makes the body produce thick mucus in the bowel and lungs. This can cause chest infections and diarrhoea and may stop the baby gaining weight. Improved treatment means people with cystic fibrosis now have a longer lifespan.

Early diagnosis and treatment are important for all these disorders. It's also possible to detect up to 40 other extremely rare disorders, using the same blood sample.

If the test results are normal – and most test results are – you won't get the results. About one baby in every hundred will need a second blood test if the first test did not give a clear result. You'll be contacted if a second test is needed. The second test almost always gives a normal result. Your doctor will be sent the result.

In a very small number of babies the blood test will be abnormal. The baby will need more tests and may need treatment too. Your doctor will let you know.

The third test that all babies in NSW are offered is a **hearing check**. One or two in every thousand babies needs help with a hearing problem.

The NSW Statewide Infant Screening – Hearing (SWISH) Program aims to make sure these babies are identified. The hearing test is offered as soon as possible after birth. If the test can't be done in hospital for some reason, it can be done in hospital outpatients or at a local Community Health Centre soon after you leave hospital.

The hearing test takes about 10-20 minutes and is done when your baby is asleep or resting quietly. You can stay with your baby while the test is done. You'll get the results as soon as the test is finished. The results will be written in your baby's Personal Health Record or "Blue Book".

If the results show your baby needs to have the test done again, it doesn't necessarily mean your baby has hearing problems. There may be other reasons for this result (e.g. your baby may have been unsettled during the test, or there may have been fluid or a temporary blockage in the ear).

Will injections and blood tests hurt my baby?

Whenever your baby has to have a procedure such as injections or blood tests, there are simple ways you can comfort your baby and minimise their pain. You can breastfeed your baby during the procedure or offer them a clean finger to suck. You can also speak soothingly to your baby, massage or stroke them and give lots of eye contact. Sometimes, your baby might be offered a few drops of a sucrose (sugar) solution which distracts them from any discomfort.



Newborn Screening

After the dried blood has been tested, it will be stored in the laboratory for 18 years and then destroyed. You can read more about why the tests are stored for so long at <http://www.chw.edu.au/prof/services/newborn/tests030194.pdf>



Baby car seat/capsule

If you are intending to take your baby home by car, you are required by law to have a baby seat or capsule fitted in the car. You can rent, buy or borrow a baby seat.

You can find information about baby capsules and child restraints on the RTA website. Visit <http://roadsafety.transport.nsw.gov.au/stayingsafe/children/childcarseats/>

Your baby's Personal Health Record (the Blue Book)

In the first few days after birth, your baby will be given a Blue Book. This Blue Book is for parents, doctors, child and family health nurses and other health workers to record details of your child's health from birth to the teenage years and beyond. It's a great way to keep important health information all in one place.

Take the Blue Book each time you take your child to the doctor, Early Childhood Health Service or hospital. The Blue Book also has reminders about important health checks and immunisation for your child, useful telephone numbers and a page for you to write down important phone numbers.



If your baby is unwell, or you are worried about a health problem, take your baby to your GP or the nearest hospital Emergency Department as quickly as possible. The condition of a new baby can change very rapidly.

Newborn babies: common features and problems

Skin

- **Telangiectatic nevi** (stork bites) are pale pink or red spots found around the eyelids, nose or neck. You can see them more clearly when the baby cries. They don't cause any problems and will fade over time.
- **'Mongolian spots'** are bluish-black pigmentations found around the buttocks. They are common in babies with dark skin. They don't cause any problems and will fade by the first or second birthday.
- **Nevus flammeus** (port wine stains) are sharply defined red-to-purple areas that usually appear on the face. They do not grow but they also do not fade with time.
- **Nevus vasculosus** (strawberry marks) are clearly defined, raised, dark red area that most often appear on the head. They initially increase in size and then will gradually shrink over time.
- **Milia** Raised, white spots that a baby may have over their nose and sometimes face. These are exposed sebaceous glands and are considered normal and will fade over time.
- **Erythema toxicum** (newborn rash) is a rash of small white or yellow pimples that may appear suddenly, usually over a baby's chest, tummy and nappy area within the first week of life. The cause is unknown and no treatment is necessary. They will disappear but may take some time.
- **Jaundice** affects many newborns. The baby's skin appears slightly yellow in the first few days of life. It isn't usually serious but in some cases a test may be required to measure the level of a substance called bilirubin in the baby's blood. If the bilirubin is considered higher than normal then the baby will be encouraged to drink more, and may be placed under special lights or on a BiliBed for a period of time until the jaundice has subsided. If you'd like to know more about jaundice, speak with your midwife or doctor.

Eyes

Some newborn babies have sticky eyes in the early days and weeks after the birth. It's not serious and will usually just go away. You can use cool boiled water to clean your baby's eyes. If it persists talk to your doctor or midwife.

Genitals

Sometimes, newborn girls may have a small amount of vaginal discharge – a thick, white mucus which may sometimes be tinged with blood. This is called pseudomenstruation and happens because your baby is no longer getting your hormones through the placenta. It's perfectly normal. A white cheese-like substance called smegma is often found under the labia. Again, it's normal.

There's no need to retract your baby boy's uncircumcised foreskin: it will roll back by itself when he is about 3-4 years of age. There are a lot of different opinions about the risks and potential benefits of circumcision. The Royal Australasian College of Physicians (RACP) recommends that there is no medical reason to routinely circumcise baby boys. More information is available at www.racp.edu.au click on 'policy and advocacy', then 'Division, Faculty and Chapter Policy & Advocacy' and then 'Paediatrics & Child Health'.

Umbilical cord care

At first, your baby's umbilical cord is white, thick and jelly-like. Within one or two hours of birth, it will begin to dry and it will fall off within 7 to 10 days. The umbilical cord stump may release a little discharge and this often occurs on the day it falls off, or just after. You can clean the area with cotton buds moistened in cool, boiled water and dry it with another cotton bud. Talk to your midwife or doctor if bleeding continues, or if it becomes red, weeping or swollen.

Things to do...paperwork!

Maternity Payment and Family Tax Benefit

After your baby's born, you'll be given forms from the Australian Government's Family Assistance Office that you can use to claim financial entitlements for you and your new baby. There are currently four main types of payment:

1. Paid Parental Leave scheme for working parents:

The Paid Parental Leave scheme is a new entitlement for working parents of children born or adopted from 1 January 2011. Eligible working parents can receive 18 weeks of government-funded Parental Leave Pay at the rate of the National Minimum Wage.

2. Baby Bonus: The Baby Bonus is an income-tested payment for a child born or adopted to eligible families. It helps with the cost of a new baby or child and is paid in 13 fortnightly installments. It's paid for each child in a multiple birth. You can't receive both Paid Parental Leave and the Baby Bonus so, if you meet the eligibility requirements for both payments, take a little time to figure out which will suit you and your family best.

3. Maternity Immunisation Allowance: This payment encourages parents to immunise their children. It's generally paid in two separate amounts for children who have been fully immunised with the first payment between 18 and 24 months and the second payment between 4 and 5 years of age.

4. Family Tax Benefit: This is a payment to help families with the cost of raising children. It is worked out on your family's total annual income, and the ages and number of dependent children in your family.

For more information, visit www.humanservices.gov.au and click on 'Families', call the family assistance line on 136 150 or visit your local Family Assistance Office. Phone 131 202 for assistance and information in languages other than English for Centrelink payments and services. For information in languages other than English visit www.humanservices.gov.au and click on 'Information in other languages'.

Early Childhood Health Services (may also be referred to as the Child and Family Health Centre or Baby Health Centre) provide free services for families with children under five years of age, including important health checks for your baby. The hospital will send your contact details through to the child and family health nurse in your area, who'll contact you to arrange a visit soon after you go home with your new baby.

Early Childhood Health Services can provide support and advice on anything that concerns you such as:

- feeding your baby
- crying and settling your baby
- safe sleeping strategies to prevent SIDS
- parenting skills
- playing with your baby
- the immunisation schedule
- your wellbeing
- your baby's or preschooler's health and development
- other services in your area.

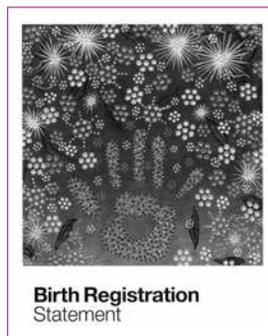
Your hospital or midwife can put you in touch with your local Early Childhood Health Service.

Registering your baby

The hospital or midwife will give you a **Birth Registration Statement** form in an information pack when you have your baby. Please complete the form and send to the NSW Registry of Births Deaths & Marriages by following the instructions on the form.

- Birth registration is compulsory and free
- The hospital or midwife does not register the birth of your child
- You must register your child's birth **within 60 days**
- You must register your child to get their birth certificate (fees apply).

A birth certificate provides legal evidence of your child's age, place of birth and parent's details and is required for some government benefits, enrolment in school and sport, opening a bank account and to apply for a passport.



Late birth registrations (after 60 days of the birth of your child) are accepted by the Registry.

If you require help with any part of the birth registration process, please call the Registry on

13 77 88. Further information including Registry office locations, can be obtained from the Registry's website www.bdm.nsw.gov.au

Medicare and the Australian Childhood Immunisation Register

It's important to register your baby with Medicare as soon as possible after birth. Registering your child with Medicare automatically registers your baby on the Australian Childhood Immunisation Register. You'll receive reminder notices when immunisations are due or overdue. Once registered, you will also be able to access up to date statements of your child's immunisation status online.

To enrol your child in Medicare, create a Medicare online account through the myGov website at www.my.gov.au

Feeding your baby

Feeding your baby

Breastfeeding – great for babies and mothers

For about the first six months of your baby's life, he or she only needs to have breastmilk.

If you and your baby are well, breastfeeding can start in the first hour after birth. Your baby is born with a strong instinct to suck, and if placed on your tummy or chest skin-to-skin, he or she will seek out the breast.

For the first few days after you give birth, your body produces a rich milk called colostrum which nourishes your baby while you get breastfeeding established. After three or four days, your milk “comes in” and your breasts will get bigger and firmer.

From 6 months, babies need to be introduced to family foods. Breastfeeding continues to be the most important part of your baby's diet until she or he is one year old. Between one and two years of age, breastfeeding can continue to make a significant contribution to your baby's health.

Water can be offered from around 6-8 months and cow's milk can be introduced from 12 months. Babies feed very well from a training cup and bottles, however, bottles are not recommended over the age of 12 months.

Breastfeeding is important for babies because it:

- promotes a good immune system during childhood and adult life
- promotes normal growth and development
- promotes brain development
- decreases the risk of infections and childhood illnesses
- decreases the risk of SIDS
- decreases the risk of Type 1 diabetes, overweight and obesity in childhood and later in life
- decreases the risks of respiratory disease, gastroenteritis, middle ear infections, allergies and eczema.

Breastfeeding is important for mothers because it:

- helps you bond with your baby
- improves your bone density
- helps heal the body faster after childbirth
- decreases the risk of pre-menopausal breast cancer, diabetes and ovarian cancer
- helps you return to your pre-pregnancy weight
- takes the worry out of whether your baby is getting what he or she needs. Breastmilk is never too strong or too weak – it's always just right.

Getting started

Soon after birth – usually within the first hour – babies show signs of wanting their first breastfeed, especially when they have had skin-to-skin contact. Your midwife will help by making sure you and the baby are comfortable and well-supported during the feed. After the first feed, babies often have a long sleep.

Don't be worried or upset if you and your baby don't get it straight away – breastfeeding is a learned art for both of you and it can sometimes take some effort to get breastfeeding established. Once you've got the knack, it's easy and convenient. Many women who have a difficult start go on to breastfeed happily and successfully.

Midwives and child and family health nurses are trained in lactation management and can provide expert advice on breastfeeding. If needed, you can also get specialist support from a lactation consultant (often a midwife) who has advanced training in supporting breastfeeding mothers and babies.

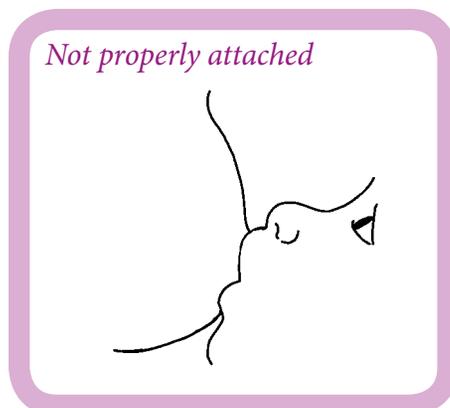
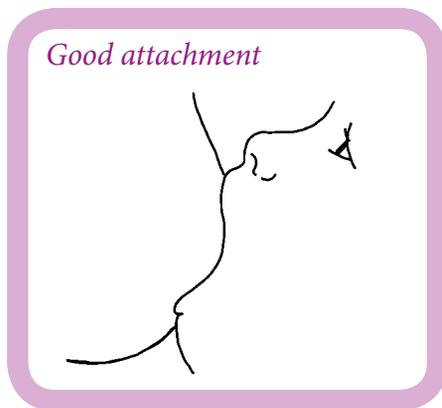
Putting your baby to the breast

Before you feed it's important to find a comfortable position. If you're sitting down to feed, try to make sure that:

- your back is supported
- your lap is almost flat
- your feet are flat (you may need a footstool or a thick book to support them)
- you have extra pillows to support your back and arms if needed.

There are various ways that you can hold your baby for breastfeeding. Your midwife will help you find a position that feels comfortable for you. Whichever way you choose:

- hold your baby close to you
- your baby should be facing your breast with head, shoulders and body straight (chest-to-chest)
- his or her nose or top lip should be opposite the nipple
- he or she should be able to reach the breast easily, without having to stretch or twist
- your baby's chin should be against the breast.



Once your baby is attaching well to the nipple and you're feeling confident, breastfeeding lying down can be very comfortable – it helps you to rest while your baby feeds, however, you should ensure that your baby's face is kept clear so that he/she has room to breathe. It's also important to remember that babies under four months of age are at an increased risk of sudden unexpected death in infancy when they share a bed with you or your partner. For information on safe sleeping, see *The first weeks of parenthood* on page 104.



If you have any questions during pregnancy about breastfeeding, your midwife or doctor can provide support and information.

Attaching your baby to the breast

It's important to make sure your baby latches onto the breast properly, otherwise he or she may not get enough milk during the feed and your nipples could become sore. To attach your baby to your breast:

- position your baby with his or her nose or top lip opposite your nipple
- wait until the baby opens his or her mouth really wide (you can gently brush his or her lips with your nipple to encourage this)
- quickly move your baby onto your breast, so that the bottom lip touches the breast as far away as possible from the base of the nipple. This way, your nipple will be pointing towards the roof of your baby's mouth
- always remember to move your baby towards the breast rather than your breast towards the baby.

When your baby is properly attached you will notice:

- more areola visible above your baby's top lip than below the bottom one
- the sucking pattern will change from short, fast sucks to long deep sucking with pauses
- a deep pulling or tugging sensation on your breast that is not uncomfortable
- your baby will look relaxed with eyes wide open at first. They'll close towards the end of the feed
- when your baby comes off the breast, your nipple will look softened and longer but rounded on the end, not pinched or flattened
- once your supply has increased you will hear swallowing.

During the first week or so, you may notice some pain or discomfort when your baby first attaches. This should soon go away, but if it continues through the feed, your baby may not have attached well, and you will need to gently take your baby off and help him or her to re-attach.

It's normal for your nipples to feel sensitive in the first 7-10 days after birth. You may notice this when you have a shower or when your clothes brush your breasts.

Pain during the feed and a pinched or flat nipple on detachment are signs your baby isn't attaching properly. Ask your midwife, child and family health nurse, or lactation consultant for help and to watch you feed. You can also contact the Australian Breastfeeding Association's Breastfeeding Helpline on 1800 686 268 (1800 mum2mum).

How do I know my baby is getting enough breastmilk?

Breastfeeding works on supply and demand. The more your baby feeds, the more milk your breasts will produce. To reassure you that you are making enough milk for your baby:

- feed when baby shows signs of hunger. Don't make him/her wait! Crying is a late sign of hunger
- in the early weeks, expect to feed at least 6-8 times each day (and maybe up to 10 or 12 times a day). Some of those feeds will be overnight
- your baby will have at least 4 (disposable) or 6 (cloth) wet nappies
- he or she may poo once a day, several times a day or once every few days – the poos will be soft or runny and mustard-yellow
- you will feel a strong sucking action during feeds
- you will hear the sound of milk being swallowed
- expect your baby to be settled after some feeds and restless after others – there will be no pattern to this at first but after a few weeks one may appear.

Some important questions...

Can I breastfeed if I have hepatitis B?

Yes, this is safe - when your baby has received an immunoglobulin injection after birth, and has started the course of hepatitis B vaccinations.

Can I breastfeed if I have HIV?

In Australia, HIV positive women are advised not to breastfeed. Current research shows there is a risk of passing HIV onto the baby through breastfeeding.

Can I breastfeed if I have hepatitis C?

Yes, the health benefits of breastfeeding are considered to outweigh the very low risk of transmitting hepatitis C in breastmilk. If you develop cracked or bleeding nipples, you should express and discard milk from that breast until the cracks have healed, as blood may be present in the breastmilk. For more information, contact Hepatitis NSW. Tel: (02) 9332 1853.

The first few weeks

Mothers and babies usually take several weeks to feel comfortable and confident with breastfeeding. It takes around four weeks for your milk supply to become "established". At first, your breasts may be quite full and uncomfortable but this will soon settle.

Most babies will be wakeful at night and sleepy during the day for the first week or two as this is what they were used to while still in the womb. Most babies also continue to need at least one to two feeds at night for many months in order to grow and develop normally.

Your baby's wakeful time will gradually move to the late afternoon or early evening. During this time, babies like to be cuddled and breastfed frequently. This is an important process: they are making sure there will be plenty of milk available the next day as the breast will now only refill if it is well drained. It is perfectly normal to feel "empty" at the end of the day.

Remember, breastfeeding is a new skill you and your baby are learning. Even if you've breastfed before, your baby hasn't and you might need some help in the early days and weeks. There are lots of places you can turn for support and help:

- your midwife
- the Australian Breastfeeding Association on 1800 686 268 (1800 mum2mum)
- your local child and family health nurse – see Community Health Centres or Early Childhood Health Services in the *White Pages*
- Karitane on 9794 2300 or 1800 677 961
- Tresillian Family Care Centres on (02) 9787 0855 (Sydney metropolitan) or 1800 637 357 (regional NSW)
- your GP or paediatrician
- a certified lactation consultant. Ask for a list before you go home.



When do I start solids?

You can start to introduce solid foods around six months. Contact your child and family health nurse for advice.

Babies are constantly growing so it's not surprising for them to have at least one "hungry day" a week where they feed more often. Every few weeks, they may also have a bigger appetite where they feed frequently for several days then settle. There is nothing wrong with your supply; they are just "topping" it up.

The table on the inside back cover describes breastfeeding in the first few days after birth.

To maintain your milk supply and decrease the risk of lumps, blocked ducts and mastitis, it is important to drain one breast well at each feed. Let your baby feed from the first breast until your breast feels comfortable, then offer your baby the second breast. Depending on your baby's age, how hungry he or she is, how long since the last feed, the amount of milk available in the first breast and the time of day, your baby may want one or both breasts. Alternate the first breast at each feed (so start on the right breast for one feed, and start on the left at the next feed).

Breastfeeding and food

When you start breastfeeding, it's normal to feel hungrier and thirstier than usual. You can enjoy more of the healthy foods you need. Keep planning your food based on the table in the section *Healthy eating for pregnancy* (page 28), and add one or two extra serves of each of these food groups:

- bread, cereals, rice, pasta, noodles
- vegetables, legumes
- fruit.

Can I use a dummy or pacifier?

While many women offer their babies dummies, there are some things to think about when you're deciding whether to start one or not. Studies suggest that introducing a dummy before breastfeeding is well-established may reduce the length of time you and your baby enjoy breastfeeding. It's thought that the different sucking techniques that a baby uses for a dummy and the breast may have a negative effect on breastmilk supply. Older babies seem to be able to recognise the difference between the dummy and the breast.

If you decide to go ahead and use a dummy, we recommend you wait until breastfeeding is well-established. Clean and sterilise your baby's dummies every day. Keep the dummy in its container when it's not in use. Never put a dummy in your mouth (to "clean" it) and never put any food or other substance (such as honey) on a dummy.

Talk to your midwife or child and family health nurse about the different ways in which you can settle your baby.

Alcohol, other drugs and breastfeeding

Alcohol and other drugs can be passed to your baby through breast milk. The safest option, for both you and your baby, is to not drink alcohol or take any illicit drugs when breastfeeding. Experts recommend that women avoid drinking alcohol for at least a month following the birth of your child until breastfeeding is well-established. After that, if you drink alcohol, they recommend that you limit your alcohol intake to two standard drinks a day.

Alcohol passes into your bloodstream and into your breastmilk 30-60 minutes after you start drinking. Avoid drinking alcohol immediately before breastfeeding and consider expressing milk in advance if you wish to drink alcohol. You can find more information on the MotherSafe website at www.mothersafe.org.au

The Australian Breastfeeding Association's also produces a brochure on alcohol and breastfeeding. You can access it online at <https://www.breastfeeding.asn.au/bf-info/safe-when-breastfeeding/alcohol-and-breastfeeding>

Health alert!

Medications and breastfeeding

If you need to take any prescribed or over-the-counter medications, tell your doctor or pharmacist that you are breastfeeding. They'll help you choose a safe medication. You can also call MotherSafe on (02) 9382 6539 (Sydney metropolitan area) or 1800 647 848 (regional NSW).



Methadone, buprenorphine treatment and breastfeeding

If you take methadone or buprenorphine treatment you can still breastfeed, as long as you are not using other drugs. Only a small amount of the methadone or buprenorphine pass into the breast milk.

Speak with your doctor to discuss your options and any potential risks. Additional support and information is available from MotherSafe on (02) 9382 6539 (Sydney) or 1800 647 848 (regional NSW) or from ADIS on (02) 9361 8000 (Sydney) or 1800 422 599 (regional NSW).

“In the beginning, breastfeeding was a bit difficult and uncomfortable at times. I managed by getting help from my midwife and child and family health nurse and by setting myself goals – six weeks, three months, etc. By the time I reached that first goal, it had become so much more comfortable and easy that I was happy to keep going to the next marker. In the end, I breastfed for 16 months. In those first few tough weeks, I wouldn’t have believed I’d do that.” Chloe

Breastfeeding involves your partner too

Your partner has an important role to play in supporting breastfeeding and helping you and your baby get breastfeeding established. Research shows that mothers who are encouraged and supported by their partner and family find parenting more enjoyable.

Your partner can:

- make sure you are comfortable and have enough to eat and drink while you are breastfeeding
- give you some 'time out' by helping to settle the baby after the breastfeed
- provide practical support by bathing and changing baby before or after the breastfeed
- monitor and manage visitors in the early days and weeks so you're not overwhelmed.

About expressing breastmilk

Many women express breastmilk for different reasons. You might want to express because:

- your breasts are too full for your baby to attach properly, so you need to remove some milk before the feed
- your baby is too sick or small to feed directly from the breast
- you need to be away from your baby for a couple of hours and he or she might want to feed
- you are going back to work and need to leave milk for the carer to feed your baby.

You can express milk by hand, or you can use a hand pump or electric pump. How you do it depends on why you want to express, how often and how much you want to express. You can ask your midwife or hospital lactation consultant to show you how to hand-express and how to use a pump. There are lots of different types of pumps available, so before

you buy or hire one, it's best to talk to a lactation consultant or the Australian Breastfeeding Association for advice about which type would suit you.

Express your breastmilk into a clean container. Expressed breastmilk should be used immediately, or stored in a sealed container in the coldest part of the fridge (towards the back) until you're ready to use it. Breastmilk can also be frozen.

To learn more about expressing and storing breastmilk, ask your midwife or child and family nurse for a copy of the NSW Health booklet *Breastfeeding your baby*. It's also available online at http://www0.health.nsw.gov.au/pubs/2011/pdf/breastfeeding_your_baby_w.pdf

Possible breastfeeding issues

Tender nipples

Sore and damaged nipples usually mean that the baby is not attaching well to the breast. Leave your bra or top off after you breastfeed so your nipples dry naturally. If any of the following problems continue after the first week of breastfeeding, contact your child and family health nurse or the Australian Breastfeeding Association if you have:

- persistently tender nipples
- damage to the skin on your nipples
- distorted or pinched nipples.

Mastitis

Mastitis is a breast inflammation or infection. It's more common in the first weeks when the milk supply is still establishing. Prompt treatment will resolve mastitis quickly.

Watch out for:

- tender or red painful areas on the breast
- lumps and firm areas on the breast
- flu-like symptoms with a mild temperature or suddenly becoming very sick with a high temperature and headache.

Formula feeding your baby

Mastitis can be caused by:

- the first breast not being well drained before the second breast is offered
- nipple damage (grazes or cracks caused by poor attachment)
- blocked milk ducts
- sudden changes in feeding pattern
- being overtired and skipping meals.

If you develop symptoms of mastitis treat the breast that's affected by:

- offering frequent feeds, draining the breast well
- expressing milk if you can't put the baby to the breast
- starting feeds on that side two feeds in a row (then go back to alternating starts)
- using cold compresses before and after feeds if they symptoms are in the first ten days of breastfeeding
- applying moist heat (such as a shower, bath or warm pack) before feeds and cold compresses afterwards if the symptoms occur later in the breastfeeding relationship
- gently massaging the area towards the nipple during the feed
- resting, increasing fluids and accepting any offers of help.

If you are not able to soften the lump/decrease the redness within about 12 hours or begin to feel unwell, it is important to contact your doctor as you may need antibiotics. There are antibiotics available that are safe for you and your baby so that you can continue breastfeeding. It is important to keep breastfeeding to empty the breast.

If you have decided to formula feed, make it safe for your baby:

- use only approved infant formula – most are based on cow's milk
- all formula in Australia meets the required food and safety standards
- be careful with preparation, sterilisation and storage:
 - follow the instructions on the label for the preparation and storage of the formula
 - sterilise all equipment used.

Always follow food safety guidelines:

- follow manufacturer's instructions for safe storage of formula
- make formula up as you need it as bacteria can grow in unused formula
- throw out any formula in a bottle that your baby doesn't finish during a feed – don't keep it for later.

What to bring to hospital if formula feeding:

If you have decided to formula feed, you will need to bring formula and your equipment into hospital with you when you have the baby. Bring with you:

- one container of your chosen formula
- two to six large bottles with teats, caps and teat covers. Decorations and odd shapes make bottles hard to clean and there is no evidence that a particular shape of bottle or teat prevents wind or colic.

Before you go home, staff will make sure you feel confident with making up the bottles and feeding. The midwives will also provide you with written information on the correct preparation and storage of formula. Please contact your midwife or child and family health nurse for information, assistance and support when using infant formula.

Can I combine breastfeeding with formula feeding?

Replacing a breastfeed with a formula feed on a regular basis will reduce your milk supply. You can express breast milk which your baby can take from a bottle if you are unable to directly breastfeed your baby. Do this in advance so you are not rushing at the last minute. If your expressed breast milk is not available, then infant formula can be used but it is important to breastfeed or express again as soon as possible. Many mothers find that they are able to successfully maintain breastfeeding when they return to work or study by combining breastfeeding with expressing. For more information, contact your Early Childhood Health Service or the Australian Breastfeeding Association.

Health alert!

Babies can get sick from incorrect preparation of formula feeds. Follow the instructions on the label.

Breastfeeding, formula feeding and allergies

Breastfeeding may help prevent children from developing allergies or eczema. If you have a family history of allergies or eczema and you are worried about your baby might need formula talk to your midwife, doctor or a paediatrician during your pregnancy.

If you have any questions during pregnancy about breastfeeding, your midwife or doctor can provide support and information.

*The first weeks of
parenthood*

The first weeks of parenthood

What's happening to me?

Being at home with your newborn baby is usually a wonderful time, but it can also be chaotic and exhausting.

Life with a new baby is demanding and unpredictable. This makes it hard to find time for your own needs – even things as basic as having a shower or making your own meals. You'll be tired, and sometimes overwhelmed. It may feel as if you have no control over your life.

This is normal. It doesn't last. By six to eight weeks, you'll start to get more organised. By three to four months, everything will be more settled.

How to survive the early weeks

- Try and rest or sleep during the day when the baby sleeps.
- Do as little as possible. Keep housework to a minimum (you and your baby are more important).
- Get your partner to bath and change the baby – it gives you a break and helps the baby get to know both parents.
- Remember your relaxation techniques (see *Getting ready for labour and birth* on page 67). Use the techniques if you feel edgy or when you want to rest.
- Save energy by sitting down to do things. Sit on the floor or lounge to change a nappy and sit down to fold laundry
- Keep food simple, as you won't have time or energy for much cooking. The simplest meals are often the healthiest, such as salads with some lean grilled meat or fish, canned fish or cold chicken with wholegrain bread. Snack on fresh fruit and yoghurt.
- If friends drop in, ask them to give you a hand if there are things to do like shopping or putting out the washing. Most people like to feel useful.
- Fresh air and gentle exercise such as taking the baby for a walk can help you feel less 'housebound'.
- Remember that if you don't care for yourself, you'll be in no shape to care for anyone else.

All new parents need support, especially if you don't have family close by or you're a single parent. Don't be afraid to ask for, and accept, help.

Some parents find it hard to sort out the different advice they get from friends, family and health professionals. Some advice may be good, some not so good. It's best to decide on a couple of people whose advice you trust. Then do what feels right for you and the baby – trust your intuition. If you're confused or don't know what to do, call your Early Childhood Health Service or:

- Karitane Careline on 1300 227 464 (1300 CARING)
- Tresillian Parent's Helpline on (02) 9787 0855 (Sydney metropolitan) 1800 637 357 (Regional NSW)
- Australian Breastfeeding Association 1800 686 268 (1800 mum2mum)
- Local Women's Health and Community Centres offer individual counselling and support groups. You can look for these centres at Women's Health NSW website <http://www.whnsw.asn.au/centres.htm> or read more information on the internet from the NSW Health website (www.health.nsw.gov.au).

Looking after your baby

Many new parents feel overwhelmed by the first few weeks of family life, and so do many babies. Your baby has left that snug, dark place inside you and arrived in a strange and sometimes scary place full of unfamiliar sights and sounds. There are some important things to remember about new babies:

- You can't spoil a newborn baby. Crying is your baby's only way of letting you know that he or she needs you. Babies aren't old enough to be naughty or to try to get their own way.
- All babies cry. Some babies cry more than others. Some cry more than you would

think possible. The afternoons and early evenings are often the worst. Comforting your baby quickly when

he or she cries helps your baby feel safe.

- Babies who are comforted when they are upset and get what they need quickly – a feed, a dry nappy, a cuddle – tend to cry less.
- Remember that although this is your baby, the relationship between you both is new. When we meet someone new, it takes time to get to know how they behave, what makes them upset and how to comfort them. It's the same with babies... even if you've had a baby before.
- The chaos of the first few weeks doesn't last. Your baby will gradually get into a more regular pattern of sleeping and eating.
- It is very important that babies live in a completely smoke-free environment. Babies exposed to cigarette smoke have a much greater risk of respiratory problems and SIDS.

What if the baby won't stop crying?

It can be very stressful when nothing you do seems to comfort your baby.

- First of all, check that your baby isn't hungry, isn't too hot or cold, and has a dry and clean nappy.
- Remember that babies are like anyone else – it can take time to calm down when you're upset.
- If your baby is unsettled during the day, try putting him/her in the pram and going for a walk in the fresh air to calm you both. If that's not possible, skin-to-skin contact often soothes. If this does not help, put your baby in a safe place (their bassinet or cot) and call someone to come and help you.

Often, babies respond to someone other than their mothers if they're particularly unsettled.

- If no-one else is at home you may need to call a friend or family member and ask them to come over. If they are not close by, sometimes putting the baby in the car and driving to someone else's place will help.

If you need help at any time, you can also call:

- Tresillian Parent's Helpline on (02) 9787 0855 (Sydney metropolitan area) or 1800 637 357 (regional NSW)
- Karitane Careline on 1300 227 464 (1300 CARING)
- Child Abuse Prevention Helpline on 1800 688 009
- Men's Line on 1300 789 978
- healthdirect Australia on 1800 022 222

“We were really well-prepared for the crying. One of the best things about the pregnancy classes we went to was they really made a point of telling us about how a baby behaves including how much and how often they cry in the first few weeks. The classes also helped us understand that comforting a baby was the right thing to do and meant that babies settle quickly this way. Because we knew what to

expect I think it really helped us cope.” Tim

Looking after yourself

Your body

Vaginal bleeding (lochia) will continue for around two to four weeks after the birth. After the first few days, it should be pinky-brown rather than red. See your doctor if the bleeding becomes brighter, heavier, you pass clots or the bleeding is smelly.

Constipation may be a problem but there are simple solutions. Some of the fastest foods – big salads with raw mixed vegetables, fresh fruit, dried fruit, wholegrain bread, baked beans on toast – have lots of fibre which will help. Drinking plenty of fluids (less tea and coffee) and walking help too.

Vaginal or perineal stitches If you have stitches, you may still be sore. See your doctor if the area becomes more painful or inflamed. You may also

see fragments of stitches over the next few weeks. The repairs aren't falling apart – it's just your stitches gradually dissolving as the area heals. Salt water

baths are not recommended as salt may weaken the stitches.

Piles (haemorrhoids) You may experience pain in your anal area after the baby is born. It's important to avoid straining when going to the toilet. You can take a warm bath to soothe the area and use over-the-counter creams and/or medications such as paracetamol.

Sex It's okay to have sex when the bleeding has stopped – usually by four or six weeks. Some women do want to have sex at this time but there's a good chance that all you want to do in bed is sleep! Besides fatigue, other things that can make sex difficult are:

Stitches If you've had stitches, it may take longer than six to eight weeks before sex feels comfortable. If penetration still hurts after three months, see your doctor.

Less lubrication Hormonal changes mean your vagina isn't as well lubricated as usual. This will get better after about 10 weeks. Until then, try a lubricant and more foreplay.

Health alert!

Never shake your baby

Shaking your baby causes his or her head to jolt backwards and forwards and may cause bleeding in the brain. This can cause brain damage and may result in the death of the baby. If you feel yourself getting frustrated, upset or angry, put the baby in a safe place (his or her bassinet or cot), walk away and take time to take care for yourself. Ask for help. If someone else is home, ask them to try and settle the baby. If you're alone, ring a friend or family member and ask them to help. Remember, no matter how upset you get – never shake your baby.

Your feelings about your body Some women feel okay about their bodies at this time – but some don't. You may feel shapeless. You may feel like your body isn't your own. It's not like your pregnant body – but neither is it the body you had before.

Breastmilk Some women will leak milk during sex. If you or your partner are not comfortable with this try feeding your baby or expressing first to decrease the amount of milk present or wear a bra with breast pads.

The good news is that in a few months both your shape and your sex life should start to improve. In the meantime:

- talk to each other about how you feel
- have some 'couple time'
- don't expect too much the first time you have sex
- if it's uncomfortable, wait for another week or so
- remember that there are other ways to feel close and enjoy each other.

Six-week postnatal check See your midwife or doctor for a check-up six weeks after the birth. This is an important check for you and your baby. It is also a good time to have a Pap smear test if you hadn't had one in the last two or three years.

“You have no idea of how difficult that first week at home is going to be. The most helpful thing was my partner taking time off after the birth. The other thing that made a huge difference was cooking and freezing meals for two weeks in advance – it's even better if you can get your mother in-law to make her lasagna as well.” Kate

Contraceptives

It's important to think about using contraception after the birth of your baby. Don't wait until your six-week postnatal check to think about it – you can get pregnant before then (even if you are breastfeeding) because you will ovulate before your periods return. Breastfeeding can delay ovulation but if you want to plan the timing of your next pregnancy, it's a good idea to use contraception.

If you are breastfeeding, you won't be able to take the combined pill because it can affect your milk supply but there are some options that won't affect your milk. See your doctor or Family Planning NSW Health clinic to talk about what would suit you best. You can get more information on the Family Planning NSW website at www.fpnsw.org.au or call the Family Planning NSW Healthline on 1300 658 886.

Hormonal contraceptives

- **Contraceptive injection (Depo-Provera®)** is a hormonal injection that you have every three months to prevent pregnancy. If you want to use it after having a baby, the best time to have the injection is five or six weeks after the birth. A small amount of the hormone will go into the breastmilk. Depo-Provera™ is effective straight away. It's important to make sure you're not pregnant before having the injection.
- **Progesterone-only pill (or mini-pill)** is a reliable contraceptive, as long as you remember to take it at the same time every day. You can start taking it shortly after the birth (talk to your doctor). You need to use condoms for 48 hours until the mini-pill takes effect.
The Morning After Pill (emergency contraception) contains the same hormone as the mini-pill, but in a larger dose. It is available in a single tablet or two-tablet pack. You can keep breastfeeding if you take these.
- **Contraceptive implant (Implanon NXT®)** is a small rod implanted under the skin of the inner arm. It releases small amounts of a hormone that prevents pregnancy and has a less than one in a hundred failure rate. It stays in place for three years.

Implanon must be inserted by a health professional who has been trained to do it. It can take up to a week for Implanon to become effective. You need to use condoms until it takes effect. Some women have irregular bleeding as a side effect.

These contraceptives don't affect your milk supply. Very small amounts of hormones may pass into breastmilk, but they have no effect on the baby.

Intra Uterine Devices (IUDs)

A small device is inserted inside your uterus (womb). You could have the IUD put in at your six-week check after the birth, but it's usually done at least eight weeks after the birth.

One IUD known as Mirena™ also has a hormonal ingredient. This ingredient has not been shown to have adverse affect on babies or milk production which means that women who are breastfeeding can safely use this method.

Male Condom

Condoms are an effective contraceptive when they are used consistently. They don't contain hormones. You may need to use extra lubrication with condoms while you're breastfeeding. Polyurethane condoms are available for people with latex allergy. Condoms protect against STIs.

Female condom

Women can use this condom especially if they have a latex allergy. It lines the vagina and provides a barrier for sperm and also prevents STIs. Female condoms are available through Family Planning NSW and sexual health clinics.

Diaphragm

If you normally use a diaphragm or cap, you may need a different size to the one you used before. Your doctor can check this at the six-week visit.

If you're not breastfeeding, you can use the combined pill or any of these other options.

Will breastfeeding prevent pregnancy?

The World Health Organisation (WHO) says breastfeeding can be effective in preventing pregnancy for 98 out of a 100 women in the first six months after birth as long as:

- you breastfeed your baby during the day and night
- you don't go for more than four hours without breastfeeding (if you go without breastfeeding for longer than this, you'd need to express milk every four hours)
- you don't give the baby any other food or drink (babies need only breastmilk for the first six months)
- you haven't had a period.

You can choose to combine breastfeeding with another method of contraception

When will I get my period back?

Most times women who breastfeed may not get their period until they stop breastfeeding exclusively, however, some women's period may return before this time. If you bottle feed, you may get a period four weeks after the birth. Just remember that you will ovulate before you get your period and you can get pregnant if you don't use contraception.

Getting back into shape

Don't expect to get back into your old jeans just yet. Accept that your belly will bulge for a while and the skin may look loose – but it's not forever.

Healthy eating, regular exercise and time will get you back into shape. For information about postnatal exercise, see the sections *Give me strength: pre- and post-natal exercises* on page 37. Being active with a new baby is easier than you think. You can:

- Entertain your baby by letting him/her watch you do your postnatal exercises.
- Go for regular walks with the baby in a safe baby carrier or pram. Walking helps you get fitter and stronger, and gives you energy. Babies like getting out and seeing new things. It helps them learn about their world.
- Join a pram-walking group. These are groups of new mothers who get together to walk, talk and have fun. They're a great way of getting out and meeting people, lifting your mood and getting back into shape all at the same time. To find out if there's a pram-walking group near you, contact your Early Childhood Health Service or the NSW Department of Sport and Recreation on 13 13 02. You can find more information about setting up a pram-walking group at <http://www.dsr.nsw.gov.au/> and click on 'Get Active'.
- Find out what other activities are available in your area – some community exercise programs and gyms offer childcare. Ask at your Community Health Centre.

Regular checks for your baby

It's good if you can take your baby to the child and family health nurse at the Early Childhood Health Service in your area regularly. The nurse will:

- check your baby's growth, development and general health
- answer any questions you have about caring for your baby
- help you with any problems or concerns you have about yourself and your family
- refer you to other services that can help.

Your child and family health nurse can link you into new parent groups which are a great way to meet other new parents in your area and learn about parenting.

Don't share mouth bacteria

You may not think twice about putting something in your mouth that's meant for your baby – 'washing' your baby's dummy in your mouth, for instance, or sharing a spoon. But this can pass bacteria that cause tooth decay from your mouth to the baby. This can affect the baby's teeth in the future.

Putting your baby to bed with a bottle can also cause tooth decay. Start cleaning your baby's teeth as soon as they appear, with water only. Use a soft, small baby toothbrush.

Have your baby's teeth checked by a health professional at all child health visits.

In NSW all families with a newborn are offered a free Universal Health Home Visit by a child and family health nurse who will contact you to arrange the visit soon after you go home with your new baby. The hospital where your baby was born can put you in touch your local Early Childhood Health Service. You can also contact them through your local Community Health Centre. Find the contact details for your local centre in the *White Pages* or online at www.whitepages.com.au

At the Universal Health Home Visit the child and family health nurse will listen to and provide advice on any concerns you may have about your newborn such as breastfeeding your baby, crying and settling your baby, safe sleeping strategies to prevent SIDS, Early Childhood Health Services etc. The child and family health nurse will also ask you questions about things such as your health, depression, anxiety, domestic violence, support networks and recent major stressors.

All women in NSW will be asked these questions to make sure that you are offered the best possible services that will support you in caring for your baby.

Reducing the risk of sudden unexpected death in infancy

Sudden unexpected death in infancy is when an infant less than one year of age dies suddenly and unexpectedly. Sometimes a cause can be found but often these deaths are attributed to Sudden Infant Death Syndrome (SIDS). While the causes of SIDS are still unclear, over the past 20 years, the number of babies dying from SIDS has reduced by over 80%. This reduction is related to promoting safer sleeping practices to parents and in particular, placing infants on their backs when sleeping. Despite this, too many infant deaths still continue to occur. The risk of SIDS is highest in the first six months of life.

By following the safer sleeping practices outlined below, and breastfeeding if you are able, you can reduce the risk of sudden unexpected death in infancy.

Safe sleeping and your baby

It's important to know how to put your baby to sleep in a safe position to reduce the risk of SIDS:

- put your baby to sleep on their back from birth, not on their tummy or side
- keep your baby's head and face uncovered while sleeping
- keep your baby smoke free before and after birth
- provide a safe sleeping environment for your baby, night and day:
 - safe bedding (no loose bedding, pillow, doonas, lambs-wool, bumpers or soft toys)
 - safe cot (should meet current Australian Standard AS2172)
 - safe, clean mattress (should be firm, flat and the right size for the cot)

Sleep your baby on their back, from birth

The risk of SIDS can be reduced by sleeping a baby on their back. Babies are more likely to die from SIDS if they sleep on their tummies or sides. Unless written advice is provided by a paediatrician, do not put your baby to sleep on their tummies or sides.

Healthy babies placed to sleep on their back are less likely to choke on vomit than tummy-sleeping infants.

The side position is not recommended for babies as they can roll onto their tummies during sleep.

When your baby is awake, it's important to vary the baby's position from lying on the back. Tummy play is safe and good for babies when they are awake and an adult is present. When carrying your baby alternate the arm you carry them with so your baby can practise looking both left and right.

Babies over the age of 4 months can usually turn over in their cot. Babies may be placed in a safe baby sleeping bag (i.e. fitted neck and arm holes, and no hood). Put them on their back but let them find their own sleeping position. The risk of sudden infant death in babies over six months is extremely low.

Health alert!

The safest place for your baby to sleep in the first six to twelve months is in their own safe cot next to your bed.

Make sure baby's head stays uncovered during sleep

Loose bedding can cover your baby's head. Make up the bed so that the baby's feet are at the foot of the bed. Tuck your baby in securely so that he or she can't slip under the bedclothes. Quilts, doonas, duvets, pillows, soft toys and cot bumpers should not be put where your baby sleeps during the first year.

Taking your baby into bed with you may be unsafe if he or she:

- gets caught under adult bedding or pillows
- is trapped between the wall and the bed
- falls out of bed
- is rolled on by someone who sleeps very deeply or who is affected by drugs or alcohol
- is sleeping with a person who smokes
- is sleeping with a person who is extremely tired.

Soft sleeping places where a baby's face may get covered:

- there is a high risk of a sleeping accident if you fall asleep with the baby on a couch or sofa
- don't put the baby on a waterbed or beanbag.

Keep your baby smoke-free, before birth and after

Cigarette smoke harms babies. Parents who smoke during the pregnancy and after the baby is born increase the risk of sudden infant death for their baby.

If the mother smokes, the risk of sudden infant death is 4 times greater compared to the risk for non smoking mothers.

If the dad smokes too, the risk of SIDS almost doubles.

Make sure friends and relatives don't smoke near your baby.

If your baby is in the car, keep the car smoke-free.

You can get more information about SIDS and reducing the risks to your baby from the SIDS and Kids website at www.sidsandkids.org

Six ways to sleep baby safely and reduce the risk of sudden unexpected death in infancy:



- ✓ Sleep baby on back
- ✓ Keep head and face uncovered
- ✓ Keep baby smoke free before and after birth
- ✓ Safe sleeping environment night and day
- ✓ Sleep baby in safe cot in parents' room
- ✓ Breastfeed baby if you can

Health alert!

Sleeping with your baby in the same bed or other sleeping surface increases the risk of Sudden Infant Death Syndrome (SIDS) or a fatal sleep accident.

Special thanks to SIDS and Kids ACT and ACT Health and the Department of Disability, Housing and Community services for original development.

Prenatal testing and genetic counselling

Prenatal testing and genetic counselling

Every couple wants to have a healthy baby. However, there are some couples whose baby may have (or will develop) a serious physical and/or intellectual condition. There are a number of different tests available to assess the health and development of a baby before birth. Each has advantages, disadvantages and limitations. The decision to undertake testing during a pregnancy is a very personal one. It's also a decision best made on all the available information.

What are prenatal tests?

Prenatal tests are tests done while you are pregnant to assess the health and development of your baby. There are two main types of prenatal tests:

Screening tests

A screening test can indicate that there's a need for further testing (called diagnostic testing), but it can't tell if your baby definitely has a particular condition. You can choose whether or not you have a prenatal screening test.

Screening tests may be performed from 11 weeks of pregnancy and may include:

- ultrasound examination of developing baby and blood tests for you
- a nuchal (pronounced new-cal) translucency ultrasound which is sometimes combined with a blood test for the mother. This screening test is performed in the first trimester
- a maternal serum test which tests the mother's blood in the second trimester

Prenatal diagnostic tests

Diagnostic tests look for more specific conditions that your baby might be at risk. They are generally only performed if a screening test identifies an increased risk of a baby having a particular condition (although women over 35 can choose to have a diagnostic test). These types of tests can assess your baby for a chromosome condition or a condition caused by a variation in a single gene (these are called genetic conditions). A diagnostic test does not check every possible physical or intellectual problem that could affect your baby.

Diagnostic tests include chorionic villus sampling (CVS) and amniocentesis (pronounced am-nee-o-cen-tee-sis)

Each prenatal test is done at a certain time during the pregnancy. The tests and their timings are shown in the table *Prenatal Screening and Diagnostic Testing* on pages 118-119.

What information does a prenatal test provide?

A prenatal test may be done to check if your baby is developing in the usual way. It can also be performed to see if your baby is at risk of (or is affected by) a specific physical and/or intellectual condition.

Some of the conditions that prenatal tests are able to detect include **genetic conditions**.

Genetic conditions include many of the physical and/or intellectual conditions that are found at birth, in childhood, adolescence or adulthood. A genetic condition can occur for a number of reasons. Prenatal tests identify the sorts of conditions that are caused by a chromosome imbalance (chromosome condition) or by a change in a single gene.

A **chromosome condition** occurs when a baby has a change in the number, size or structure of their chromosomes. This change in the amount of genetic information or the way it's arranged in the cells may result in problems in growth, development and/or functioning of the body systems.

Chromosome changes can be inherited from a parent. More commonly, chromosome changes occur when the egg or sperm cells are forming, during conception or just after. The reason for such changes is unknown. The most commonly known chromosome condition is Down Syndrome.

Other genetic conditions, which are caused by a variation that makes a single gene faulty, are known to affect babies in some families. A couple may already have a child with one of these conditions, or one of the parents may have the condition themselves. In these situations, a prenatal test can be used to specifically identify if the baby has the faulty gene that causes the genetic condition.

Prenatal Testing: Special tests for your baby during pregnancy is a detailed booklet produced by the Centre for Genetics Education. To obtain a copy, contact
Tel: (02) 9462 9599 or visit <http://www.genetics.edu.au/> Information about these tests is also available in other languages from <http://www.genetics.edu.au/Information/multilingual-resources>



Counselling before a test is done will help you decide which test, if any, is best for you and your baby.

A booklet called *Your choice: screening and diagnostic tests in pregnancy* is available online. It talks about the different tests that are available, explains the conditions that can be detected and gives you some things to think about to help you decide about testing during your pregnancy. You can find it at <http://www.mcri.edu.au/Downloads/PrenatalTestingDecisionAid.pdf>

Why would I consider having a prenatal test?

Before you make any decision about having a prenatal test, you should get as much information as possible so that you feel confident you're making the right choice for you. You need to be able to discuss your concerns and thoughts about prenatal testing with professionals in a safe and understanding environment. Getting help and advice at this time can help you make informed decisions about the future of your pregnancy.

It is important to discuss:

- how and when the tests are done
- the advantages and disadvantages of each test
- any risks to you or your baby that may result from each test
- any further testing that might be offered and what it involves.

What if a test shows my baby may have a problem?

If the result of a prenatal test shows that your baby is not developing normally or could develop a problem after birth, you and your partner will be given as much information as possible about the condition. Genetic counselling will give you the opportunity to discuss:

- what the results mean for your baby and your family
- the options for further testing and what it involves
- your feelings about people with physical and/or intellectual disabilities
- your feelings about termination of pregnancy.

If you want to know more about prenatal testing and genetic counselling, contact the Centre for Genetics Education on (02) 9462 9599 or visit www.genetics.edu.au

What is genetic counselling?

Genetic counselling is available at most large hospitals and many local Community Health Centres. It is provided by a team of health professionals who work together to give you current information and counselling regarding genetic problems in the growth, development and health of your baby. It can help you to understand and make informed choices about special prenatal testing during pregnancy or adjust to the diagnosis of a genetic condition in your baby.

Who should consider having genetic counselling early in pregnancy?

When you are pregnant it is important to discuss with your partner any health concerns you have and whether you or other members of your family have medical problems which may run in the family.

There are a number of situations in which genetic counselling may be helpful. These include:

- you or your partner have a close relative or a child with a physical and/or intellectual condition
- you or your partner has a serious condition that may be passed on to a baby
- you and your partner are carriers of the same faulty gene
- you are in your older than 35 (not necessarily your first pregnancy) as there is an increased risk for having a baby with chromosome condition
- you have been exposed to a chemical or other environmental agent during this pregnancy
- the results of a screening test such as ultrasound or first and second trimester screening have suggested that your baby is at increased risk for a particular genetic condition
- you and your partner are related e.g. first cousins
- you and your partner are both from an ethnic or cultural background which is known to carry certain genes for a common condition in that population.

Knowing about your family health history is important

Health-related information about you and your partner's parents, brothers and sisters is valuable information that can identify some health conditions you might be at an increased risk of developing or passing on to your children. In some cases, you might be able to take preventative measures to reduce your risk and that of future generations.

There are many health conditions that can be passed on by family members. However, it is important to remember that lifestyle factors (e.g. smoking or an unhealthy diet) can also play a part in the chances of developing a condition.

When discussing your family health history with your relatives, you should think about some well-known conditions such as:

- hearing problems
- learning or developmental problems
- cystic fibrosis – a genetic condition which affects lung and digestive function
- thalassaemia – a genetic condition that affects normal blood processes
- sickle cell disease – a genetic condition that leads to serious blood anaemia
- haemophilia – a genetic condition affecting boys that leads to excessive bleeding
- heart disease
- diabetes
- cholesterol problems
- breast, ovarian or bowel cancer.

It is also important to think about the geographic background of your family and that of your partner. For example, people from Northern Europe and the United Kingdom are more likely to carry a faulty gene that causes cystic fibrosis than thalassaemia which affects more people who come from the Middle East and the Pacific.

More information about collecting your family health history and some of the conditions mentioned above is available by contacting the Centre for Genetics Education on (02) 9462 9599 or visiting www.genetics.edu.au

Prenatal Screening and Diagnostic Testing

Stage of pregnancy	Name of test	Type of test	How is the test done?
8-12 weeks	First trimester ultrasound – dating scan.	Screening and diagnostic.	A small probe is pressed on to the mother's abdomen or inserted into the vagina. This shows a picture of the developing baby.
11-13 weeks	Chorionic villus sampling (CVS).	Diagnostic.	With the help of ultrasound, a small sample of the placenta is taken through the mother's abdomen, using a thin needle or through the cervix using a thin flexible tube.
11.5-13.5 weeks	Nuchal translucency (ultrasound) test with or without testing of the mother's blood.	Screening.	Using an ultrasound, a special measurement (nuchal translucency) is taken of the baby. Also, a sample of the mother's blood may be taken for testing.
15-18 weeks	Second trimester screening test – maternal serum testing.	Screening.	A sample of the mother's blood is taken for testing.
15-19 weeks	Amniocentesis.	Diagnostic.	With the help of ultrasound, a small sample of the amniotic fluid is taken through the mother's abdomen, using a thin needle.
18-20 weeks	Second trimester ultrasound – fetal anomaly scan .	Screening and diagnostic.	An instrument like a microphone is pressed on to the mother's abdomen. This shows a picture of the developing baby.

	<i>What does this test look for?</i>	<i>Are there any risks to the baby or mother?</i>
	<p>This test can check the size of the baby, check if there is more than one baby and see some physical features such as the heartbeat.</p>	<p>This test does not harm the baby or the mother.</p>
	<p>This test can check for a range of physical and/or intellectual conditions that the baby may have. These are known as chromosomal problems. Sometimes more testing may be needed.</p>	<p>There is a small chance (less than 1 in a 100) that this test may cause a miscarriage. The mother may feel some discomfort during the test.</p>
	<p>This test can tell if a baby has an increased risk of certain physical and/or intellectual conditions.</p> <p>About 5 out of a 100 babies tested may have an increased risk result. Most of these babies will NOT have a problem.</p> <p>If the nuchal translucency test is done without the blood test:</p> <ul style="list-style-type: none"> • About 75 out of a 100 babies who have a chromosome condition called Down Syndrome will return an increased risk result. 25 out of a 100 babies with Down Syndrome will be missed by this test. <p>If the nuchal translucency ultrasound is done together with the blood test:</p> <ul style="list-style-type: none"> • About 80-90 out of a 100 babies who have Down Syndrome will return an increased risk result. 10-20 out of a 100 babies with Down Syndrome will be missed by this test. 	<p>This test does not harm the baby or the mother.</p>
	<p>This test can tell if a baby has an increased risk of certain physical and/or intellectual conditions.</p> <p>About 5 out of a 100 babies tested may have an increased risk result. Most of these babies will NOT have a problem.</p> <p>About 60 out of a 100 babies who have Down Syndrome will return an increased risk result.</p> <p>40 out of a 100 babies with Down Syndrome will be missed using this test.</p> <p>If this test is done at the same time as a detailed ultrasound scan, it will also identify about 95 out of a 100 babies who have spinal problems or neural tube defects.</p>	<p>This test does not harm the baby or the mother.</p>
	<p>This test can check for a range of physical and/or intellectual conditions that the baby may have, including chromosome conditions.</p>	<p>There is a small chance (less than 1 out of a 100 babies) that this test may cause a miscarriage. The mother may feel some discomfort during the test.</p>
	<p>This test can check the size of the baby and many physical features such as the heart, brain, spine and kidney development.</p>	<p>This test does not harm the baby or the mother.</p>

*Having a baby at
35+*

Having a baby at 35+

More women now have their first baby over the age of 30. It's true that the risks increase with age, especially after 35, and you need to know about them. But the important thing to remember is that most women over 35 have healthy babies.

Many of the risks and complications have less to do with your age and more to do with having problems like high blood pressure or diabetes (health problems that are more common as we get older). Being in good health, having good antenatal care, healthy eating and regular exercise will reduce your risk of complications.

What are the extra risks?

- **Miscarriage** The risk of a miscarriage is generally about one in five. This rises to about one in four (25 per cent) by the age of 40. But that still means that most pregnancies will continue.
- **Having a baby with a chromosome condition** such as Down Syndrome. The risk increases with age. The extra risk of chromosomal conditions is the main reason for increased miscarriages in older women. At age 37, the risk of having a child with a chromosome condition is about 1 in 200. By age 40, it's more than twice as high – about 1 in 84. At 45, it's about 1 in 32.

For women over 35, there's also a higher risk of:

- premature birth
- low birth weight (not smoking will reduce the risk of this)
- placenta praevia
- high blood pressure
- bleeding in pregnancy
- pre-eclampsia
- gestational diabetes
- stillbirth.

For more about these risks see *Complications in pregnancy* on page 124.

Again, this is nothing to get too gloomy about – most women over 35 won't have these problems (especially if they're in good health to begin with). And these are all risks that can be minimised by good antenatal care and healthy habits.

*Multiple pregnancy:
when it's twins or
more*

*Multiple pregnancy: when it's twins
or more*

Twins happen about once in every hundred births. You're more likely to have them if:

- you or your partner have identical twins in your family
- you're over 35 years of age
- you're having fertility treatment.

Identical twins happen when one fertilised egg splits into two separate cells. Each cell then develops into a baby. Because they have come from the same egg, the babies have the same genes. They are the same sex and they look very much alike. Identical twins are likely to share one placenta but have separate cords.

Non-identical (fraternal) twins happen when two separate eggs are fertilised by two sperm. They look like each other in the same way that brothers and sisters do. Each twin has its own placenta. Non-identical twins can be different sexes.

Triplets are rare and quads (four babies) rarer still, although the use of fertility drugs means multiple births are more common than they once were.

What are the signs that I may be carrying more than one baby?

Fast weight gain or a uterus that is larger than usual for your particular stage of pregnancy might indicate a multiple pregnancy. An extra baby can also mean that the normal discomforts of pregnancy, like nausea or more frequent trips to the toilet, are more severe. An ultrasound around 10 or 18 weeks can confirm a multiple pregnancy.

There is a small risk of miscarriage of one twin early in pregnancy.

What's different about a multiple pregnancy?

The prospect of twins can be exciting, but a multiple pregnancy also carries an increased risk of complications. These include:

- anaemia
- premature birth
- one or both babies not growing well.

This means that regular antenatal visits are really important – good care will help reduce the risk of problems. It is particularly important to identify twins that share a single placenta. This type of multiple pregnancy carries the highest risk to the babies and needs careful monitoring.

It's best to be in a hospital that has the facilities you need as more than half of women with multiple pregnancies go into labour early. Speak to your midwife or doctor to make sure that your hospital has the services needed for multiple births.

Most women with multiple pregnancies can give birth normally, but you may need a caesarean section operation or labour induction if there are complications. It's recommended that the babies be carefully monitored in pregnancy and labour. This may include using electronic fetal monitoring.

You may also be in hospital a little longer after giving birth – the babies may be premature, or you may need more time to get used to feeding and caring for more than one baby.

Knowing that you're having more than one baby may also make you more anxious. You may worry about complications, and how you'll cope with two or more babies. The extra fatigue and discomfort of carrying more than one baby can make things harder if you're feeling anxious or down.

Don't keep these feelings to yourself. Talk to your doctor, midwife, hospital social worker or a counsellor.

For more information visit Australian Multiple Birth Association www.amba.org.au

Complications in pregnancy

Complications in pregnancy

Most pregnancies go smoothly. But get to know the warning signs of complications so you can act quickly – just in case. Contact your doctor, midwife or hospital immediately if you have any of the following symptoms:

- significant vaginal bleeding (more than spotting)
- very severe nausea or vomiting several times during a short period
- severe abdominal pain
- constant clear 'watery' vaginal discharge
- a severe headache that won't go away (especially in the second half of pregnancy)
- sudden swelling of the ankles, fingers and face
- sudden blurring of vision
- a temperature of more than 37.8°C
- the baby stops moving or has a marked decrease in movement for any 24-hour period from the 30th week of pregnancy onwards
- regular painful contractions any time before the 37th week.

Bleeding and miscarriage

Bleeding in early pregnancy (before 20 weeks) is called a threatened miscarriage. Usually, the bleeding stops and the pregnancy continues. But if there's bleeding and pain or discomfort in the lower back or abdomen (perhaps like period pains), it's more likely to be a miscarriage.

Miscarriages are common. One in five pregnancies that have been confirmed end in miscarriage, usually in the first 14 weeks. After a miscarriage, some women may need a procedure called a dilation and curettage (D&C). It's usually done under a general anaesthetic, and involves gently removing all the remaining pregnancy tissue from inside the uterus. This prevents any heavy bleeding and infection. But if an ultrasound scan shows the uterus is empty, a D&C isn't necessary.

Most parents grieve the loss of the pregnancy. One of the hardest things is that other people don't always understand how much grief you can feel when you lose a baby through miscarriage. Although you might get a lot of support from family and friends if a baby is stillborn, or dies soon after birth, many people don't realise you can experience terrible grief for the loss of a baby through miscarriage.

For more information about coping with the grief of a miscarriage, see *When a baby dies* on page 148.

NSW hospitals have two services available for women experiencing bleeding or lower abdominal pain in early pregnancy.

Early Pregnancy Units (EPU) have been established in selected high volume Emergency Departments where trained and skilled nurses provide rapid assessment and advice to mothers who may have miscarried or are at risk of miscarriage.

Another service is the Early Pregnancy Assessment Service (EPAS) which provides an alternative to Emergency Departments for women experiencing mild lower abdominal pain and or slight bleeding in the first 20 weeks of pregnancy. Early Pregnancy Assessment Services are established in most major metropolitan and major rural hospitals throughout NSW.

Ectopic pregnancy

An ectopic pregnancy is when the embryo implants inside a fallopian tube or other areas outside the uterus. Symptoms you may experience with an ectopic pregnancy include severe pain in your lower abdomen, vaginal bleeding, feeling faint, vomiting or pain in the tip of one shoulder. If you experience these symptoms, it's important to seek urgent medical attention.

Miscarriages are a common outcome of ectopic pregnancies and are generally not preventable.

Bleeding after week 20

Bleeding after week 20 is called an antepartum haemorrhage. It's uncommon, but needs immediate treatment. Always contact your doctor, midwife or hospital at the first sign of bleeding at any stage in pregnancy.

The cause may be a problem with the placenta called 'placenta praevia'. This means that instead of being attached to the top part of the uterus, some or all of the placenta is attached to the lower part of the uterus. When the uterus stretches in late pregnancy, it can dislodge part of the placenta, causing bleeding.

Sometimes, the placenta can separate slightly from the uterus, even though it's in the correct place. This can cause slight or heavy bleeding and, occasionally, abdominal pain. If a lot of the placenta comes away, there's a major risk to you and the baby. Prompt treatment usually saves the baby, although she or he may be born by caesarean section operation and/or be pre-term.

Sometimes a cause for the bleeding cannot be found.

Diabetes

When someone has diabetes, their body can't control the levels of glucose (sugar) in their blood. Uncontrolled blood sugar levels can cause serious health problems. There are two kinds of diabetes:

In people with type 1 (or insulin-dependent) diabetes, the body doesn't produce enough insulin to control blood sugar. They need to inject insulin to keep blood sugar levels under control.

In people with type 2 diabetes, the problem is a little different. They have enough insulin, but the body doesn't use it properly so blood sugar levels can become too high. Type 2 diabetes is usually controlled by diet and exercise, and sometimes medication.

It is important to see your doctor or diabetes specialist early in pregnancy or even before you get pregnant, so that you get good care and control of sugar levels. With good care and treatment for their condition, most women with diabetes will have successful pregnancies. They will need to take extra care with diet, and self-test their blood glucose levels more often. Pregnant women with diabetes will need to see their doctor/specialist frequently for care and for adjustments to their medication.

Gestational diabetes

Gestational diabetes can occur in the second half of a pregnancy. Women with gestational diabetes have abnormally raised blood sugar levels. All women diagnosed with gestational diabetes need to follow a strict diet and exercise program. In some cases, women may require medication including insulin injection.

About 30 out of a 100 women with gestational diabetes will have larger than average babies. They are more likely to have some form of intervention in labour such as a caesarean section operation.

Studies have suggested that women who develop gestational diabetes have an increased risk of developing type 2 diabetes later in life.

It's common for pregnant women to be offered a glucose test at least once during pregnancy.

For more information on diabetes, contact Australian Diabetes Council on 1300 342 238 or visit www.australiandiabetescouncil.com

High blood pressure

The reason why doctors and midwives carefully check blood pressure in pregnancy is because untreated high blood pressure (called hypertension) can:

- reduce the blood supply to the baby causing growth problems
- have serious effects on the mother's kidneys, liver and brain.

With regular checking, high blood pressure can be found early and treated – another good reason for seeing a doctor or midwife as soon as you think you're pregnant, and for having regular antenatal care.

Raised blood pressure in later pregnancy can be an early sign of a condition called pre-eclampsia. Other signs of pre-eclampsia are protein in the urine and problems with the liver or clotting levels in the blood. Pre-eclampsia needs prompt treatment because it can develop into a more serious (but rare) condition called eclampsia which causes fits.

A very small number of women with high blood pressure who don't respond to anti-hypertensive medication may need to spend time in hospital during the pregnancy so that their blood pressure can be monitored and stabilised. This stay may be days, weeks or months, depending on how severe the problem is. Some large hospitals now have special day assessment units where you can stay during the day and go home at night.

Asthma

You will still need to take your asthma medication when pregnant. See your doctor regularly during pregnancy, as well-managed asthma is less likely to cause problems during the pregnancy. Uncontrolled asthma has been linked with premature births and low birth weight babies. Asthma may improve or worsen during the pregnancy. You can improve your asthma if you don't smoke. It is also important that women with asthma have the influenza vaccine. If you experience breathing difficulties, it is important that you consult your doctor.

Epilepsy

If you have epilepsy it is important that you check with your doctor before getting pregnant as the medication and dose that you take to control epilepsy may change. Do not change the dose without discussing options with your doctor.

Depression

If you are planning a pregnancy and are on medications for depression, check with your doctor to make sure the medication is safe for pregnancy. Being pregnant may make your depression worse so it is important that you tell your midwife, doctor, or counsellor how you are feeling so they can provide or organise extra support for you. If you don't normally feel depressed and depression and/or anxiety develops during the pregnancy, please let your midwife or doctor know so they can provide or organise appropriate support for you.

Complications in labour and birthing

*Complications in labour and
birthing*

Even if you're healthy and well-prepared for labour and giving birth, there's always a chance of unexpected difficulties.

Slow progress of labour

Your midwife or doctor can assess how labour is progressing by feeling your baby in your abdomen, checking how much the cervix has opened and how far the baby has dropped. If your cervix is opening slowly, or the contractions have slowed down or stopped your midwife or doctor may say that your labour isn't progressing as well as it should be.

It's good if you can relax and stay calm – anxiety can slow things down even more. Ask what you and your partner or support person can do to get things going. The midwife or doctor may suggest:

- changing position
- walking around – movement can encourage contractions and help the baby move further down
- a warm shower or bath
- a back rub
- a nap to regain your energy
- something to eat or drink.

If progress continues to be slow your midwife or doctor may suggest breaking your waters or inserting an IV drip with synthetic oxytocin to make your contractions more effective. If you're tired or have unmanageable pain, you may want to ask about options for pain relief.

“You’ve got to have a plan. But you can’t expect to be too much in control of what happens. The main thing is to be as informed as possible.” Katrina

When the baby is in an unusual position

Most babies are born head first, but some are in positions that may complicate labour and the birth.

Posterior position

This means the baby's head enters the pelvis facing your stomach instead of your back. It can lead to a longer labour with more backache. Most babies will turn around during labour, but some don't. If a baby doesn't turn, you may be able to push it out yourself or the doctor may need to turn the baby's head and/or help it out with either forceps or a vacuum pump. You can help by getting down on your hands and knees and rotating or rocking your pelvis - this may also help ease the backache.

Concern about the baby's condition

Sometimes there may be a concern that the baby is distressed during labour. Signs include:

- a faster, slower or unusual pattern to the baby's heartbeat
- a bowel movement by the baby (seen as a greenish-black fluid called meconium in the fluid around the baby).

If your baby seems to be not coping well, the first step will be to closely monitor their heart beat. Your baby may need to be born quickly, with a vacuum or forceps delivery or perhaps by caesarean section operation.

Postpartum haemorrhage (heavier than normal bleeding)

It's normal to bleed a little after the birth. Usually, the muscles of your uterus will continue to contract to reduce and prevent bleeding. However, some women experience heavier than normal bleeding, which is called a postpartum haemorrhage.

A postpartum haemorrhage occurs when a mother loses 500ml or more of blood. The most common cause of a postpartum haemorrhage is that the muscles of the uterus relax instead of contracting. An injection (synthetic oxytocin) given after the baby's birth helps the uterus push the placenta out and reduces the risk of heavy bleeding. Your midwife will check your uterus regularly after the birth to make sure that it is firm and contracting.

Postpartum haemorrhage can cause a number of complications and may mean a longer stay in hospital. Some complications are severe but they rarely result in death.

Retained placenta

Occasionally the placenta doesn't come away after the baby is born, so the doctor needs to remove it promptly. This is usually done in the operating theatre. You'll be given an epidural or a general anaesthetic.

*Early arrival: when
a baby comes too
soon*

*Early arrival: when a baby comes
too soon*

While most pregnancies last between 37 and 42 weeks, it's not unusual for babies to arrive earlier. If a baby is born before the end of the 37th week, it's considered premature or pre-term. About eight in every hundred babies born in Australia are premature.

Babies arrive prematurely because:

- there are problems with the placenta or cervix
- it's a multiple pregnancy
- the waters have broken
- the mother has high blood pressure or diabetes
- the mother has an infection, particularly in the urinary tract.

There's also a higher risk of premature labour in women who haven't had regular antenatal care, but often the cause is unknown. If you have any symptoms of labour before 37 weeks, contact your midwife, doctor or hospital immediately.

It's safer for premature babies to be born in large, well-equipped hospitals with staff specially trained to care for small babies (especially those born before 33 weeks). If you live in a country area, it is important to go to the hospital as soon as possible so that you can be transferred to a hospital better equipped to handle a premature baby.

The chances of survival depend on how early the baby arrives and how quickly expert care is available. Before 26 weeks of pregnancy about 60 out of 100 babies will survive birth. By 28 to 30 weeks of pregnancy 98 out of 100 babies will survive birth.

The risk of a disability depends on how premature the baby is. About 40 per cent of babies born at 24 weeks have a risk of a moderate or severe disability such as cerebral palsy, blindness, deafness or an intellectual disability. Babies born close to the end of pregnancy usually have no long-term problems.

Because their organs aren't fully developed, premature babies may experience:

- **Lung problems** Premature babies often need help to breathe because their lungs aren't fully developed. Steroid injections are often given to women before a pre-term birth to reduce the risk of lung and other problems in pre-term babies.
- **Apnoea** This means the baby stops breathing. It happens because the part of the brain that controls breathing isn't fully developed. Premature babies are monitored closely so they can be helped to restart breathing if it stops.
- **Difficulty feeding** If babies can't suck, they may need feeding through a tube until they're ready to suck and swallow.
- **Trouble staying warm** Premature babies' natural thermostats haven't developed properly so they can't control their own body temperature. They may need to be cared for in a humidicrib or under special overhead heaters until they are mature enough to regulate their own temperature.
- **Jaundice** The baby's skin may be yellow because the liver is still not working properly. For more information, see *After your baby is born* on page 86.

Will my baby survive?

Normally, each extra week spent growing in the womb increases a baby's chance of survival dramatically. The earlier the baby is born, the greater the risk to survival. Babies born before 32 weeks of pregnancy are more likely to survive if they have specialised medical and nursing care in a neonatal intensive care unit.

If your baby is born early, it's really good for you and your partner to hold your baby in close, skin-to-skin contact for long periods regularly. It's called "kangaroo care". Your stable body temperature helps to regulate your baby's temperature more smoothly than an incubator and, because your baby doesn't have to use a lot of energy to stay warm, they grow and develop faster. Kangaroo care helps you build

your relationship with your baby, and helps you feel closer to them. It can also help you establish and maintain your milk supply. Pre-term babies grow better on breastmilk.

Before 24 weeks, the chance of survival is very small and intensive care is not routinely given to babies born this early. If it looks as though your baby might be born before 24 weeks, your doctor will discuss this with you. It's important to be involved in the decision about whether or not to try to save your baby. To help you decide what is best for you and your family, your doctor will give you as much information as possible.

At 24 weeks, the survival rates are still low, but they improve dramatically after that time. By 28 weeks, more than 90 out of a 100 babies born will survive with highly specialised care in a neonatal intensive care unit.

If you want to know more about premature birth and what it might mean for you and your baby, you can read *Outcomes for premature babies: An information booklet for parents*. It's available from your doctor, or visit www.psn.org.au

If your baby is premature or likely to be born prematurely, you may want to ask:

- where is the best place for my pre-term baby to be born
- what can be done before birth to improve my baby's chances
- what happens after my baby is born
- what if my baby is born in a hospital without a neonatal intensive care unit (NICU)
- can I breastfeed my baby
- how long will my baby be in hospital
- how will my pre-term baby develop in the long-term
- where can we find more information about pre-term birth?

“I was having twins and went into labour at 28 weeks. Looking back, I can remember lying in the ambulance going to the nearest hospital which had specialised care, and I was calm. I didn't panic. Somehow I think nature programs you to cope in these difficult situations. You just do what you have to do. Of course, after it was all over, I cried for a whole day. The twins were very sick at first, and they were monitored carefully for the first three years, but they're fine now.”Carol

*Babies with special
needs*

Babies with special needs

Some babies are born with a condition that will make their life different in some ways, at least for a time. They have been born prematurely, or they may have an illness or condition that affects the way their body or brain works. These babies need special care in hospital. Their care will be supervised by a paediatrician. If your hospital doesn't have the facilities to care for your baby, he or she may go to a different hospital. NSW Health has a Newborn and paediatric Emergency Transport Service (NETS), which will arrange this by road or by air. It's often possible for you or your partner to travel with your baby to the new hospital.

Some parents know in advance that their baby will have a problem, but whether the news comes before or after the birth, you may have feelings that are hard to cope with. Grief, anger and disbelief are natural at this time. Many parents, especially mothers, are worried that they are somehow to blame for the problem – but this is very unlikely.

Babies with health problems usually need to stay in hospital for special attention after their mother has gone home, but it's very important for you and your baby to get to know each other. You'll be encouraged to do this as soon as possible after the birth, even if the baby is in a humidicrib.

You may hesitate to touch and handle your baby at first. The hospital staff understand your feelings and will try to help you cope with them.

You need as much support and information as you can get. Talking to your midwife, doctor, hospital staff, social worker or counsellor may help. So will talking to parents of babies with the same condition. Ask your midwife, doctor, hospital or Community Health Centre to put you in touch with appropriate community organisations or support groups. These organisations can provide information and support for you and your family.

When your baby is well enough to go home make sure you contact the Early Childhood Health Service near you or ask your hospital about making this contact for you. Early Childhood Health Services can support you, your family and your baby. They can advise on infant care, health and development concerns you may have. They provide regular health checks so that any concerns are addressed early. It is also good to make an appointment with your GP to let them know about your baby's health and ongoing medical needs.

If your baby has a problem, you'll have a lot of questions. Don't hesitate to ask them. It's a good idea to write your questions down to make sure they all get answered.

*Your feelings in
pregnancy and early
parenthood: what all
parents need to know*

*Your feelings in pregnancy and early
parenthood: what all parents need to
know*

Flip through a magazine or flick on TV, and you'd be forgiven for thinking that:

- all pregnant women glow with happiness
- no mother of a newborn baby ever felt worn out or overwhelmed
- every newborn baby has two devoted parents who share the workload and never fight about anything
- parenting comes naturally.

When you're pregnant or coping with early parenthood, life can seem very different to the rosy images in magazines and on TV. That doesn't mean there's something wrong with you – just that popular images of pregnancy and babyhood don't prepare you for the real thing.

The reality is that pregnancy and early parenthood can have a lot of ups and downs.

Any big event in your life (even good ones) can cause a lot of stress. That goes for weddings, new jobs, moving house, winning Lotto or having babies. Stress can make you feel down. Feeling tired – normal in pregnancy for women, and for both parents in early parenthood – adds to the load. For some parents, the fatigue in the first weeks can be overwhelming.

On top of this, women are dealing with the changes in their bodies and changing hormone levels that come after childbirth. They're also learning to breastfeed and while it's best for mother and baby where possible, breastfeeding takes time to learn. As for babies, it's not easy for them to adjust to their new world either. And if your baby has trouble feeding and settling, this will affect you too.

Don't be surprised if you feel down sometimes both in pregnancy and after the birth. Things that can help include:

- talking to someone – your partner, a friend, your midwife
- making more time for yourself – do something you enjoy
- trying not to get overtired when you're pregnant
- going for walks
- arranging for someone you trust to care for the baby for a few hours to give you some uninterrupted sleep.

Bonding with your baby

Some women find it hard to identify with the stories they hear about mothers "falling in love" with their babies. They are happy their baby is here, but just don't feel the connection that other women, their family and friends and the media talk about.

For them, the pressure of not having strong feelings about the baby and not living up to other people's expectations can make the first weeks and months of motherhood even harder.

These feelings are normal, but if they become intense or overwhelming you may need some help to understand what you are feeling. You can be a good mother and not feel a perfect bond with your baby. If you are struggling with feeling as if you're not bonding with your baby, or don't love your baby like you should, talk about it with your midwife, doctor or child and family health nurse.

Depression in pregnancy

While almost everyone feels down sometimes in pregnancy, some women feel down a lot of the time. If you're depressed it can be hard for you to tell how serious your feelings are. It's best to get help early. Tell your midwife or doctor about your feelings – they can help work out if you're just feeling down, or if it's something more serious.

Always tell your midwife or doctor if you are:

- feeling low a lot of the time

- feeling guilty
- not enjoying things you normally enjoy

- crying a lot
- blaming yourself for things that go wrong in your life
- irritable most of the time
- having difficulty concentrating and making decisions
- feeling hopeless or helpless
- cutting yourself off from other people
- wanting to harm yourself.

If you have many of these feelings, get help. Depression can be treated very successfully. It's better to do something now than risk postnatal depression later – if you experience depression in pregnancy you are at greater risk of postnatal depression. Some women may need antidepressant medication (many antidepressants can be safely prescribed in pregnancy).

Do you have an existing mental health problem?

Many symptoms of mental health problems make parenting difficult. If you suffer from a mental illness such as bipolar mood disorder or depression, you may feel irritable, extremely sad or tearful or lacking in how you look after your baby and children. However, parents with a mental illness can be great parents.

While many mothers with past and ongoing mental health problems cope well with parenting, pregnancy and having a new baby can significantly increase the

level of stress in your life. And high stress levels can play a big part in making mental health problems or illness worse.

If you have a mental health problem, it's very important that you let somebody know about any concerns you have. You can speak with your midwife, child and family health nurse, doctor and/or a mental health worker. Treatment and ongoing support can help to reduce and even eliminate symptoms.

It is very important that you get the appropriate support during pregnancy and ensure that it continues after the birth of your baby. Having the support and assistance you need will also help you create a positive and healthy attachment between you and your baby, which in turn is likely to boost your confidence and reduce the likelihood of you becoming unwell. Receiving the right support at the right time will help keep you and your baby safe and well.

Feeling down or worried after the baby is born

There's nothing unusual about feeling down, overwhelmed or having new and scary thoughts when you're at home with a new baby. You're probably worn out, your body is recovering from childbirth, and you're learning a new and challenging job. But if you're still feeling depressed, worried, having concerning thoughts about yourself or your baby or you are feeling inadequate more than two weeks after the baby is born, talk to your GP or your child and family health nurse as soon as possible. You

may have postnatal depression or a related mental health problem. Remember, if you've experienced a mental health problem in the past, it's common to experience a relapse or a different kind of problem in pregnancy or early parenthood so it is important to talk with someone who can help as soon as possible.

According to beyondblue, postnatal depression affects almost 16 out of a 100 women who become mothers every year. It's helpful for you and your partner to understand the signs and symptoms of postnatal depression so some important information from beyondblue has been included here. You can also find out more about postnatal depression by visiting <http://www.beyondblue.org.au/the-facts/pregnancy-and-early-parenthood>

“During pregnancy, I felt a lot of anxiety. What was happening didn't seem real and I was afraid of the unknown – I'd never had much to do with babies, so how was I going to look after this one?” Jay

What is postnatal depression?

Postnatal depression is the name given to a mood disorder that can affect women in the months following childbirth. It can develop any time in the first year after your baby is born and can begin suddenly or develop gradually and may persist for many months. If left untreated, it could develop into a chronic depression or recur after a subsequent pregnancy.

What causes postnatal depression?

It's not certain what the real cause is. It's thought to be a mixture of physical and psychological things, as well as difficulties you may be having in your life. You might be vulnerable to postnatal depression if:

- you've had depression before
- you have problems with your partner
- you don't have much support (practical help as well as emotional support)
- there have been a number of stressful life events all piling up
- others in your family have depression or other mental health problems
- you're a single parent
- you tend towards negative thinking – 'looking on the black side of things'
- you had complications with labour and birth
- there are problems with your baby's health (including a premature baby)
- you have a 'difficult' baby (a baby that's easily upset, or is difficult to settle, or has problems with feeding and sleeping).

In the first few months of caring for a baby, it's normal to feel stressed, have disturbed sleep and changes to your routine. This can make it hard for you to know what's just part of the normal strain of early parenting, and what are signs of depression. Let other people know how you are feeling and let them help. Talk to your doctor or child and family health nurse about how you feel. They can help monitor the situation.

“Many partners feel the burden of responsibility that comes with a new baby. My partner asked me for a list of things so he could do the shopping. He was really trying to help. But all I could do was lie down on the bed and cry because I was too tired to think what I needed. But it doesn't last. Once you start getting more sleep, everything seems a

lot easier.” Mina

Are postnatal depression and the baby blues the same thing?

No. Postnatal depression is different from the baby blues. The baby blues is a relatively mild period of sadness, which peaks three to five days after birth and affects up to 80 out of a 100 women. Women with the baby blues cry more easily, may be more irritable and more easily upset than usual. There is usually no specific treatment aside from empathy and emotional support from family, friends and hospital

staff.

Am I a bad mother if I become depressed?

No! The challenges of motherhood are enormous and there is a lot to learn. Most women want to be good mothers and anything less than perfection can seem like a huge disappointment. Some women also have unrealistic expectations of pregnancy and motherhood and reality may be very different to what they were expecting. These expectations may lead women to blame themselves for their depression and be reluctant to seek help. Mothers may worry that they will be labelled as an inadequate or poor mother, rather than recognising that it takes time to adjust to motherhood.

If you feel very low and lose interest or pleasure in things you normally enjoy, and have any four of the following symptoms for two weeks or more, you may have postnatal depression:

- feeling down
- feeling inadequate
- feeling you're not a good mother
- feeling hopeless about the future
- feeling helpless
- feeling guilty or ashamed
- anxiety or feelings of panic
- fears for the baby
- fears being alone or of going out
- feeling worn out, tearful, sad and 'empty'
- waking up early and having trouble getting back to sleep or being unable to sleep
- eating too little or eating too much
- difficulty concentrating, making decisions or remembering things
- thinking about harming yourself or wanting to die
- constantly thinking about running away from everything
- worrying about your partner leaving

- generally worrying about something bad happening to your baby or partner.

Don't be ashamed of these feelings – many women feel like this. See your doctor or talk to your child and family health nurse as soon as possible.

Some situations can make you vulnerable to feeling down or overwhelmed during pregnancy or the first few weeks at home with your baby:

- you didn't plan to get pregnant
- you've previously experienced trauma or the loss of a child
- feeling very alone and without support
- financial problems
- relationship problems
- having had depression or other mental health problems in the past
- using alcohol or other drugs, or coping with an addiction
- having high expectations of yourself and feeling you're not meeting them – perhaps you feel you're not coping, not getting enough done through the day, or you feel others are judging you
- distancing yourself from other people.

Did you know partners can also be at risk of PND?

Your partner may be struggling to cope and this can affect their emotions too. With all the attention on the baby and mother, the stress on partners often goes unrecognised and they don't get the support they need.

All new parents – not just mothers – need to look after their physical and emotional wellbeing. So:

- Make sure you have some time to yourself, apart from work and family.
- Try to keep up important hobbies and interests as much as possible.
- Talk to close family and friends about your feelings and concerns.
- Talk to your child and family health nurse or GP if you are worried about how you are coping.



If you want to talk to someone about feeling down or depressed in pregnancy, or when you're at home with your baby, call:

- Tresillian Parent's Helpline on (02) 9787 0855 (Sydney metropolitan area) or 1800 637 357 (regional NSW) – 24 hours, 7 days a week.
- Karitane Careline on 1300 227 464 (1300 CARING) – 24 hours, 7 days a week.

How is postnatal depression treated?

Everyone has different needs. Treatment can include a number of approaches including counselling, medication, self-help and other support services.

Postpartum psychosis

Postpartum psychosis isn't common. But it's very serious and needs immediate treatment. It can start anytime but usually starts within four to six weeks after birth. Symptoms include:

- severe mood swings
- very unusual beliefs, thoughts and ideas (delusions)
- hallucinations – seeing, hearing or smelling things that aren't there
- behaviour that is very odd and out of character
- extreme despair
- withdrawing from people
- thinking or talking about morbid things or saying things like 'you'd be better off without me'.

Postpartum psychosis affects only one or two women in every thousand mothers. It's more likely to affect women who have been previously diagnosed with a mental illness, or who have family members with these illnesses.

Treatment usually includes admission to hospital, medication and help to look after the baby.

How experiences of neglect and abuse can affect pregnancy and early parenthood

Childhood abuse or neglect

Some women who've experienced these things feel fine in pregnancy and parenthood. But for others, being pregnant or becoming a parent themselves can bring problems to the surface. It can be a painful reminder of things that happened to them in the past, or can make people feel more anxious about what kind of parent they will be.

Some people worry that they will be parents who neglect or abuse their children too. Some things you can do:

- Remember that just because you were abused yourself doesn't mean you'll be a bad parent.
- Talk to someone about how you feel. Many pregnant women find that talking can really help and there are services to help. Your midwife can put you in touch with the hospital social worker, counsellor or other services.
- If you want to improve your parenting skills, there are people who can help. Your midwife can refer you to services. Or ask for support from a friend or relative whose parenting skills you respect (most people will be pleased – and flattered – to be asked).

Sexual abuse

About one in three to four women experience some form of sexual abuse in their lifetime. Many of them have no problems in pregnancy or parenthood. But sometimes this experience can bring extra problems with pregnancy, childbirth and early parenting. Feelings from the past may come back. You may feel you're not coping. If you feel anxious at this time, it's not surprising. It is a normal response to a reminder of a difficult time.

For some women, experiences of sexual abuse make it hard for them to let other people – even health professionals – touch their bodies. They may find it difficult to cope with some medical procedures, or even with the birth itself. If this is a problem for you, you can get help from a hospital social worker or counsellor. They can work with your midwife or doctor to make sure you feel as comfortable as possible.

You don't have to go into details about the sexual abuse either. A social worker or counsellor can help you plan for the birth, get ready for parenthood and help you with any worries about relationships with your partner or your own family without knowing the details.

Other things that may help include:

- taking a friend or other support person with you to examinations and other medical appointments
- talking to a friend
- asking to have medical tests and treatments explained to you first. If you think you may have difficulty with something, ask if there's another option
- remembering that flashbacks and feeling panicky or unsafe can be a common experience for women who have experienced sexual abuse. If this happens to you, it may help to talk to someone and remind yourself that you are safe now.

For support and information, contact a sexual assault service at your local hospital or Community Health Centre or NSW Rape Crisis Centre on 1800 424 017.

*Relationships in
pregnancy and early
parenthood*

*Relationships in pregnancy and
early parenthood*

Becoming a parent – get ready for some changes ...

Many people aren't prepared for the changes that being a parent brings to their relationship. The change from being a couple with time to spend on yourselves and each other to being parents with a small baby is a big one.

Attention pregnant partners!

Because the woman is carrying the baby, it's often easy for a pregnant woman to bond with the baby and to get used to the idea of being a parent. But for you, it may not be so easy. There are simple ways to get to know your baby before he or she arrives, and to get used to the idea that you're a parent now.

- Be there for ultrasound scans. It's a very powerful experience to see your baby for the first time.
- Talk to other friends who are parents. Talk to your own parents. Ask about their feelings and experiences.
- If you're apprehensive about being with your partner during labour and birth, talk to her about it. Ask other parents about their experiences in labour and talk to the midwife – this can give you an idea of what to expect.
- Go with your partner to childbirth education sessions (they're for both parents, not just mothers). Ask if you can go on a tour of the delivery/birthing unit at the hospital to see what it's like.
- Whenever you can, feel the baby kick.
- Get involved with caring for the baby as soon as possible after the birth. It does more than give your partner a break: it helps you feel more confident about parenting and closer to the baby too.

Parents at last

Some people think having a baby won't change their relationship much and that the baby will fit into their lifestyle. But your lifestyle will change. Thinking about this and getting used to the idea before the baby arrives will help prepare you emotionally for these changes. Some things to think about:

All babies are different. Yours will arrive with a unique personality and temperament. As with any other person in your life, there will be things about your baby that you can't change. You'll need to spend time getting to know, understanding – and learning to live with – this little person just the way they are.

It's not just first babies that change things. The arrival of other children also affects relationships between parents, and relationships between parents and their children.

Babies have a habit of changing other relationships too, especially with a couple's own parents. Some women find that motherhood deepens the bond they have with their own mother, for instance. Some partners may find this change a bit threatening ('she's at her mum's again ...'). But this doesn't mean that she's abandoning her partner. It's just natural for some women to feel closer to their mothers (or other mother figures) at this time.

“If you're a partner, talking about the baby helps you feel connected and involved. But the ultrasound really helped too – that's when the baby seemed to become real.”
Mark

The experience of changing from being partner to partner-and-parent can be different for each person. If you're the one doing most of the nurturing of your baby in the early days, your experience will be different to your partner's. Yet at the same time, many concerns and experiences will be similar. See the examples below. Don't be put off by the list of losses some parents feel – most people find the gains of parenting more than make up for them.

Women may feel

- I've lost the identity I had before.
- I've gained a new identity as a mother.
- I've gained a different relationship with my partner as we learn to be parents together.
- I've gained a new relationship with my child.
- I have less time for myself.
- I have less time to spend with my partner and less time for just being together and talking.
- What will happen to our sex life?
- I've lost my work identity.
- I've lost my body shape.
- I've lost control over my body.
- I've lost control over my routine.

Partners may feel

- I've lost the identity I had before.
- I've gained a new identity as a parent.
- I've gained a different relationship with my partner as we learn to be parents together.
- I've gained a new relationship with my child.
- I have less time for myself.
- I have less time to spend with my partner and less time for just being together and talking.
- What will happen to our sex life?
- I wonder how much my life will change?
- What will happen to my time with friends?
- Will I have time for activities I enjoy?

Emotional ups and downs – tips for coping

- Remind yourself that some emotional ups and downs and arguments are normal for both of you. They're normal at any time – but especially in pregnancy and early parenthood when you're both coping with big changes.
- Share your feelings with each other. This will help you understand and support each other. Although it's usually the pregnant woman who's the centre of attention and concern, you're not the only one who needs support. Your partner is often dealing with the same worries.
- Remember your partner isn't a mind reader. If one of you feels you're not getting the support and understanding you need, talk about it.
- Talk about possible changes to your life that being a parent will bring. These may include financial changes, sharing household tasks, sharing the care of your baby, changes to your social life, less time to go out as a couple or changes to your working life. Think about how you'll cope with these changes.
- Remember that parents still need 'couple time' after the baby is born. This is a part of the glue that strengthens a relationship when you become parents. Try to find friends and relatives who'll mind your baby while you have time together as a couple, or just some time for one or both of you to get a few hours' sleep.

“While I was euphoric about my new son, I wasn't prepared for the lack of closeness with my wife. It took many months to rebuild the loving, sexual relationship we'd previously enjoyed.”Lex

Domestic violence

Domestic violence has a big impact on the health of families, especially on

women and their children. Domestic violence is also a crime – a crime that affects all kinds of women from

all kinds of backgrounds.

Domestic violence isn't just being punched or hit. It can mean other things that are done to control and dominate another person, such as:

- making threats
- forcing you to do sexual things when you don't want to
- controlling your money
- stopping you from seeing family and friends.

Research tells us that:

- many women experience domestic violence for the first time in pregnancy
- for women already living with domestic violence, the violence gets worse in pregnancy.

Domestic violence can affect a baby before they're born. Sometimes it's because their mother is physically injured. But new research also shows that the stress of living with violence (whether physical violence or another kind of violence) has a significant effect on pregnant women. It can influence how their baby develops. Babies of women affected by domestic violence in pregnancy may have a lower birth weight, and may grow up with social and emotional problems (even if they don't experience violence after they are born).

This is why all women are likely to be asked about domestic violence by their midwife or child and family health nurse.

You may be asked more than once – it's part of routine health care in NSW. You don't have to answer questions about violence if you don't want to, but it's important to know that violence is a health issue. If you tell a health worker you are experiencing domestic violence and that you are afraid, they will offer to help you get in touch with services that can help.

If you're afraid or concerned for your safety or the safety of your children, you can:

- call the police or a local refuge
- tell someone you trust (a friend, your midwife, your doctor or health worker)
- go to a safe place
- use the law to protect you and your children – talk to the police or local court about how to get help
- make a safety plan in case you and your children have to leave quickly.

There is free counselling, information and medical help for anyone who has been assaulted or abused. These services are based in many hospitals.

You can also call the Domestic Violence Helpline on 1800 656 463 or TTY 1800 671 442 (toll free, 24 hours a day, 7 days a week). This service can give you details of the nearest refuge, court assistance schemes and other services.

If you are in danger, call the police on 000.

When a baby dies

When a baby dies

Sometimes, a pregnancy has a sad ending when a baby is lost through miscarriage, is stillborn or dies soon after birth.

Miscarriage

Miscarriages are common, with one in five confirmed pregnancies ending in miscarriage. Most happen in the first 14 weeks, but any loss before the 20th week is known as a miscarriage.

While many women do not have ongoing distress from an early miscarriage, others find it devastating. One of the worst problems can be that other people don't always understand how much grief you can feel when you lose a baby this way. Although you can expect sympathy if your baby is stillborn or dies after birth, many people don't realise you can still feel real grief for a baby that is not fully formed.

Feelings of guilt are part of grieving after a miscarriage and are not uncommon: you may think the miscarriage was caused by something you did (or didn't do). It helps to talk to someone who understands what you're going through. This could be another woman who has miscarried, a hospital social worker, counsellor, doctor or midwife.

Women start to produce breastmilk from around 16 weeks of pregnancy. With the loss of a baby from this point of the pregnancy on, your body will go through normal hormonal changes and breastmilk production will increase to some extent over the first few days. You may experience sensations of breast fullness, tenderness and possibly leaking of breastmilk. Try avoiding any stimulation to the breast and use gentle expression to relieve discomfort if required. Cold compresses may be soothing. Over-the-counter pain relief like paracetamol may be helpful. Your breasts will settle soon.

For more information about miscarriages, see *Complications in pregnancy* on page 124.

Stillbirth and the death of a newborn

When a baby dies in the uterus and is born after the 20th week of pregnancy, it's known as a stillbirth rather than a miscarriage.

Of all babies born in Australia, almost one in hundred is stillborn or dies soon after birth. It's more likely with a low birth weight baby or a baby with a developmental problem.

Whatever the reason for your baby's death, the grief you and your partner feel may be overwhelming. Most hospitals have specially trained staff to help bereaved parents. As well as counselling, you will have the chance to spend time with and hold your baby, if you wish. You may also be able to go home and then come back and spend more time with the baby. Some people find this helps them understand the reality of the baby's death and allows them to express their grief.

You may want to have keepsakes of your baby – photographs, a hair clipping or a handprint, for example. It may be possible to bath your baby and video your time together. Again, for some people, these things help them cope better with their grief.

Mourning the loss of a baby is a very individual thing. It varies from person to person and culture to culture. The important thing is that your needs and choices are treated with respect. If there are cultural or religious practices you need to follow, let the hospital staff know.

“Losing Rebecca was the most emotionally shattering experience of my life. Holding her and having a funeral allowed me to have a sense of closure.” David

SIDS and Kids NSW supports parents and families who have lost a child during pregnancy, birth, infancy and childhood up to 6 years of age. Whether you have experienced a miscarriage, ectopic pregnancy, termination, stillbirth, neonatal death or the death of a baby or child from any other cause you can contact the 24 hour Bereavement Line on 1800 651 186 for information, support and counselling.



Pregnancy and Infant Loss Remembrance Day

On the 15th October each year, parents and families across Australia honour their babies who passed away from miscarriage, stillbirth or postnatal causes. For more information visit <http://15october.com.au>

“My greatest sorrow was that I was never able to see Rebecca’s eyes open, and the casts we made of her hand and footprints are more precious than any money in the world. When I fell pregnant again, I kept changing doctors until I found one who truly understood my absolute terror that I might also lose this new baby.” Lindy

It’s normal for you and your partner to feel angry and even wonder if you or other people were to blame for your baby’s death. You may worry that other pregnancies will end the same way. It will help to talk about these things with a doctor, midwife, grief counsellor or social worker at the hospital.

After you leave hospital you may find that you have more questions in the weeks or months following the stillbirth or death of your newborn. The social worker at your hospital is available to talk through any issues or concerns, no matter how long it has been.

When a baby dies, the hospital will give you as much information as possible about what caused your baby’s death. To find out more about this, you will be asked to consent to a post-mortem, and possibly to tests on you and your baby. This can be very distressing. You don’t have to agree to a post-mortem or tests, but remember that finding out more about the cause of death may prevent similar problems in future pregnancies. Again, talking to a midwife, doctor, hospital social worker and your partner can help you make these decisions.

When you lose a baby through either miscarriage or stillbirth, you may find it helpful to spend time with other parents who have had a similar experience. To find a support group near you, contact SIDS and Kids NSW on 1800 651 186 (24 hour service) or visit www.sidsandkidsnsw.org

Genetic counselling after a baby dies

In the days, weeks and months following a miscarriage or the death of your baby, counsellors, doctors, midwives and social workers can provide you with a lot of support. This support can help you cope with and understand your feelings about what has happened.

However, as time moves on, you may want to consider genetic counselling particularly if you have experienced two or more miscarriages, a stillbirth or if your baby died soon after birth. For more information, talk with your doctor or midwife, or contact the Centre for Genetics Education on (02) 9462 9599.

*Learning more about
pregnancy, birth, babies
and parenthood*

*Learning more about pregnancy,
birth, babies and parenthood*

The following pages list some website and contact details for organisations that provide information, advice and support for parents.

There are lots of places to find out more about the things you've just read about but how do you know you can trust the information? Here's a checklist to help you decide how much you should trust the information you might read. Think about these questions when you read anything, even this book.

- 1. Is the purpose of the information clear?** Why are you being given this information? Is it to inform you about a subject or is it trying to persuade you to choose something or buy a product?
- 2. Where does the information come from?** Can you tell who wrote it? What qualifications or experience do they have? Has it been scientifically tested? Does it come from a range of experts or from just one person?
- 3. Is the information balanced and unbiased?** Does it give you all the options or does it push one point of view? Does it come from a range of sources?
- 4. Is it relevant?** Does the information apply to your circumstances?
- 5. Is it up-to-date?** Can you tell when it was first published? Has it been updated since? Does it agree with what other sources of information are saying?
- 6. Does it let you know if the experts don't have all the answers on an issue?** Does it admit that not all the answers are known or that there is a debate about the subject?
- 7. Does it encourage you to find out more elsewhere?** Does it refer you to other books, websites or organisations for more information about the subject?
- 8. Does it encourage you to make your own choices?** Is it pushing you to do something or does it help you to make your own decision about an issue, regardless of what that choice is?

Information about pregnancy, birth and babies

Australian Government

www.australia.gov.au

The Cochrane Collaboration Consumer Network

www.cochrane.org

healthdirect Australia

www.healthdirect.org.au

NSW Health

www.health.nsw.gov.au/pubs

(02) 9391 9000

Victorian Government

www.betterhealth.vic.gov.au

Women's Health Victoria

<http://whv.org.au>

Resources and services for a healthy pregnancy

Alcohol, tobacco and drugs

Alcohol and Drug Information Service

<http://yourroom.com.au>

(02) 9361 8000 or 1800 422 599

Australian Drug Foundation

www.stvincents.com.au

www.adf.org.au

(03) 9611 6100

MotherSafe

www.mothersafe.org.au

(02) 9382 6539 or

1800 647 848

The Quitline

www.icanquit.com.au

13 78 48 (13 QUIT)

Diet and pregnancy

Food Standards Australia New Zealand

www.foodstandards.gov.au

(02) 6271 2222

Nutrition Australia

www.nutritionaustralia.org

(02) 4257 9011

NSW Food Authority

www.foodauthority.nsw.gov.au

1300 552 406

Domestic violence and assault

Domestic Violence Line

www.domesticviolence.nsw.gov.au

1800 656 463

TTY 1800 671 442

NSW Rape Crisis Centre

www.nswrapecrisis.com.au

1800 424 017

Grief and loss

SIDS and Kids NSW

www.sidsandkidsnsw.org

(02) 8585 8700 or

1800 651 186

Health and safety

The Children's Hospital at Westmead

www.chw.edu.au/parents/factsheets

Roads and Maritime Services

<http://roadsafety.transport.nsw.gov.au/stayingsafe/children/>

[childcarseats/index.html](http://roadsafety.transport.nsw.gov.au/stayingsafe/children/childcarseats/index.html)

13 22 13

Women's Health Centres

www.whnsw.asn.au

(02) 9560 0866

Infections, genetic conditions and other health conditions

ACON (AIDS Council of NSW)

www.acon.org.au

(02) 9206 2000

Australian Action on Pre-eclampsia

www.aapec.org.au

(03) 9330 0441

Centre for Genetics Education

www.genetics.edu.au

(02) 9462 9599

Cystic Fibrosis (NSW)

www.cysticfibrosis.org.au/nsw

(02) 9878 2075 or

1800 650614

Australian Diabetes Council

www.australiandiabetescouncil.com

1300 342 238 (1300 DIABETES)

Down Syndrome NSW

www.downsyndromensw.org.au (02)

9841 4444

Hepatitis NSW

www.hep.org.au

(02) 9332 1599 or

1800 803 990

Pre-eclampsia Foundation

www.preeclampsia.org

Thalassaemia Society of NSW

www.thalnsw.org.au

(02) 9550 4844

Labour and birth

Homebirth Access Sydney
www.homebirthsydney.org.au
(02) 9501 0863

Homebirth Australia
www.homebirthaustralia.org
0423 349 464

Australian Society of Independent Midwives
www.australiansocietyofindependentmidwives.com

Money matters

Centrelink Families and Parents Line
www.humanservices.gov.au
136 150

Centrelink Multilingual Service
131 202

Multiple pregnancy

Multiple Birth Association of Australia
www.amba.org.au
1300 886 499

Parenting and caring for your baby

Families NSW
www.families.nsw.gov.au
1800 789 123

Australian Breastfeeding Association
www.breastfeeding.asn.au
1800 686 268 (1800 mum2mum)

Family Planning NSW Healthline
www.fpnsw.org.au
1300 658 886

Infant Massage Information Service
www.babymassage.net.au
1300 558 608

Immunise Australia Program
www.immunise.health.gov.au
1800 671 811

Karitane Careline
www.karitane.com.au
1300 227 464 (1300 CARING)

Australian Scholarships Group Resources for Parents
www.asg.com.au/resources

Lactation Consultants of Australia and New Zealand
www.lcanz.org
(02) 9431 8621

Parent line
1300 1300 52

Raising Children Network
http://raisingchildren.net.au

Relationships Australia
www.relationships.org.au
1300 364 277

Tresillian Parent's Helpline
www.tresillian.net
(02) 9787 0855 or 1800 637 357

Postnatal depression

Beyond Blue
www.beyondblue.org.au
1300 224 636

Depression After Delivery
www.depressionafterdelivery.com

Product Safety Australia

Australian Competition and Consumer Commission
Keeping baby safe – a guide to infant and nursery products
www.productsafety.gov.au

Sport and exercise

Australian Sports Commission
www.ausport.gov.au
(02) 6214 1111

Australian Physiotherapy Association (NSW Branch)
www.physiotherapy.asn.au
1300 306 622

NSW Department of Sport and Recreation
www.dsr.nsw.gov.au
13 13 02

Sports Medicine Australia
http://sma.org.au
(02) 8116 9815

Work and pregnancy

WorkCover Authority of NSW
www.workcover.nsw.gov.au
13 10 50

Your comments matter

If you want to comment about the quality of your maternity care, consider talking or writing to the organisation that provided the service. If you have concerns or a complaint, it is particularly important to do this because it shows areas that may need improvement.

If you have concerns about the treatment or health care that was provided to you, you can also contact the **Health Care Complaints Commission**:

Telephone: 1800 043 159 (toll free) or
(02) 9219 7444
TTY: (02) 9219 7555
Fax: (02) 9281 4585
Email: hccc@hccc.nsw.gov.au
Website: www.hccc.nsw.gov.au

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Breastfeeding – the early days

Baby	Breasts	Breastfeeds	Milk	Urine	Stools
First 24-48 hours after birth	The first feed occurs soon after birth while the baby is alert.	At least 2 – may be many more. Offer both breasts.	Colostrum – small volume, highly nutritious. Thick clear yellow/orange in colour.	At least 1-2 wet nappies	Meconium – thick, sticky black/green stool.
48-72 hours old	Soft Becoming firmer and fuller.	Offer both breasts. At least 6-8, maybe many more. May hear the suck/swallow.	Whiter in colour, increased volume. Milk is “coming in”.	At least 2-3 wet nappies. You may see urates – a pink/orange stain on the nappy.	Softer, green/brown in colour.
Over 72 hours old	Usually full and quite firm. Your breasts may leak between feeds.	Offer both breasts at each feed. Start each feed with different breast.	Thinner and whiter in colour. Milk has “come in”.	At least 3-4 pale or colourless wet nappies.	Softer or runny, brown/yellow in colour.
5-6 days old	Full, soften with feeds. Leaking common.	At least 6-8. Feed from the first side till comfortable then offer the second side.	Thin and white in colour. Flows freely during the feed.	At least 4-6 pale or colourless wet nappies.	Runny mustard/yellow colour. Fluid plus little lumps (curds).
7 days old and older	Comfortable – fuller if longer time between feeds.	Varies, 6-10 taking 1-2 breasts as required.		6 pale or colourless wet nappies.	



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ISBN 978-1-74187-780-9