

mother



The Pregnancy Book

father

Your complete guide to:

A healthy pregnancy

Labour and childbirth

The first weeks with your new baby

boy

The Department of Health would like to thank all those involved in shaping the updated edition of *The Pregnancy Book*, including the mothers and fathers, medical and health professionals, and the many individuals and organisations. In particular, the Department extends thanks to:

Community Practitioners' and Health Visitors' Association
Department for Children, Schools and Families
Department for Work and Pensions
Food Standards Agency
NCT
National Institute for Health and Clinical Excellence
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
UK Medicines Information
Sheena Byrom, Jill Cooper, Anne Edington, Dr David Elliman, Kathryn Gutteridge, Sue Henry,
Dr Judy Shakespeare and Dr Helen Scholefield.

This book is given free to all expectant mothers.

Every effort has been made to make this book reflect the most up-to-date medical advice at the time of publication. Because developments can be very rapid, significant changes will always be notified to doctors and other health professionals at once. They will then be incorporated into the text for the next reprint. For the most up-to-date information and advice, visit the online version of the book (pregnancy planner) at www.nhs.uk/pregnancyplanner

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Produced by COI for the Department of Health.
Design and layout by the Rafferty Consultancy.
Cartoons by Alex Hallatt. Medical illustrations by Anne Wadmore and Florence Woolgar.

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The Pregnancy Book

Your complete guide to:

A healthy pregnancy

Labour and childbirth

The first weeks with your new baby

your complete guide

pregnancy



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introduction

find everything you need to know in this book



Having a baby is one of the most exciting things that can happen to you. But you might be feeling nervous as well. If it's your first baby, it's hard to know what to expect.

Your mum, colleagues, friends and relations might all be giving you advice. And then there is all the information on the internet as well as in magazines and books. At times it can feel overwhelming and it's hard to know who is right when people say different things.

This book brings together everything you need to know to have a healthy and happy pregnancy, and to make sure you get the care that is right for you. The guidance about pregnancy and babies does change.

So it's important to get up-to-date, trusted advice so that you can make the right decisions and choices.

If you have any questions or concerns – no matter how trivial they may seem – talk to your midwife or doctor. They are there to support you.



The information in this book is also available online from the NHS interactive pregnancy planner, which is available at www.nhs.uk/pregnancyplanner

You can download an interactive widget at www.nhs.uk/pregnancywidget that delivers weekly

information and tips tailored to you and your pregnancy.



YOUR PREGNANCY AT A GLANCE



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BEFORE YOU GET PREGNANT



- Think about the lifestyle factors that might affect your ability to get pregnant and have a healthy pregnancy (see Chapter 3). This applies to men too. You are more likely to get pregnant if you are both in good health.

- If you smoke, get advice about stopping. You can talk to your doctor, visit www.nhs.uk/smokefree or call the free NHS smoking helpline on 0800 022 4 332.
- Eat a balanced diet.
- Maintain a healthy weight.

- You should avoid drinking alcohol if you are pregnant or trying to conceive. If you do choose to drink, then protect your baby by drinking no more than one to two units of alcohol once or twice a week and don't get drunk (see page 32).

- Take exercise.

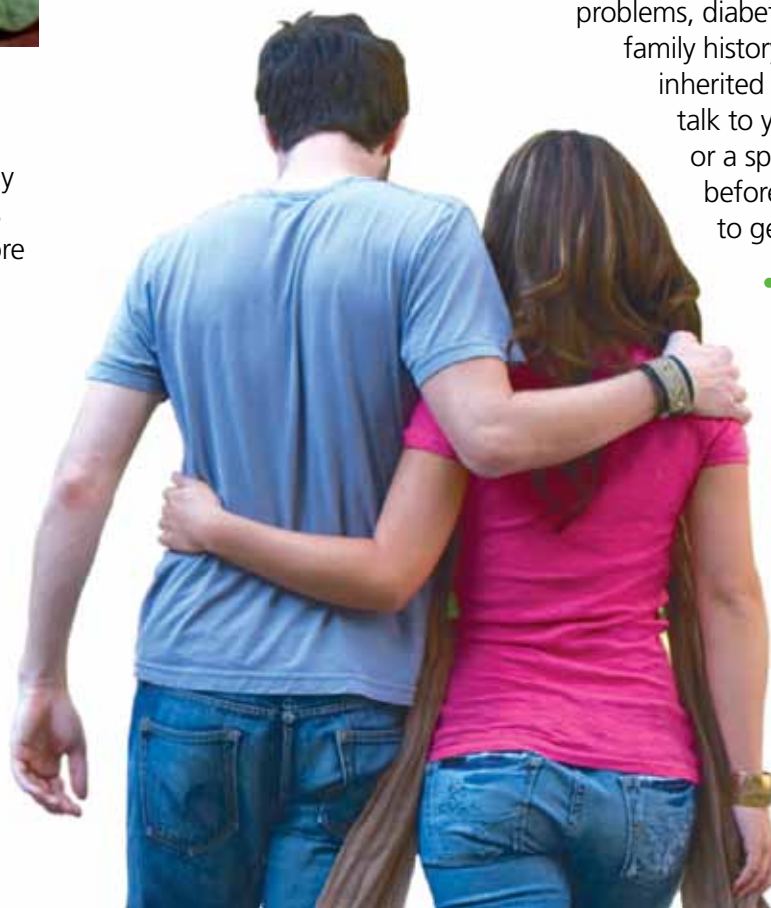
- If you or your partner take any medication, talk to your doctor about whether it will affect your pregnancy.

- Take 400 micrograms of folic acid a day. You should continue to take this until you are 12 weeks pregnant (see page 27).



- If you have a health condition, for example mental health problems, diabetes or a family history of any inherited diseases, talk to your GP or a specialist before you try to get pregnant.

- Talk to your GP or a healthcare professional if you have any concerns or need support.





0–8 WEEKS

- You can take a pregnancy test from the first day that you miss your period (see **Finding out that you are pregnant** on page 16).
- As soon as you know you are pregnant, get in touch with a midwife or your GP to organise your antenatal care (see **Finding out that you are pregnant** on page 16 and **Antenatal care** on page 40). Begin to think about where you want your baby to be born (see **Choosing where to have your baby** on page 70).
- Some pregnant women start to feel sick or tired or have other minor physical problems for a few weeks (see **Common minor problems** on page 58).
- Take 10 micrograms of vitamin D per day, which is in Healthy Start vitamin supplements or other supplements recommended by your midwife. You should continue to take vitamin D throughout your pregnancy and while you are breastfeeding.

8–12 WEEKS

- You will usually attend your first appointment by 10 weeks and your booking appointment by 12 weeks.
- At the booking appointment, your weight, height and body mass index will be measured. You will be asked about your health and family history as well as about your baby's father's family history. This is to find out if you are at risk of certain inherited conditions.
- Your hand-held notes and plan of care will be completed.
- Your midwife will discuss various tests you will be offered during your pregnancy, one of which is an ultrasound scan to check for abnormalities in your baby (see page 48). You will be offered information about what to expect during pregnancy and how to have a healthy pregnancy. Ask if you are unsure about anything.
- You can ask your midwife about your rights at work and the benefits available (see **Rights and benefits** on page 156).
- You will usually be offered an ultrasound scan between eight and 14 weeks. This will check the baby's measurements and give an accurate due date. The scan can also detect abnormalities and check if you are carrying more than one baby. Your partner can come along to the scan (see **Antenatal care** on page 40).
- If you get Income Support, income-based Jobseeker's Allowance or income-related Employment and Support Allowance or are on a low income and receive Child Tax Credit, you should complete a Healthy Start application form (see page 28). This is to claim vouchers to spend on milk, fruit and vegetables. Healthy Start vitamin supplements (containing vitamin D) are free without prescription for any pregnant woman, new mother or child who gets Healthy Start vouchers (see **Rights and benefits** on page 156).

- Make a dental appointment. NHS dental care is free during pregnancy and for a year after the birth of your baby.
- Just 12 weeks after conception, your baby is fully formed. It has all its organs, muscles, limbs and bones, and its sex organs are well developed.
- Your baby is already moving about but you cannot feel the movements yet.



growing
and developing



12–16 WEEKS

- Find out about antenatal education (see **Antenatal care** on page 40).
- Start to think about how you want to feed your baby (see **Feeding your baby** on page 102).
- Make sure you are wearing a supportive bra. Your breasts will probably increase in size during pregnancy so you need to make sure you are wearing the right sized bra.
- If you have been feeling sick and tired, you will probably start to feel better around this time.
- At 14 weeks, your baby's heartbeat is strong and can be heard using an ultrasound detector.
- Your pregnancy may just be beginning to show. This varies a lot from woman to woman.



16–20 WEEKS

- You may start to feel your baby move (see **How your baby develops** on page 18).
- Your tummy will begin to get bigger and you will need looser clothes.
- You may feel a surge of energy.
- Try to do your pregnancy exercises regularly (see **Your health in pregnancy** on page 24).
- Your midwife or doctor should:
 - review, discuss and record the results of any screening tests
 - measure your blood pressure and test your urine for protein
 - consider an iron supplement if you are anaemic.
- Your midwife or doctor should give you information about the anomaly scan you will be offered at 18–20 weeks and answer any questions you have.
- Your baby is now growing quickly. Their face becomes much more defined and their hair, eyebrows and eyelashes are beginning to grow.
- Ask your doctor or midwife to let you hear your baby's heartbeat.



20–25 WEEKS

- Your uterus will begin to get bigger more quickly and you will really begin to look pregnant.
- You may feel hungrier than before. Stick to a sensible balanced diet (see **Your health in pregnancy** on page 24).



- Ask your midwife about antenatal education (see **Antenatal education** on page 56).
- You will begin to feel your baby move.
- Get your maternity certificate (form MAT B1) from your doctor or midwife (see **Rights and benefits** on page 156).

25 WEEKS (if this is your first baby)

- Your baby is now moving around vigorously and responds to touch and sound.
- If this is your first baby, your midwife or doctor should:
 - check the size of your uterus
 - measure your blood pressure and test your urine for protein.
- If you are taking maternity leave, inform your employer in writing 15 weeks before the week your baby is due. You can claim for Statutory Maternity Pay (SMP) and the Health in Pregnancy Grant at the same time (see **Rights and benefits** on page 156).
- If you are entitled to Maternity Allowance, you can claim from when you are 26 weeks pregnant (see **Rights and benefits** on page 156).
- If your partner plans to take paternity leave, they will need to inform their employer.



28 WEEKS

- Your baby will be perfectly formed by now, but still quite small.
- You may find that you are getting more tired.
- Your midwife or doctor should:
 - use a tape to measure the size of your uterus
 - measure your blood pressure and test your urine for protein
 - offer more blood screening tests
 - offer your first anti-D treatment if your blood type is rhesus negative.
- If you are claiming Statutory Maternity Pay (SMP), you must inform your employer at least 28 days before you stop work (see **Rights and benefits** on page 156).
- You can claim a lump sum Sure Start Maternity Grant to help buy things for your new baby if you get one of the following:
 - Income Support
 - income-based Jobseeker's Allowance
 - income-related Employment and Support Allowance
 - Pension Credit
 - Working Tax Credit where the disability or severe disability element is included in the award
 - Child Tax Credit payable at a rate higher than the family element (see **Rights and benefits** on page 156).

- Think about what you need for the baby (see **What you need for your baby** on page 127).
- If you have young children, it's good to talk to them about the new baby.
- Make sure your shoes are comfortable. If you get tired, try to rest with your feet up.



excitement and apprehension



31 WEEKS (if this is your first baby)

- If this is your first baby, your midwife or doctor should:
 - review, discuss and record the results of any screening tests from the last appointment
 - measure the size of your uterus and check which way up the baby is
 - measure your blood pressure and test your urine for protein.

34 WEEKS

- Your midwife or doctor will give you information about preparing for labour and birth, including how to recognise active labour, ways of coping with pain in labour and developing your birth plan. They should also:
 - review, discuss and record the results of any screening tests from the last appointment
 - measure the size of your uterus
 - measure your blood pressure and test your urine for protein
 - offer your second anti-D treatment if your blood type is rhesus negative (see page 46).
- Make arrangements for the birth. You can give birth at home, in a midwifery unit or in hospital. If you have children already, you may want to make childcare arrangements for when you go into labour.
- You may want to ask about whether tours of maternity facilities for birth are available.





36 WEEKS

- Think about who you would like to have with you during labour.
- Get your bag ready if you are planning to give birth in hospital or in a midwifery unit.
- You will probably be attending antenatal classes now (see **Antenatal care** on page 40).
- You may be more aware of your uterus tightening from time to time. These are mild contractions known as Braxton Hicks contractions (see **Labour and birth** on page 85).
- You may feel quite tired. Make sure you get plenty of rest.



- Make sure you have all your important telephone numbers handy in case labour starts (see **Labour and birth** on page 85).
- Your midwife or doctor should give you information about:
 - feeding your baby
 - caring for your newborn baby
 - vitamin K and screening tests for your newborn baby
 - the 'baby blues' and postnatal depression.
- Your midwife or doctor should:
 - measure the size of your uterus
 - check the position of your baby
 - measure your blood pressure and test your urine for protein.
- Sleeping may be increasingly difficult.

38 WEEKS

- Most women will go into labour spontaneously between 38 and 42 weeks. Your midwife or doctor should give you information about your options if your pregnancy lasts longer than 41 weeks.
- Your midwife or doctor should:
 - measure the size of your uterus
 - measure your blood pressure and test your urine for protein.
- Call your hospital or midwife at any time if you have any worries about your baby or about labour and birth.

40 WEEKS (if this is your first baby)

- Your midwife or doctor should give you more information about what happens if your pregnancy lasts longer than 41 weeks.
- Your midwife or doctor should:
 - measure the size of your uterus
 - measure your blood pressure and test your urine for protein.

41 WEEKS

- If your pregnancy lasts longer than 41 weeks, you may be induced. Your midwife or doctor will explain what this means and what the risks are.
- Your midwife or doctor should:
 - measure the size of your uterus
 - measure your blood pressure and test your urine for protein
 - offer a membrane sweep (see page 96).
- Discuss options and choices for induction of labour.
- Call your hospital or midwife if you have any worries about your baby or about labour and birth.
- See www.nice.org.uk/Guidance/CG70 for guidelines on induction of labour.

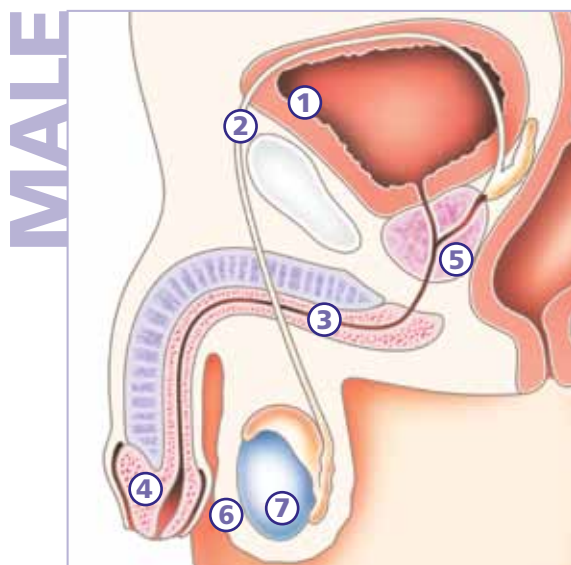


BECOMING PREGNANT



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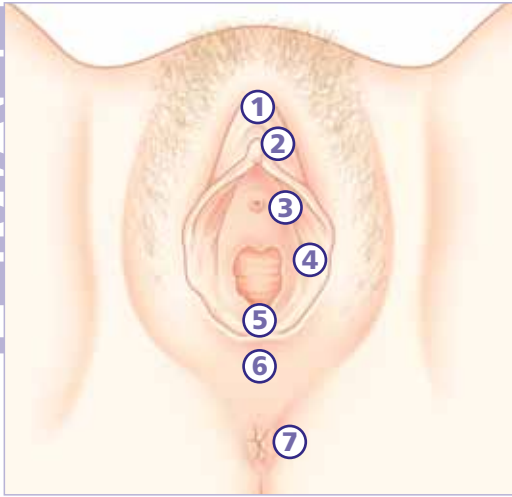
This chapter describes the physical process of getting pregnant and includes information about the male and female sex organs, the female monthly cycle and when you are most likely to conceive. It also explains what you should do when you find out you are pregnant and how you might feel when you first conceive.



MALE SEX ORGANS

- ① **Bladder**
- ② **Vas deferens** The two tubes called the vas deferens carry sperm from the testes (testicles), where sperm are made, to the prostate and other glands. These glands add secretions that are ejaculated along with the sperm.
- ③ **Urethra** The urethra is a tube running down the length of the penis from the bladder, through the prostate gland, to an opening at the tip of the penis. Sperm travel down the urethra to be ejaculated.
- ④ **Penis** The penis is made of erectile tissue, which acts like a sponge. When it becomes filled with blood, the penis becomes hard and erect.
- ⑤ **Prostate gland** This is a gland at the base of the penis.
- ⑥ **Scrotum** The testes are contained in a bag of skin called the scrotum, which hangs outside the body. The scrotum helps to keep the testes at a constant temperature, just below body temperature. This is necessary for sperm to be produced. When it is warm, the scrotum hangs down away from the body to keep the testes cool. When it is cold, the scrotum draws up closer to the body for warmth.
- ⑦ **Testes** Men have two testes, which are glands where sperm are made and stored.

parts of
the
body

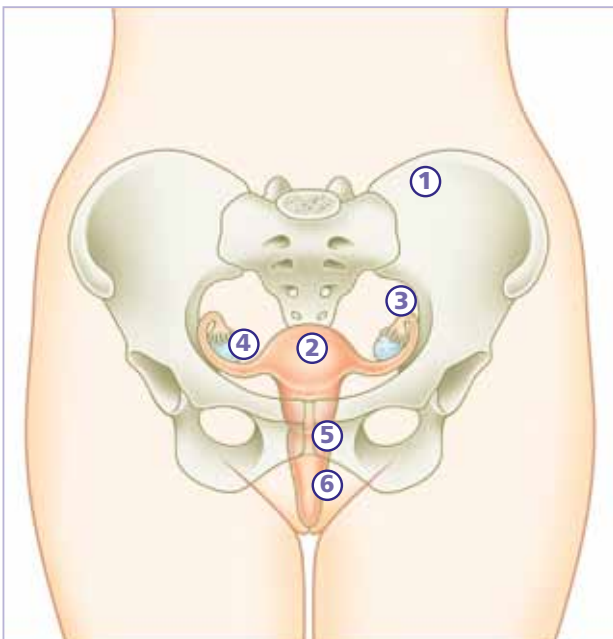


FEMALE SEX ORGANS

- ① Hood of clitoris
- ② Clitoris
- ③ Urethra
- ④ Vulva
- ⑤ Opening of vagina
- ⑥ Perineum
- ⑦ Anus



- ① Fallopian tube
- ② Ovary
- ③ Womb or uterus
- ④ Bladder
- ⑤ Cervix
- ⑥ Vagina
- ⑦ Urethra
- ⑧ Rectum
- ⑨ Anus
- ⑩ Perineum



- ① **Pelvis** The pelvis is the bony structure that the baby will pass through when it is born.
- ② **Womb or uterus** The uterus is about the size and shape of a small, upside down pear. It is made of muscle and increases in size as the baby grows.
- ③ **Fallopian tubes** The fallopian tubes lead from the ovaries to the uterus. Eggs are released from the ovaries into the fallopian tubes each month. This is where fertilisation takes place.
- ④ **Ovaries** There are two ovaries, each about the size of a walnut. They produce the eggs or ova.
- ⑤ **Cervix** The cervix is the neck of the uterus. It is normally almost closed, with just a small opening through which blood passes during monthly periods. During labour, the cervix will dilate to let the baby move from the uterus into the vagina.
- ⑥ **Vagina** Most babies are born through the vagina, which is a tube about 8cm (3 inches) long. It leads from the cervix down to the vulva, where it opens between the legs. The vagina is very elastic, so it can easily stretch around a man's penis during sex or around a baby during labour.

The female monthly cycle



- A** Egg being released
- B** Fallopian tube
- C** Vagina
- D** Ovary

Ovulation occurs each month when an egg (ovum) is released from one of the ovaries. Occasionally, more than one egg is released, usually within 24 hours of the first egg. The 'fingers' at the end of the fallopian tubes help to direct the egg down into the tube. At the same time, the lining of the uterus begins to thicken and the mucus in the cervix becomes thinner so that sperm can swim through it more easily.

- E** Egg progressing down the fallopian tube

The egg begins to travel down the fallopian tube. If a man and woman have recently had sex, the egg might be fertilised here by the man's sperm. The lining of the uterus is now thick enough for the fertilised egg to be implanted.

- F** Uterus lining being shed

If the egg is not fertilised, it will pass out of the body during the woman's monthly period along with the lining of the uterus, which is also shed. The egg is so small that it cannot be seen.

Conception

Conception is the process that begins with the fertilisation of an egg and ends with the implantation of an egg into a woman's uterus.



- A** Egg
- B** Sperm being ejaculated
- C** Penis

Ovulation

A woman conceives around the time when she is ovulating; that is, when an egg has been released from one of her ovaries into one of her fallopian tubes.

- D** Egg being fertilised
- E** Sperm

Fertilisation

During sex, sperm are ejaculated from a man's penis into a woman's vagina. In one ejaculation there may be more than 300 million sperm. Most of the sperm leak out of the vagina but some begin to swim up through the cervix. When a woman is ovulating, the mucus in the cervix is thinner than usual to let sperm pass through more easily. Sperm swim into the uterus and into the fallopian tubes. Fertilisation takes place if a sperm joins with an egg and fertilises it.

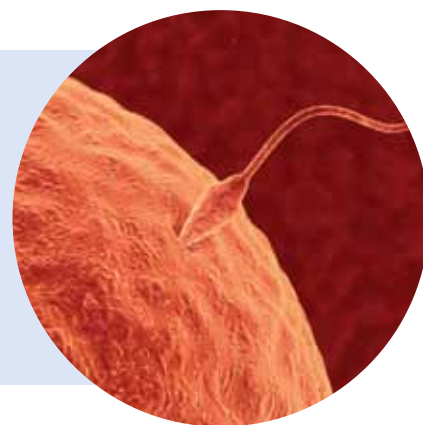
- F** Attached embryo

Implantation

During the week after fertilisation, the fertilised egg (which is now an embryo) moves slowly down the fallopian tube and into the uterus. It is already growing. The embryo attaches itself firmly to the specially thickened uterus lining. This is called implantation. Hormones released by the embryonic tissue prevent the uterus lining from being shed. This is why women miss their periods when they are pregnant.

Sperm is about 1/25th of a millimetre long and has a head, neck and tail. The tail moves from side to side so that the sperm can swim up the vagina into the uterus and fallopian tubes.

One egg or ovum (occasionally two or more) is released from the woman's ovaries every month. It moves down into the fallopian tube where it may be fertilised by a man's sperm.



HORMONES

Both men and women have hormones, which are chemicals that circulate in the bloodstream. They carry messages to different parts of the body and result in certain changes taking place. Female hormones, which include oestrogen and progesterone, control many of the events of a woman's monthly cycle, such as the release of eggs from her ovaries and the thickening of her uterus lining.

During pregnancy, your hormone levels change. As soon as you have conceived, the amount of oestrogen and progesterone in your blood increases. This causes the uterus lining to build up, the blood supply to your uterus and breasts to increase and the muscles of your uterus to relax to make room for the growing baby.



The increase in hormone levels can affect how you feel. You may have mood swings, feel tearful or be easily irritated. For a while you may feel that you cannot control your emotions, but these symptoms should ease after the first three months of your pregnancy.



BOY OR GIRL?

Every normal human cell contains 46 chromosomes, except for male sperm and female eggs. These contain 23 chromosomes each. When a sperm fertilises an egg, the 23 chromosomes from the father pair with the 23 from the mother, making 46 in all.

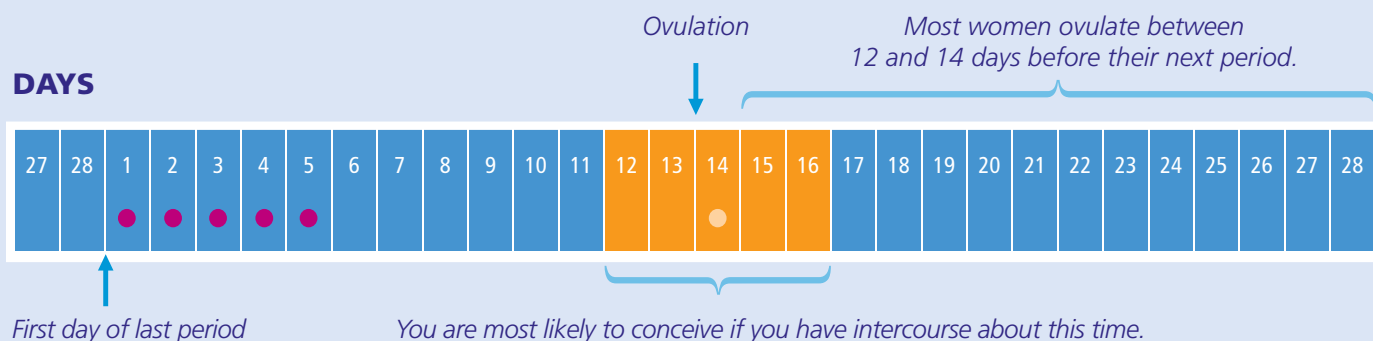
Chromosomes are tiny, thread-like structures which each carry about 2,000 genes. Genes determine a baby's inherited characteristics, such as hair and eye colour, blood group, height and build. A fertilised egg contains one sex chromosome from its mother and one from its father. The sex chromosome from

the mother's egg is always the same and is known as the X chromosome. But the sex chromosome from the father's sperm can be an X or a Y chromosome.

If the egg is fertilised by a sperm containing an X chromosome, the baby will be a girl (XX). If the sperm contains a Y chromosome, the baby will be a boy (XY).



This chart shows a 28-day cycle. Yours may be longer or shorter.



THE BEST TIME TO GET PREGNANT

You are most likely to get pregnant if you have sex within a day or so of ovulation (see chart). This is usually about 14 days after the first day of your last period.

An egg lives for about 12–24 hours after it is released. For you to get pregnant, the egg must be fertilised by a sperm within this time. Sperm can live for up to seven days inside a woman's body. So if you have had sex in the seven days before ovulation, the sperm will have had time to travel up the fallopian tubes to 'wait' for the egg to be released.

TWINS, TRIPLETS OR MORE

Identical twins occur when one fertilised egg splits into two; each baby will have the same genes – and therefore they will be the same sex and look very alike. Non-identical twins are more common. They are the result of two eggs being fertilised by two sperm at the same time. The babies may be of the same sex or different sexes, and will probably look no more alike than any other brothers and sisters. A third of all twins will be identical and two-thirds non-identical.

Twins happen in about 1 in every 65 pregnancies. A couple is more likely to have twins if there are twins in the woman's family. Triplets occur naturally in 1 in 10,000 pregnancies and quads are even rarer. Nowadays, the use of drugs in the treatment of infertility has made multiple births more common.

Are you carrying twins?

You might suspect that you are carrying more than one baby if:

- you are very sick in early pregnancy

- you seem bigger than you should be for your 'dates'
- twins run in your family, or
- you have had fertility treatment.

It is usually possible to find out through your dating ultrasound scan, which happens between eight and 14 weeks (see page 48).

You should be told at this point whether the babies share a placenta (are identical) or if they have two separate placentas, in which case they can be either identical or non-identical. If this cannot be determined, you should be offered a further scan. A third of identical twins have two separate placentas. This happens when the fertilised egg splits in the first 3–4 days after conception and before it implants in the uterus.



What is different about being pregnant with twins or more?

All multiple pregnancies have a higher risk of complications – particularly premature birth. If your babies share a placenta (identical twins) it is recommended that you are scanned every two weeks from 16 weeks onwards, and every four weeks if your babies have separate placentas. You may be advised to have a caesarean section. You should discuss this with your doctor, but it is your choice. It is possible to breastfeed twins and triplets and there is more information about how you can do this in Chapter 9. You may find that a combination of breast and formula feeding is best for you – particularly if you have triplets or more.

Help and support



You might find it helpful to contact support groups like **Tamba** (Twins and Multiple Births Association) and the **Multiple Births Foundation** (see pages 188 and 183) before your babies are born.



THE SIGNS OF PREGNANCY

For women who have a regular monthly cycle, the earliest and most reliable sign of pregnancy is a missed period. Sometimes women who are pregnant have a very light period, losing only a little blood. Other signs of pregnancy are as follows:

- Feeling sick – you may feel sick, or even be sick. This is commonly known as ‘morning sickness’ but it can happen at any time of the day. If you are being sick all the time and cannot keep anything down, contact your GP.
- Changes in your breasts – your breasts may become larger and feel tender, like they might do before your period. They may also tingle. The veins may show up more and the nipples may darken and stand out.
- Needing to pass urine more often – you may find that you have to get up in the night.
- Being constipated.
- An increased vaginal discharge without any soreness or irritation.
- Feeling tired.
- Having a strange taste in your mouth – many women describe it as metallic.
- ‘Going off’ certain things, for example tea, coffee, tobacco smoke or fatty food.

PREGNANCY TESTS

Pregnancy tests can be carried out on a sample of urine from the first day of a missed period, which means that, if you are pregnant, you are about two weeks after conception. Some very sensitive tests can be used even before you miss a period.

You can collect urine at any time of the day. Use a clean, soap-free, well-rinsed container to collect it. You can get pregnancy tests free of charge from your GP or family planning clinic. Pregnancy tests are also available at NHS walk-in centres.

Many pharmacists and most pregnancy advisory services also offer tests, usually for a small fee. You can buy do-it-yourself pregnancy testing kits from pharmacists. They can give you a quick result and you can do the test in private. There are a range of tests that are available. How they work varies, so check the instructions.

Results of the test

A positive test result is almost certainly correct. A negative result is less reliable. If you still think you are pregnant, wait a week and try again or go and see a midwife or GP.



See your midwife or doctor as soon as possible if you are currently being treated for a long-term disease such as diabetes or epilepsy, or you have serious mental health problems.



FINDING OUT THAT YOU ARE PREGNANT

When you find out that you are pregnant, you may feel happy and excited or even shocked, confused and upset. Everybody is different and you should not worry if you are not feeling as happy as you might have expected. Even if you have been trying to get pregnant, your feelings may take you by surprise. Some of these feelings may be caused by changes in your hormone levels, which can make you feel more emotional.

Even if you feel anxious and uncertain now, your feelings may change. Talk to your midwife, GP

or family planning clinic, who will try to help you to adjust or will give you advice if you don't want to continue with your pregnancy.

Men may also have mixed feelings when they find out that their partner is pregnant. They may find it hard to talk about these feelings because they don't want to upset their partner. Both partners should encourage each other to talk about their feelings and any worries or concerns that they have at this stage.

However you are feeling, you should contact an NHS professional (see Chapter 4) so that you can start to receive antenatal care. This is the care that you will receive leading up to the birth of your baby.

Telling people

You may want to tell your family and friends immediately or wait a while until you have sorted out how you feel. Many women wait until they have had their first scan before they tell people that they are pregnant.

Members of your family/extended family may have mixed feelings or react in unexpected ways to your news. You may wish to discuss this with your midwife.

ACCESSING ANTENATAL CARE

When you find out that you are pregnant, it's important to contact an NHS professional as soon as possible.

You can book an appointment directly with a midwife. Your GP surgery will be able to put you in touch with your nearest midwife service.

If you have special health needs, your midwife, GP or other doctors may take shared responsibility for your maternity care.

Your first or second meeting with your midwife is the booking appointment. This will last for up to two hours and could take place at a hospital, in a clinic or a Children's Centre, in a GP surgery or at home. Your midwife will ask you many questions about your health, the health of your family and your preferences in order to develop your own plan of care. Your midwife will order a number of blood tests and scans, which will be done throughout your pregnancy. The results of these tests may affect your choices later in pregnancy, so it's important not to miss them. Your midwife will also ask about any other help or social care support you may have or need – for example support from social workers or family liaison officers. For more information about the booking appointment, see pages 42 and 44–45.



your feelings

HELP FOR YOUNG MUMS

If you are a young mum, there are a wide range of services to support you when you are pregnant and after you have had your baby. Your midwife or health visitor will be able to give you details of local services.



If you are on your own

If you are pregnant and on your own, it is even more important that there are people with whom you can share your feelings and who

Help and support

The following national organisations can also give you help and advice:

Sexwise helpline

If you think you may be pregnant, you can get confidential advice from the Sexwise helpline on **0800 282930** or get further information from **www.ruthinking.co.uk**

Brook centres

If you are under 25, you can visit a Brook centre for free, confidential advice. To find your nearest centre, go to **www.brook.org.uk** or call the national Ask Brook helpline on **0808 802 1234**.

can offer you support. Sorting out problems, whether personal or medical, is often difficult when you are by yourself, and it is better to find someone to talk to rather than let things get you down. For more information on coping on your own, see page 79.

Carrying on with your education

Becoming a mother certainly does not have to mean the end of your education. If you are still of compulsory school age, your school should not exclude you on grounds of pregnancy or health and safety issues connected with your pregnancy. However, they may talk to you about making alternative arrangements for your education. You will be allowed up to 18 calendar weeks off school before and after the birth.

After your return to education, you can get help with childcare costs through the Care to Learn scheme. Care to Learn also provides support with childcare costs for teenage parents above the compulsory schooling age who want to study. You may also be eligible for the



Education Maintenance Allowance (EMA), which is available for young people between 16 and 18. EMA provides up to £30 a week. For more information about EMA and Care to Learn, phone 0800 121 8989 or visit <http://moneytolearn.direct.gov.uk>



Somewhere to live

Many young mothers want to carry on living with their own family until they are ready to move on. If you are unable to live with your family, your local authority may be able to help you with housing. Some local authorities provide specialised accommodation where young mothers can live independently while getting support and advice from trained workers. For more information about housing, contact your local authority.

Connexions

Teenagers in England can get help and advice from the Connexions service. You have the offer of support from a personal adviser to help deal with a variety of issues so that you can make the best choices for your future. You can find Connexions advisers in a variety of places, including schools, colleges and one-stop shops and through youth and community projects.

For confidential personal advice, practical help or details of your local Connexions service, phone Connexions Direct, on **080 800 13219**, text 07766 4 13219 or go to **www.connexions-direct.com**

The young woman's guide to pregnancy

The young woman's guide to pregnancy is written specifically for women under the age of 20 and includes the real pregnancy experiences of young mums. It is produced by Tommy's and is available free to teenagers from the Tommy's website at **www.tommys.org/publications**

For information on sex and contraception, see page 122.

HOW YOUR BABY DEVELOPS



Measuring your pregnancy	18	Weeks 15–22	21
Week 3	19	Weeks 23–30	22
Weeks 4–5	19	Weeks 31–40	23
Weeks 6–7	19		
Weeks 8–9	19		
Weeks 10–14	20		

This chapter describes how your baby develops from the day you conceive until you give birth.

Week 3

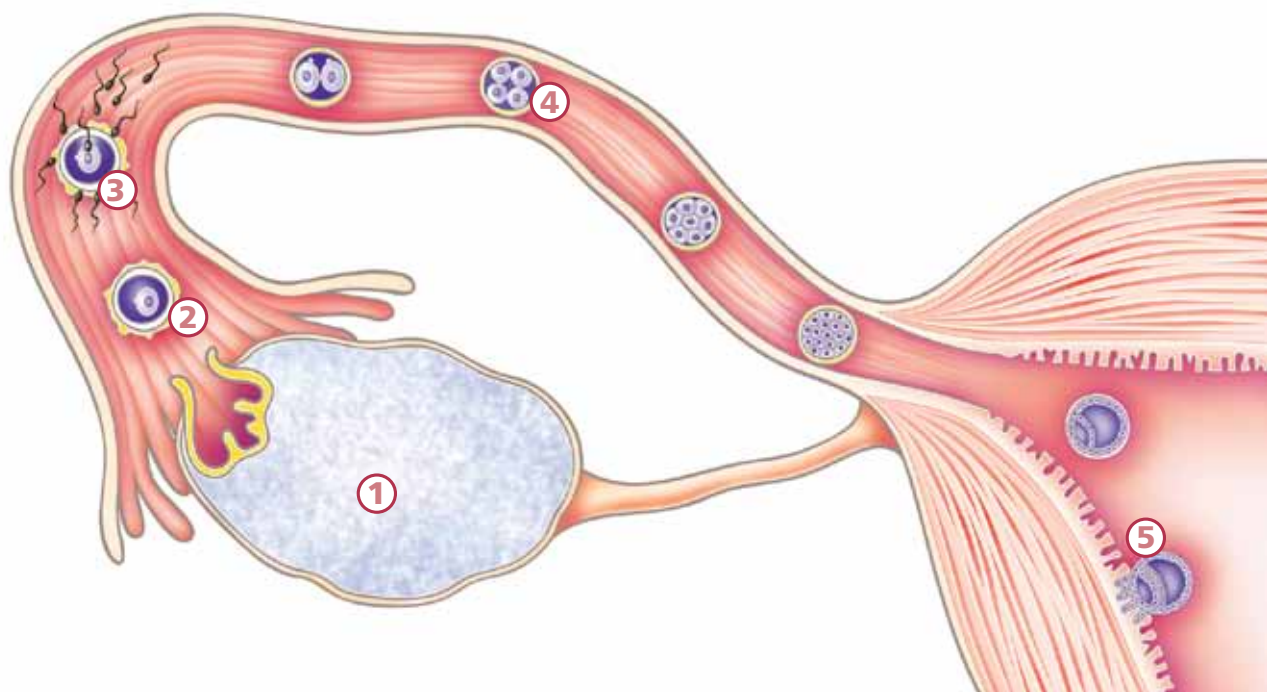
- 1 Ovary
- 2 Egg is released from the ovary
- 3 Egg is fertilised
- 4 Fertilised egg divides and travels down fallopian tube
- 5 Embryo implants itself in uterus lining

MEASURING YOUR PREGNANCY

Doctors and midwives in the UK measure the duration of pregnancy from the first day of your last menstrual period, not from the day you conceive. So when you are 'four weeks pregnant', it is actually about two weeks after you conceived. Pregnancy normally lasts for 37–42 weeks from the first day of your last period. The average is 40 weeks.

If you are not sure about the date of your last period, then your early scan (see page 48) will give a good indication of when your baby will be due.

In the very early weeks, the developing baby is called an embryo. From about eight weeks, it is called a fetus.



WEEK 3

This is three weeks from the first day of your last period. The fertilised egg moves slowly along your fallopian tube towards your uterus. It begins as one single cell, which divides again and again. By the time the fertilised egg reaches your uterus, it has become a mass of over 100 cells, called an embryo. It is still growing. Once in your uterus, the embryo attaches itself into your uterus lining. This is called implantation.

WEEKS 4-5

Week 4

The actual size of the embryo is about 5mm



The embryo now settles into your uterus lining. The outer cells reach out like roots to link with your blood supply. The inner cells form two – and then later three – layers. Each of these layers will grow to be different parts of your baby's body. One layer becomes their brain and nervous system, skin, eyes and ears. Another layer becomes their lungs, stomach and gut. The third layer becomes their heart, blood, muscles and bones.

The fifth week is when you will miss your period. At this time, most women are only just beginning to think they may be pregnant.

Already your baby's nervous system is starting to develop. A groove forms in the top layer of cells. The cells fold up and round to make a hollow tube called the neural tube. This will become your baby's brain and spinal cord, so the tube has a 'head end' and a 'tail end'. Defects in this tube are the cause of spina bifida (see page 49). The heart is also forming and your baby already has some blood vessels. A string of these blood vessels connects your baby to you – this will become the umbilical cord.

WEEKS 6-7

There is now a large bulge where your baby's heart is and a bump for the head because the brain is developing. The heart begins to beat and can be seen beating on an ultrasound scan. Dimples on the side of the head will become the ears and there are thickenings where the eyes will be. On the body, bumps are forming that will become muscles and bones. And small swellings (called 'limb buds') show where the arms and legs are growing. At seven weeks, the embryo has grown to about 10mm long from head to bottom. This measurement is called the 'crown-rump length'.

Week 6

The actual size from head to bottom is about 8mm



Week 7

The actual size from head to bottom is about 10mm



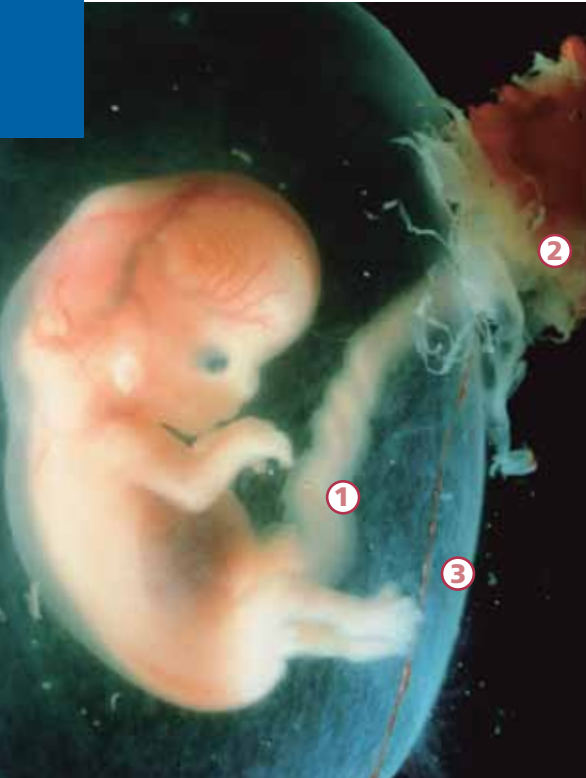
WEEKS 8-9

Your baby's face is slowly forming. The eyes are more obvious and have some colour in them. The fetus has a mouth with a tongue. There are the beginnings of hands and feet, with ridges where the fingers and toes will be. The major internal organs – the heart, brain, lungs, kidneys, liver and gut – are all developing. At nine weeks, the baby has grown to about 22mm long from head to bottom.

Week 9

The actual size from head to bottom is about 22mm





① The umbilical cord

The umbilical cord is a baby's lifeline. It is the link between you and your baby. Blood circulates through the cord, carrying oxygen and food to the baby and carrying waste away again.

② The placenta

The placenta is attached to the lining of the uterus and separates your baby's circulation from your circulation. In the placenta, oxygen and food from your bloodstream pass into your baby's bloodstream and are carried to your baby along the umbilical cord. Antibodies that give resistance to infection pass to your baby in the same way. Alcohol, nicotine and other drugs can also pass to your baby this way.

③ The amniotic sac

Inside the uterus, the baby floats in a bag of fluid called the amniotic sac. Before or during labour the sac, or 'membranes', break and the fluid drains out. This is known as the 'waters breaking'.



WEEKS 10–14

Just 12 weeks after conception, the fetus is fully formed. Your baby has all of their organs, muscles, limbs and bones, and their sex organs are developed. From now on your baby will grow and mature. Your baby is already moving about, but you will not be able to feel movements yet. By about 14 weeks, your baby's heartbeat is strong and can be heard by an ultrasound scanner. The heartbeat is very fast – about twice as fast as a normal adult's heartbeat. At 14 weeks, the baby is about 85mm long from head to bottom. Your pregnancy may start to show, but this varies a lot from woman to woman.

Week 14

The actual size from head to bottom is about 85mm



WEEKS 15–22

Your baby is growing faster than at any other time in their life. Their body grows bigger so that their head and body are more in proportion, and they don't look so 'top heavy'. The face becomes much more defined and the hair, eyebrows and eyelashes are beginning to grow. Their eyelids stay closed over their eyes. Your baby already has their own individual fingerprints, as the lines on the skin of their fingers are now formed. Their fingernails and toenails are growing and their hands can grip.

At about 22 weeks, your baby becomes covered in a very fine, soft hair called lanugo. We don't know what this hair is for, but it is thought that it may keep the baby at the right temperature. The lanugo disappears before birth or soon after.

Between 16 and 22 weeks, you will usually feel your baby move for the first time. If this is your second baby, you may feel it earlier – at about 16–18 weeks. At first, you feel a fluttering or bubbling, or a very slight shifting movement. This can feel a bit like indigestion. Later, you will be able to tell that it is the baby's movements and you may even see the baby kicking about. Sometimes you will see a bump that is clearly a hand or a foot.



Week 22

The actual size from head to bottom is about 27cm





WEEKS 23–30

Your baby is now moving about vigorously, and responds to touch and sound. A very loud noise close by may make them jump and kick. They are also swallowing small amounts of the amniotic fluid in which they are floating, and are passing tiny amounts of urine back into the fluid. Sometimes your baby may get hiccups, and you can feel the jerk of each hiccup. Your baby may also begin to follow a pattern for waking and sleeping. Very often this is a different pattern from yours. So when you go to bed at night, your baby may wake up and start kicking.

Your baby's heartbeat can be heard through a stethoscope. Later, your partner may be able to hear the heartbeat by putting their ear to your abdomen, but it can be difficult to find the right place.

Your baby is now covered in a white, greasy substance called vernix. It is thought that this may be to protect its skin as it floats in the amniotic fluid. The vernix mostly disappears before the birth.

From 24 weeks, your baby has a chance of survival if it is born. Most babies born before this time cannot live because their lungs and other vital organs are not developed well enough. The care that can now be given in neonatal units means that more and more babies born this early do survive. Babies born at around this time have increased risks of disability.

Week 30

The actual size from head to bottom is about 33cm



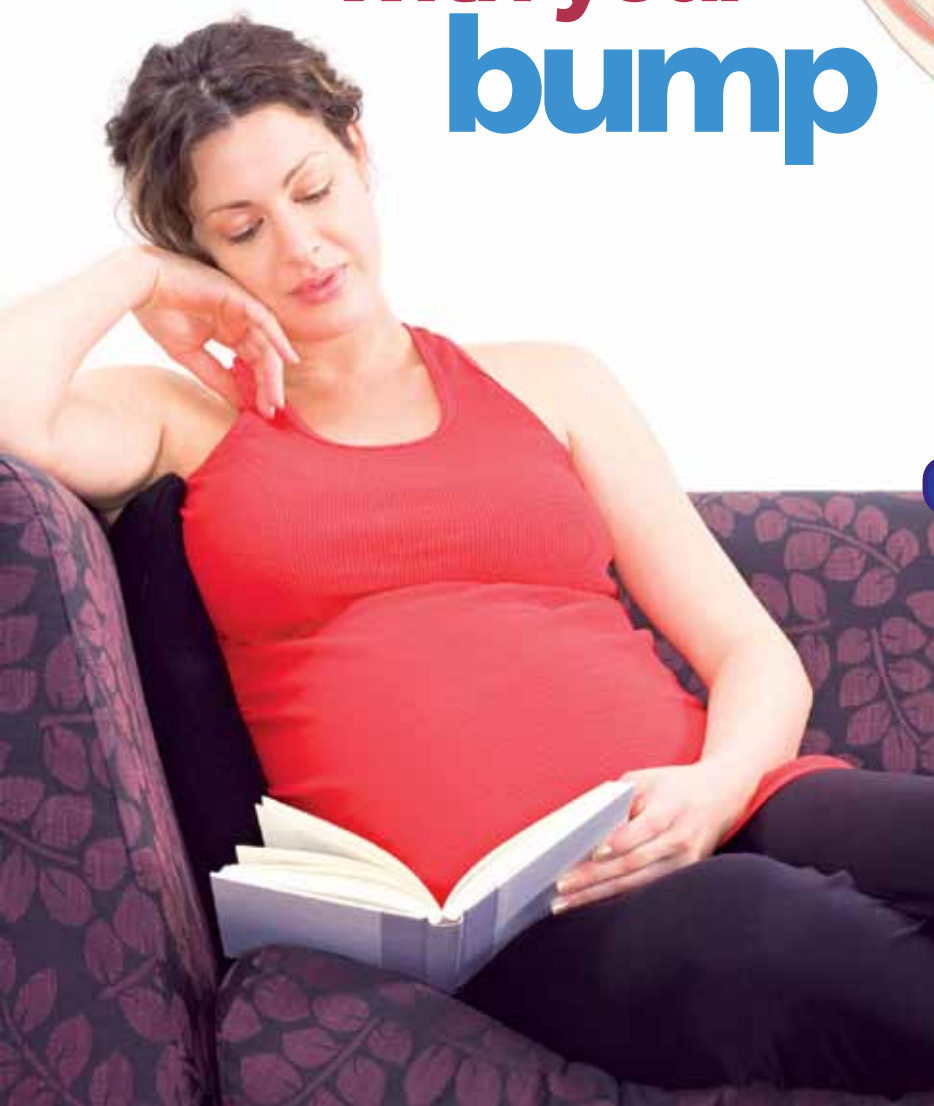
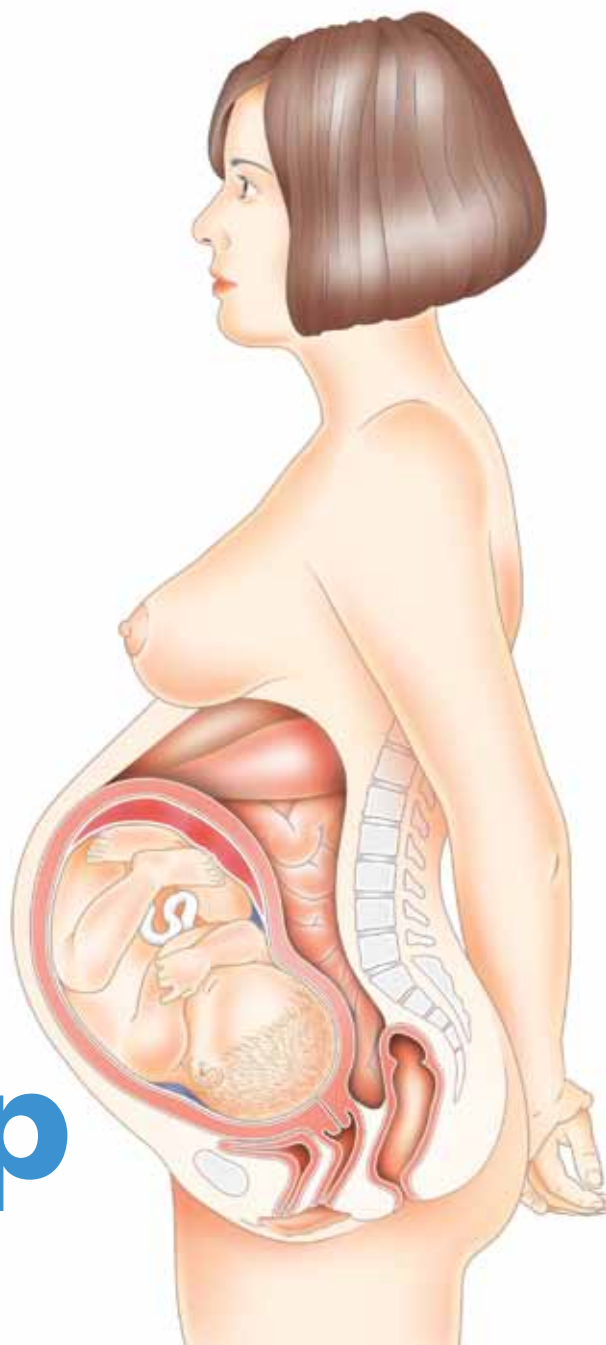
At around 26 weeks your baby's eyelids open for the first time. Babies' eyes are almost always blue or dark blue, although some babies do have brown eyes at birth. It is not until some weeks after they are born that your baby's eyes will become the colour that they will stay. The head-to-bottom length at 30 weeks is about 33cm.

WEEKS 31–40

Your baby continues to grow. Their skin, which was quite wrinkled before, becomes smoother, and both the vernix and the lanugo begin to disappear.

By about 32 weeks, the baby is usually lying with its head pointing downwards, ready for birth. The baby's head can 'engage', or move down into the pelvis, before birth. Sometimes the head doesn't engage until labour has started.

bonding with your bump



Helpful tips

Regularly talking, reading and singing to your bump while you are pregnant will help you to bond with your baby before birth.

YOUR HEALTH IN PREGNANCY



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A healthy diet and lifestyle can help you to keep well during pregnancy and give your baby the best possible start in life. This chapter explains some of the things you can do to stay healthy.

WHAT SHOULD YOU EAT?

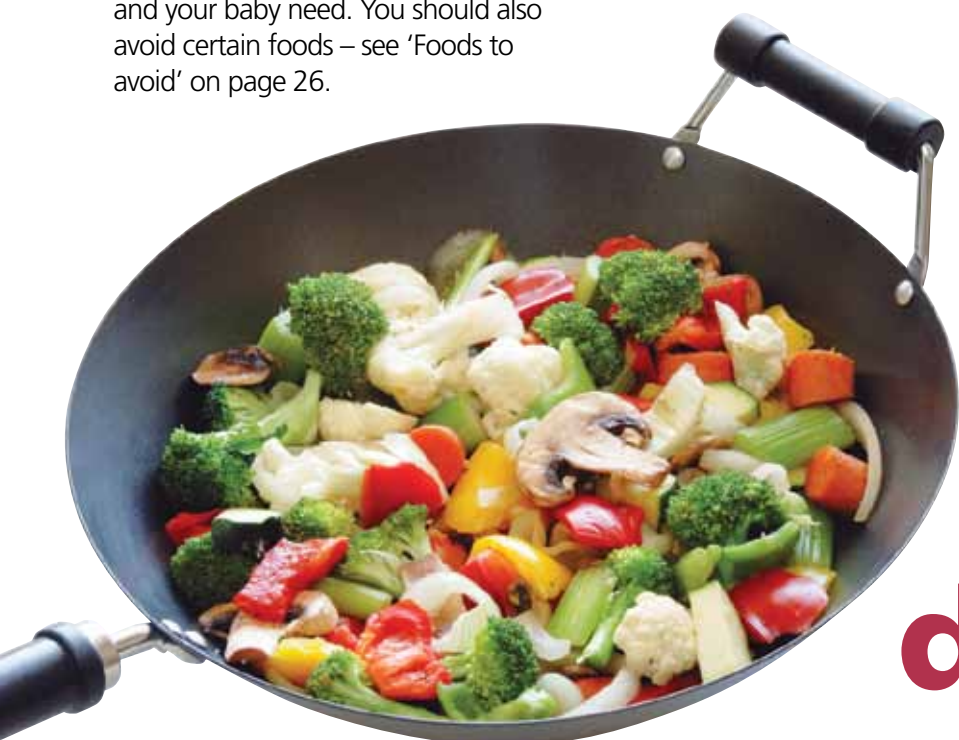
A healthy diet is very important if you are pregnant or trying to get pregnant. Eating healthily during pregnancy will help your baby to develop and grow and will help to keep you fit and well. You don't need to go on a special diet, but make sure that you eat a variety of different foods every day in order to get the right balance of nutrients that you and your baby need. You should also avoid certain foods – see 'Foods to avoid' on page 26.

You will probably find that you are more hungry than normal, but you don't need to 'eat for two' – even if you are expecting twins or triplets. Have breakfast every day – this will help you to avoid snacking on foods that are high in fat and sugar. You may have to change the amounts of different foods that you eat, rather than cutting out all your favourites.

More information

Visit www.eatwell.gov.uk for useful information on what you should eat when you are pregnant or trying for a baby. The leaflets *Eating while you are pregnant* and *Thinking of having a baby?* are also available in several languages.

Both leaflets are available online at www.food.gov.uk or can be ordered on 0845 606 0667.



**nutritious
and
delicious**

The eatwell plate

The 'eatwell plate' below shows how much of each type of food you need to have a healthy and well balanced diet.

Fruit and vegetables

As well as vitamins and minerals, fruit and vegetables provide fibre, which helps digestion and prevents constipation.

Eat at least five portions of fresh, frozen, canned, dried or juiced fruit and vegetables each day. Always wash them carefully. To get the most out of vegetables, eat them raw or lightly cooked. For more information and portion sizes, visit www.5aday.nhs.uk



Bread, rice, potatoes, pasta and other starchy foods

Carbohydrates are satisfying without containing too many calories, and are an important source of vitamins and fibre. They include bread, potatoes, breakfast cereals, pasta, rice, oats, noodles, maize, millet, yams, cornmeal and sweet potatoes. These foods should be the main part of every meal. Eat wholegrain varieties when you can.

Meat, fish, eggs, beans and other non-dairy sources of protein

Protein includes meat (except liver), fish, poultry, eggs, beans, pulses and nuts (for information on peanuts see page 112). These foods are all good sources of nutrients. Eat moderate amounts each day. Choose lean meat, remove the skin from poultry and cook using only a little fat. Make sure eggs, poultry, pork, burgers and sausages are cooked all the way through. Check that there is no pink meat and that juices have no pink or red in them. Try to eat two portions of fish a week, one of which should be oily fish. There are some fish that you should avoid – see 'Foods to avoid' on page 26 for more information.

Foods and drinks that are high in fat and/or sugar

This food group includes all spreading fats, oils, salad dressings, cream, chocolate, crisps, biscuits, pastries, ice cream, cake, puddings and fizzy drinks. You should only eat a small amount of these foods. Sugar contains calories without providing any other nutrients that the body needs. Having sugary foods and drinks too often can cause tooth decay, especially if you have them between meals. If we eat more than we need, this can lead to weight gain. Eating more fatty foods is likely to make you put on weight. Having too much saturated fat can increase the amount of cholesterol in the blood, which increases the chance of developing heart disease. Try to cut down on food that is high in saturated fat and have foods rich in unsaturated fat instead.

Milk and dairy foods

Dairy foods like milk, cheese, yoghurt and fromage frais are important because they contain calcium and other nutrients that your baby needs. Eat two or three portions a day, using low-fat varieties whenever you can – for example, semi-skimmed or skimmed milk, low-fat yoghurt and half-fat hard cheese. However, there are some cheeses that you should avoid – see 'Foods to avoid' on page 26 for more information.



FOODS TO AVOID

There are some foods that you should not eat when you are pregnant because they may make you ill or harm your baby.

You should avoid:

- **Some types of cheese.** Don't eat mould-ripened soft cheese, like Brie, Camembert and others with a similar rind. You should also avoid soft blue-veined cheese, like Danish blue. These are made with mould and they can contain listeria, a type of bacteria that can harm your unborn baby. Although listeriosis is a very rare infection, it is important to take special precautions during pregnancy because even the mild form of the illness in the mother can lead to miscarriage, stillbirth or severe illness in a newborn baby. You can eat hard cheeses such as cheddar and parmesan, and processed cheeses made from pasteurised milk such as cottage cheese, mozzarella and cheese spreads.
- **Pâté.** Avoid all types of pâté, including vegetable pâtés, as they can contain listeria.
- **Raw or partially cooked eggs.** Make sure that eggs are thoroughly cooked until the whites and yolks are solid. This prevents the risk of salmonella food poisoning. Avoid foods that contain raw and undercooked eggs, such as home-made mayonnaise.
- **Raw or undercooked meat.** Cook all meat and poultry thoroughly so that there is no trace of pink or blood. Take particular care with sausages and minced meat. It is fine to eat steaks and other whole cuts of beef and lamb rare, as long as the outside has been properly cooked or sealed.
- **Liver products.** Don't eat liver, or liver products like liver pâté or liver sausage, as they may contain a lot of vitamin A. Too much vitamin A can harm your baby.
- **Supplements containing vitamin A.** Don't take high-dose multivitamin supplements, fish liver oil supplements or any supplements containing vitamin A.
- **Some types of fish.** Don't eat shark, marlin and swordfish, and limit the amount of tuna you eat to no more than two tuna steaks a week (about 140g cooked or 170g raw each) or four medium-sized cans of tuna a week (about 140g when drained). These types of fish contain high levels of mercury, which can damage your baby's developing nervous system. Don't eat more than two portions of oily fish per week. Oily fish includes fresh tuna (but not canned tuna), salmon, mackerel, sardines and trout.
- **Raw shellfish.** Eat cooked rather than raw shellfish as they can contain harmful bacteria and viruses that can cause food poisoning.
- **Peanuts.** If you would like to eat peanuts or foods containing peanuts (such as peanut butter) during pregnancy, you can choose to do so as part of a healthy

balanced diet, unless you are allergic to them or your health professional advises you not to.

You may have heard that some women have, in the past, chosen not to eat peanuts when they were pregnant. This is because the government previously advised women that they may wish to avoid eating peanuts during pregnancy if there was a history of allergy in their child's immediate family (such as asthma, eczema, hayfever, food allergy or other types of allergy). But this advice has now been changed because the latest research has shown that there is no clear evidence to say if eating or not eating peanuts during pregnancy affects the chances of your baby developing a peanut allergy.

- **Unpasteurised milk.** Drink only pasteurised or UHT milk which has been pasteurised. If only raw or green-top milk is available, boil it first. Don't drink unpasteurised goats' or sheep's milk or eat certain food that is made out of them, e.g. soft goats' cheese.

PREPARING FOOD

- Wash fruit, vegetables and salads to remove all traces of soil, which may contain toxoplasma. This can cause toxoplasmosis, which can harm your baby (see page 37).
- Heat ready-meals until they are piping hot all the way through. This is especially important for meals containing poultry.
- Keep leftovers covered in the fridge and use within two days.
- Wash all surfaces and utensils, and your hands, after preparing raw meat. This will help to avoid infection with toxoplasma.

Your weight

Most women gain between 10kg and 12.5kg (22–28lb) while pregnant. Weight gain varies a great deal and depends on your weight before pregnancy.

Much of the extra weight is due to the baby growing. Putting on too much weight can affect your health and increase your blood pressure. Equally, it is important that you do not diet, but eat healthily. Try and stay active by keeping up your normal daily activity or exercise. If you are concerned, talk to your midwife or GP. They may give you advice if you weigh more than 100kg (about 15½ stone) or less than 50kg (about 8 stone).



VITAMINS AND MINERALS

Eating a healthy, varied diet will help you to get all the vitamins and minerals you need while you are pregnant. There are some vitamins and minerals that are especially important:

- **Folic acid.** Folic acid is important for pregnancy as it can reduce the risk of neural tube defects such as spina bifida. If you are thinking about getting pregnant, you should take a 400 microgram folic acid tablet every day until you are 12 weeks pregnant. If you did not take folic acid before you conceived, you should start as soon as you find out that you are pregnant. You should also eat foods that contain folic acid, such as green leafy vegetables, fortified breakfast cereals and brown rice. Some breakfast cereals, breads and margarines have folic acid added to them. If you already have a baby with spina bifida, or if you have coeliac disease or diabetes or take anti-epileptic medicines, ask your GP or midwife for more advice. You will need to take a bigger dose of folic acid.

More information



For more information about folic acid, read

Folic acid:

An essential

guide for making babies at www.breastfeeding.nhs.uk/en/materialforclients/dl_13.asp

Foods carrying the mark on the right have added folic acid.



- **Vitamin D.** You need vitamin D to keep your bones healthy and to provide your baby with enough vitamin D for the first few months of their life. Vitamin D regulates the amount of calcium and phosphate in the body, and these are needed to help keep bones and teeth healthy. Deficiency of vitamin D can cause children's bones to soften and can lead to rickets. You should take a supplement of 10 micrograms of vitamin D every day. Only a few foods contain vitamin D, including oily fish like sardines, fortified margarines, some breakfast cereals and taramasalata.

The best source of vitamin D is summer sunlight. The amount of time you need in the sun to make enough vitamin D is different for every person and depends on things like skin type, time of day and time of the year. But you don't need to sunbathe: the amount of sun you need to make enough vitamin D is less than the amount that causes tanning or burning. If you have dark skin or always cover your skin, you may be at particular risk of vitamin D deficiency. Talk to your midwife or doctor if you are worried about this. (See also 'Vitamin supplements' on page 28.)

- **Iron.** If you are short of iron, you will probably get very tired and you can become anaemic. Lean meat, green, leafy vegetables, dried fruit and nuts (see page 26 about avoiding peanuts) all contain iron. Many breakfast cereals have iron added. If the iron level in your blood becomes low, your GP or midwife will advise you to take iron supplements. These are available as tablets or a liquid.
- **Vitamin C.** You need vitamin C as it may help you to absorb iron. Citrus fruits, tomatoes, broccoli, peppers, blackcurrants, potatoes and some pure fruit juices are good sources of vitamin C. If your iron levels are low, it may help to drink orange juice with an iron-rich meal.
- **Calcium.** Calcium is vital for making your baby's bones and teeth. Dairy products and fish with edible bones like sardines are rich in calcium. Breakfast cereals, dried fruit such as figs and apricots, bread, almonds, tofu (a vegetable protein made from soya beans) and green leafy vegetables like watercress, broccoli and curly kale are other good sources of calcium.

Vitamin supplements

It is best to get vitamins and minerals from the food you eat, but when you are pregnant you will need to take some supplements as well:

- 10 micrograms of vitamin D throughout your pregnancy and if you breastfeed.
- 400 micrograms of folic acid – ideally this should be taken from before you get pregnant until you are 12 weeks pregnant.

If you are vegetarian or vegan, you may need to take a vitamin B12 supplement as well as other supplements. Talk to your doctor or midwife about this.

If you have a special or restricted diet, you may need additional supplements. Talk to your doctor or midwife about this.

Do not take vitamin A supplements, or any supplements containing vitamin A, as too much could harm your baby.

Which supplements?

You can get supplements from pharmacies and supermarkets or your GP may be able to prescribe them for you. If you want to get your folic acid or vitamin D from a multivitamin tablet, make sure that the tablet does not contain vitamin A (or retinol).

Healthy Start vitamins for women contain the correct amount of folic acid and vitamin D and are free from the NHS without a prescription to pregnant women receiving Healthy Start vouchers. Ask your GP or pharmacist for advice if you are unsure (see 'Healthy Start' on this page). Your primary care trust and local pharmacies may sell this supplement to women who don't receive it free.



Healthy Start

Healthy Start is a scheme that provides vouchers that can be exchanged for milk, fresh fruit and vegetables and infant formula milk. You can also receive free vitamins.

You qualify for Healthy Start if you are pregnant or have a child under four years old, and you and your family receive one of the following:

- Income Support.
- Income-based Jobseeker's Allowance.
- Child Tax Credit and have an annual family income of £16,040 or less (2008/09).
- Working Tax Credit run-on (but not Working Tax Credit). Working Tax Credit run-on is the Working Tax Credit you receive in the four weeks immediately after you have stopped working for 16 hours or more per week.

Or you qualify if you are pregnant and under 18 years of age.

You can receive vouchers that are worth £3.10 per week or £6.20 per week for children under one year old.

For further information:

- Pick up the Healthy Start leaflet HS01, *A Healthy Start for Pregnant Women and Young Children* from your local health centre or call 0845 607 6823 to request a free copy.
- Ask your health visitor for more information.
- Visit www.healthystart.nhs.uk

VEGETARIAN, VEGAN AND SPECIAL DIETS

A varied and balanced vegetarian diet should give enough nutrients for you and your baby during pregnancy. However, you might find it hard to get enough iron and vitamin B12. Talk to your doctor or midwife about how you can make sure that you are getting enough of these important nutrients.

You should also talk to your doctor or midwife if you have a restricted diet because you have a food intolerance (such as coeliac disease) or for religious reasons. Ask to be referred

to a dietician who can give you advice on how to get the nutrients you need for you and your baby.

More information

For further information, visit:

- the Vegetarian Society website at www.vegsoc.org
- the Vegan Society website at www.vegansociety.com

Healthy snacks

You may find that you get hungry between meals. Avoid snacks that are high in fat and/or sugar. Instead you could try the following:

- Fresh fruit.
- Sandwiches or pitta bread filled with grated cheese, lean ham, mashed tuna, salmon or sardines and salad.



- Salad vegetables.
- Low-fat yoghurt or fromage frais.
- Hummus and bread or vegetable sticks.
- Ready-to-eat apricots, figs or prunes.
- Vegetable and bean soups.
- Unsweetened breakfast cereals or porridge and milk.
- Milky drinks or unsweetened fruit juices.
- Baked beans on toast or a baked potato.



Caffeine

High levels of caffeine can result in babies having a low birth weight, which can increase the risk of health problems in later life.

Too much can also cause miscarriage.

Caffeine is naturally found in lots of foods, such as coffee, tea and chocolate, and is added to some soft drinks and energy drinks. It can also be found in certain cold and flu remedies. Talk to your midwife, pharmacist or another health professional before taking these remedies.

You don't need to cut caffeine out completely, but you should limit how much you have to no more than 200mg a day. Try decaffeinated tea and coffee, fruit juice or water and limit the amount of 'energy' drinks, which may be high in caffeine. Don't worry if you occasionally have more than this, because the risks are quite small.

Caffeine content in food and drink

- 1 mug of instant coffee: 100mg
- 1 mug of filter coffee: 140mg
- 1 mug of tea: 75mg
- 1 can of cola: 40mg
- 1 can of 'energy' drink: up to 80mg
- 1 x 50g bar of plain chocolate: up to 50mg
- 1 x 50g bar of milk chocolate: up to 25mg

So if you eat...

- one bar of plain chocolate and one mug of filter coffee
 - two mugs of tea and one can of cola, or
 - one mug of instant coffee and one can of energy drink
- you have reached almost 200mg of caffeine.

healthy options



Help and support

Getting help with stopping smoking



The *Smokefree Pregnancy Support* DVD will show you all the free NHS support available to help you to stop and stay stopped. To order your free DVD, call the NHS Pregnancy Smoking Helpline on 0800 169 9 169, or visit www.nhs.uk/smokefree

The NHS Pregnancy Smoking Helpline on 0800 169 9 169 is open from 12pm to 9pm every day and offers free help, support and advice on stopping smoking when you are pregnant.

You can also sign up to receive ongoing advice and support at a time that suits you.

You can also ask your midwife, health visitor, practice nurse or pharmacist for advice and for the details of your local NHS Stop Smoking Service. They offer one-to-one or group sessions with trained stop smoking advisers and may even have a pregnancy stop smoking specialist. They can offer advice about dealing with stress, weight gain and nicotine replacement therapy to help you manage your cravings.

SMOKING

Every cigarette you smoke harms your baby. Cigarettes restrict the essential oxygen supply to your baby. So their tiny heart has to beat harder every time you smoke. Cigarettes contain over 4,000 chemicals. Protecting your baby from tobacco smoke is one of the best things you can do to give your child a healthy start in life.

It's never too late to stop.

If you stop smoking now

Stopping smoking will benefit both you and your baby immediately. Carbon monoxide and chemicals will clear from the body and oxygen levels will return to normal.

Stopping smoking action plan

1 Think

Think about:

- what you and your baby will gain if you stop smoking (see above)
- how much smoking costs you.

- What else could you spend your money on? How can you treat yourself or your baby with the money you save?

- What is keeping you smoking?

List your top five reasons for going smokefree; e.g. protecting your health or the health of your baby.

1

2

3

4

5

If you stop smoking:

- You will have less morning sickness and fewer complications in pregnancy.
- You are more likely to have a healthier pregnancy and a healthier baby.
- You will reduce the risk of stillbirth.
- You will cope better with the birth.
- Your baby will cope better with any birth complications.
- Your baby is less likely to be born too early and have to face the additional breathing, feeding and health problems which often go with being premature (see Chapter 14).
- Your baby is less likely to be born underweight and have a problem keeping warm. Babies of mothers who smoke are, on average, 200g (about 8oz) lighter than other babies. These babies may have problems during and after labour and are more prone to infection.
- You will reduce the risk of cot death (see page 129 for more information about how to reduce the risk of cot death).

It will also be better for your baby later in life. Children whose parents smoke are more likely to suffer from illnesses which need hospital treatment (such as asthma).

The sooner you stop, the better. But stopping even in the last few weeks of pregnancy will benefit you and your baby.

2 Get help

Take advantage of the free NHS support that is available to you. You are four times more likely to quit successfully with NHS support. See the 'Help and support' box on the left for more information.

Ask your friends and family to help and support you.

3 Prepare

If you understand why you smoke and what triggers your smoking, you will be able to prepare yourself so that you can cope when you quit. It can help to:

- give up with somebody else, so that you can support each other
- change the habits you associate with smoking, and
- plan how you will deal with difficult situations without the use of cigarettes.

Choose a day to stop. Will the first few days be easier during a working week or over a weekend? When you are busy or relaxed? Whatever you choose, stop completely on that day.

Review your plan and get rid of all of your cigarettes the day before your day for stopping.

My chosen day for stopping smoking is:

4 Stop smoking

Lots of people start smoking again because they feel they cannot cope with the withdrawal symptoms. The first few days may not be much fun but the symptoms are a sign that your body is starting to recover.

Take one day at a time and reward yourself for success.

Go through your list of reasons for going smokefree to remind yourself why you have given up.

If you have had a scan, use your scan images to keep you going through the times when you are finding it tough.

Secondhand smoke

If your partner or anyone else who lives with you smokes, it can affect you and your baby both before and after birth. You may also find it more difficult to quit.

Secondhand smoke can cause low birth weight and cot death. Infants of parents who smoke are more likely to be admitted to hospital for bronchitis and pneumonia during the first year of life, and more than 17,000 children under the age of five are admitted to hospital every year because of the effects of secondhand smoke.



ALCOHOL

When you drink, alcohol reaches your baby through the placenta. Too much exposure to alcohol can seriously affect your baby's development.

Because of this risk, pregnant women or women trying to conceive should avoid drinking alcohol. If you do choose to drink, then protect your baby by not drinking more than 1 to 2 units of alcohol once or twice a week, and don't get drunk. Additional advice from the National Institute for Health and Clinical Excellence (NICE) advises women to avoid alcohol in the first three months in particular, because of the increased risk of miscarriage.

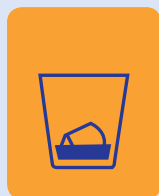
When you drink, alcohol passes from your blood, through the placenta, to your baby. A baby's liver is one of the last organs to develop fully and does not mature until the latter half of pregnancy. Your baby cannot process alcohol as well as you can.

What is a unit of alcohol?

One UK unit is 10ml, or 8g, of pure alcohol. A unit is:



or



or



1/2 pint of beer, lager or cider at 3.5% ABV

a single measure (25ml) of spirit (whisky, gin, bacardi, vodka, etc.) at 40% ABV

1/2 standard (175ml) glass of wine at 11.5% ABV

To find out more about units, visit the Know Your Limits website at www.nhs.uk/units

Drinking is not just dangerous for the baby in the first three months: alcohol can affect your baby throughout pregnancy. And if you drink heavily during pregnancy, a particular group of problems could develop that are known as Fetal Alcohol Syndrome (FAS). Children with this syndrome have:

- restricted growth
- facial abnormalities
- learning and behavioural disorders.

Drinking more than 1 to 2 units once or twice a week, as well as binge drinking, may be associated with lesser forms of FAS. The risk is likely to be greater the more you drink.

If you are drinking with friends:

- find a non-alcoholic drink that you enjoy
- sip any alcohol you do drink slowly to make it last
- don't let people pressure you into drinking, and
- avoid getting drunk.

Help and support

Getting help with drinking

If you have difficulty cutting down what you drink, talk to your doctor, midwife, pharmacist or other healthcare professional. Confidential help and support is available from local counselling services (look in the telephone directory or contact Drinkline on **0800 917 8282**).

You should talk to your midwife if you have any concerns you have about your drinking around the time of conception and early pregnancy. You can get more advice from www.nhs.uk/units



PILLS, MEDICINES AND OTHER DRUGS

Some medicines, including some common painkillers, can harm your baby's health but some are safe, for example medication to treat long-term conditions such as asthma, thyroid disease, diabetes and epilepsy. To be on the safe side, you should:

- always check with your doctor, midwife or pharmacist before taking any medicine
- make sure that your doctor, dentist or other health professional knows you are pregnant before

they prescribe you anything or give you treatment

- talk to your doctor if you take regular medication – ideally before you start trying for a baby or as soon as you find out you are pregnant, and
- use as few over the counter medicines as possible.

Medicines and treatments that are usually safe include paracetamol, most antibiotics, dental treatments (including local anaesthetics), some immunisations (including tetanus and flu injections) and nicotine replacement therapy. But you should always check with your GP, pharmacist or midwife first.

ILLEGAL DRUGS

Illegal drugs like cannabis, ecstasy, cocaine and heroin can harm your baby. If you use any of these drugs, it is important to talk to your doctor or midwife so that they can provide you with advice and support to help you stop. They can also refer you for additional support. Some dependent drug users initially need drug treatment to stabilise or come off drugs to keep the baby safe. For more information, contact Narcotics Anonymous (see page 183) or talk to FRANK, the drugs information line, on 0800 77 66 00.

Medicines for minor ailments when pregnant

- Make sure the medicine is safe to take when pregnant.
- For further information, speak to your pharmacist or NHS Direct on 0845 4647.

Minor ailment	First choice	Second choice	Do not use
Constipation	Eat more fibre. Bulk laxatives that contain ispaghula.	On your doctor's advice: bisacodyl or lactulose.	
Cough	Honey and lemon in hot water. Simple linctus.		Medicines that contain codeine, unless advised by your doctor.
Diarrhoea	Oral rehydration sachets.		Loperamide.
Haemorrhoids (piles)	Soothing creams, ointments or suppositories.	Ice pack.	
Hayfever, house dust mite and animal hair allergy	Antihistamine nasal sprays and eye drops. Steroid nasal sprays.	On your doctor's advice: occasional doses of the antihistamines loratadine or chlorphenamine.	Other antihistamines.
Head lice	Wet combing. Dimeticone lotion.	If ineffective, head lice treatments containing malathion in water (aqueous lotion).	
Indigestion	Antacids (indigestion mixtures).	On your doctor's advice: medicines that reduce acid production, e.g. omeprazole.	
Nasal congestion (stuffy or runny nose)	Steam inhalation (e.g. over a bowl of hot water) or a hot shower.	If severe, occasional doses of oxymetazoline or xylometazoline nasal spray.	Phenylephrine or pseudoephedrine, especially in the 1st trimester.
Pain (e.g. headache, toothache)	Paracetamol.	Ibuprofen may be taken in the 2nd trimester (weeks 14 to 27) but avoid taking it in the 1st or 3rd trimesters unless advised by your doctor.	Medicines that contain codeine (e.g. co-codamol, co-dydramol, dihydrocodeine), unless advised by your doctor.
Threadworms	Pharmacists cannot supply threadworm medicines to pregnant women without a prescription.	On your doctor's advice: mebendazole, but preferably not in the 1st trimester.	
Vaginal thrush	Pharmacists cannot supply medicines for vaginal thrush to pregnant women without a prescription.	On your doctor's advice: clotrimazole pessaries or cream. Do not use the pessary applicator if you are near term (at the end of your pregnancy).	Fluconazole.

Herbal and homeopathic remedies and aromatherapy

Not all 'natural' remedies are safe in pregnancy. Contact the Institute for Complementary and Natural Medicine to make sure that your practitioner is qualified (see page 183). Tell your practitioner that you are pregnant, and tell your midwife or doctor and pharmacist which remedies you are using.

X-RAYS

X-rays should be avoided in pregnancy if possible. Make sure that your dentist knows you are pregnant.

KEEPING ACTIVE

The more active and fit you are during pregnancy, the easier it will be for you to adapt to your changing shape and weight gain. It will also help you to cope with labour and to get back into shape after the birth.

Keep up your normal daily physical activity or exercise (sport, dancing or just walking to the shops and back) for as long as you feel comfortable. Don't exhaust yourself, and remember that you may need to slow down as your pregnancy progresses or if your doctor advises you to. As a general rule, you should be able to hold a conversation as you exercise. If you become breathless as you talk, then you are probably exercising too strenuously.

If you were inactive before you were pregnant, don't suddenly take up strenuous exercise. If you start an aerobic exercise programme, begin with no more than 15 minutes' continuous exercise, three times per week. Increase this gradually to a maximum of 30-minute sessions, four times a week. Inform the instructor that you are pregnant.



Exercise tips

- Exercise doesn't have to be strenuous to be beneficial.
- Make sure that you warm up and cool down.
- Try to keep active on a daily basis. Half an hour of walking each day can be enough. If you cannot manage that, any amount is better than nothing.
- Avoid any strenuous exercise in hot weather.
- Drink plenty of water and other fluids.
- If you go to exercise classes, make sure that your teacher is properly qualified and knows that you are pregnant and how far your pregnancy has progressed.
- You might like to try swimming, because the water will support your increased weight. Some local swimming pools provide aquanatal classes with qualified instructors.

Exercises to avoid

- Lying flat on your back – particularly after 16 weeks. The 'bump' presses on the big blood vessels and can make you feel faint.
- Contact sports where there is a risk of being hit, such as kickboxing, judo or squash.
- Horse riding, downhill skiing, ice hockey, gymnastics and cycling, because there is a risk of falling.
- Scuba diving, because the baby has no protection against decompression sickness and gas embolism.
- Exercising at heights over 2,500 metres until you have acclimatised. This is because you and your baby are at risk of acute mountain sickness (decrease in oxygen).

Exercises for a fitter pregnancy

Try to fit these exercises into your daily routine. They will strengthen your muscles so that you can carry extra weight, make your joints stronger, improve your circulation, ease backache and generally make you feel well.

Stomach-strengthening exercises

These strengthen your stomach (abdominal) muscles and ease backache, which can be a problem in pregnancy. As your baby gets bigger you may find that the hollow in your lower back becomes more pronounced, which can lead to backache.

- Start in a box position (on all fours), with your knees under your hips, your hands under your shoulders, your fingers facing forward and your stomach muscles lifted so that your back is straight.



- Pull in your stomach muscles and raise your back up towards the ceiling, curling your trunk and allowing your head to relax gently forward. Don't let your elbows lock.



- Hold for a few seconds then slowly return to the box position.
- Take care not to hollow your back – it should always return to a straight or neutral position.
- Do this slowly and rhythmically 10 times, making your muscles work hard and moving your back carefully. Only move your back as far as you can comfortably.

Pelvic tilt exercises

Stand with your shoulders and bottom against a wall. Keep your knees soft. Pull your belly button towards your spine, so that your back flattens against the wall. Hold for four seconds and release. Repeat up to 10 times.

Pelvic floor exercises

Pelvic floor exercises help to strengthen the muscles of the pelvic floor, which are placed under great strain in pregnancy and childbirth.

The pelvic floor consists of layers of muscles which stretch like a supportive hammock from the pubic bone (in front) to the base of the backbone. During pregnancy you may find that you leak urine when you cough or strain. This is known as stress incontinence of urine and it can continue after pregnancy. By performing pelvic floor exercises, you strengthen the pelvic floor muscles and this helps to reduce or avoid this problem after pregnancy. It is important to do them even if you are young and not suffering from stress incontinence now.

- Close up your back passage as if trying to prevent a bowel movement.
- At the same time, draw in your vagina as if you are gripping a tampon, and your urethra as if to stop the flow of urine.
- First do this exercise quickly – tightening and releasing the muscles straight away.
- Then do it slowly, holding the contractions for as long as you can before you relax. Try to count to 10.
- Try to do three sets of eight squeezes every day. To help you remember, you could do them once at each meal.

As well as these exercises, you will also need to practise tightening up the pelvic floor before and during coughing and sneezing.

Ask your midwife or doctor about these exercises.

Your local maternity unit should run classes where a specialist physiotherapist attends.

They can instruct you in groups or individually. Feel free to ask them for advice and help.



Foot exercises

Foot exercises can be done sitting or standing. They improve blood circulation, reduce swelling in the ankles and prevent cramp in the calf muscles.

- Bend and stretch your foot vigorously up and down 30 times.
- Rotate your foot eight times one way and eight times the other way.
- Repeat with the other foot.



To protect your back

- Sit up straight with your bottom against the back of your chair. Tuck a small cushion behind your waist if you wish.
- When you pick something up, bend your knees, not your back.
- Try to stand tall.

gentle exercise

INFECTIONS

Rubella

If you catch rubella (or German measles) in the first four months of pregnancy it can seriously affect your baby's sight and hearing and cause brain and heart defects. All children are now offered a vaccine against rubella through the MMR immunisation at 13 months and a second immunisation before they start school.

If you are not immune and you do come into contact with rubella, tell your doctor at once. Blood tests will show whether you have been infected.

More information

For more information, read the information on screening tests in Chapter 4 or go to www.screening.nhs.uk

Sexually transmitted infections

Sexually transmitted infections (STIs) are on the increase. The most common is chlamydia. Up to 70% of women and 50% of men who have an STI show no symptoms, so you may not know if you have one. However, many STIs can affect your baby's health during pregnancy and after birth. If you have any reason to believe that you or your partner has an STI, you should go for a check-up as soon as you can. You can ask your GP or midwife, or go to a genitourinary medicine (GUM) or sexual health clinic. You will be guaranteed strict confidentiality. You can find your nearest GUM clinic or sexual health clinic in your phone book listed under the name of your primary care trust or at www.nhsdirect.nhs.uk or you can call the Sexual Health Helpline free on 0800 567 123.

If you are under 25, you can visit a Brook centre to get free, confidential advice. To find your nearest centre, visit www.brook.org.uk or call the Ask Brook national helpline on 0808 802 1234.

You can contact the National Chlamydia Screening Programme for a free, confidential test. Visit www.chlamydia-screening.nhs.uk

HIV and AIDS

You will be offered a confidential HIV test as part of your routine antenatal care (see page 47). Your doctor or midwife will discuss the test with you, and counselling will be available if the result is positive. You can also go to a GUM clinic for an HIV test and advice.

Current evidence suggests that an HIV positive mother in good health and without symptoms of the infection is unlikely to be adversely affected by pregnancy. HIV positive mothers can pass on the virus through breastmilk. However, it is possible to reduce the risk of transmitting HIV to your baby during pregnancy and after birth (see box on page 47).

If you are HIV positive, talk to your doctor about your own health and the options open to you, or contact the organisations listed on page 185 for advice and counselling.

seek
medical
advice





Hepatitis B

Hepatitis B is a virus that infects the liver. Many people with hepatitis B, will have no signs of illness, but they might infect others. If you have hepatitis B, or are infected during pregnancy, you can pass the infection to your baby at birth. You will be offered a blood test for hepatitis B as part of your antenatal care (see page 47). Babies who are at risk should be immunised at birth. This is 90–95% effective in preventing them from getting hepatitis B and developing long-term infection. The first dose is given within 24 hours of birth and two more doses are given at one and two months, with a booster dose at 12 months. A few babies may also need an injection of hepatitis B immunoglobulin soon after birth. Your baby will be tested for hepatitis B infection at 12 months. Any babies who have become infected should be referred for specialist assessment and follow-up.

You can get infected with HIV, hepatitis B, or hepatitis C if you:

- have sex with someone who is infected without using a condom
- use injectable drugs and share equipment with an infected person.

You may have already been infected with hepatitis B if you were born or spent your childhood outside the UK in a country where hepatitis B is common. (You may have acquired the infection at birth.)

Hepatitis C

Hepatitis C is a virus that infects the liver. Many people with hepatitis C may have no symptoms and be unaware that they are infected. If you have hepatitis C, you might pass the infection to your baby, although the risk is much lower than with hepatitis B or HIV. This cannot be prevented at present. Your baby can be tested for hepatitis C. If they are infected, they can be referred for specialist assessment.

Herpes

Genital herpes infection can be caught through genital contact with an infected person or from oral sex with someone who has oral herpes (cold sores) and can be dangerous for a newborn baby. Initial infection causes very painful blisters or ulcers on the genitals. Less severe attacks usually occur for some years afterwards. If you or your partner are infected, use condoms or avoid sex during an attack. Avoid oral sex if either of you have cold sores or active genital herpes. Tell your doctor or midwife if either you or your partner have recurring herpes or develop the symptoms described above. If your first infection occurs in pregnancy, there is treatment available. If your first infection occurs towards the end of your pregnancy or during

You may have been infected with hepatitis C if you:

- received a blood transfusion in the UK prior to September 1991, or blood products prior to 1986
- received medical or dental treatment in countries where hepatitis C is common and the infection is not controlled properly.

labour, a caesarean section may be recommended to reduce the risk of transmission to your baby.

Chickenpox

Around 95% of women are immune to chickenpox. If you have not had it and you come into contact with someone who has it, speak to your GP, midwife or obstetrician at once. A blood test will establish whether you are immune. Chickenpox infection in pregnancy can be dangerous for both mother and baby, so seek advice as soon as possible.

Toxoplasmosis

This infection can damage your baby if you catch it during pregnancy, so take precautions (see page 38). Most women have already had the infection before pregnancy and will be immune. If you feel you may have been at risk, talk to your GP, midwife or obstetrician. If you do catch toxoplasmosis while you are pregnant, you can get treatment.

Parvovirus B19 (slapped cheek disease)

Parvovirus B19 infection is common in children and causes a characteristic red rash on the face, so it is often called 'slapped cheek disease'.

60% of women are immune to this infection. However, parvovirus B19 is very infectious and can be harmful to your baby. If you come into contact with someone who is infected you should talk to your doctor, who can check whether you are immune through a blood test. In most cases, the baby is not affected when a pregnant woman is infected with parvovirus.

Group B streptococcus

Group B streptococcus (GBS) is a bacterium carried by up to 30% of people which causes no harm or symptoms. In women it is found in the intestine and vagina and causes no problem in most pregnancies. In a very small number it infects the baby, usually just before or during labour, leading to serious illness.

If you have already had a baby who had group B streptococcal infection, you should be offered antibiotics during labour to reduce the chances of your new baby getting the infection. If you have had a group B streptococcal urinary tract infection with GBS (cystitis) during the pregnancy, you should also be offered antibiotics in labour. Group B streptococcal infection of the baby is more likely if your labour is premature, your waters break early, you have a fever during labour or you currently carry GBS. Your midwife or doctor will assess whether you need antibiotics during labour to protect your baby from being infected.

It is possible to be tested for GBS late in pregnancy if you have concerns. Talk to your doctor or midwife.



Infections transmitted by animals

Cats

Cats' faeces can contain an organism which causes toxoplasmosis. Avoid emptying cat litter trays while you are pregnant. If no one else can do it, use disposable rubber gloves. Trays should be cleaned daily and filled with boiling water for five minutes.

Avoid close contact with sick cats and wear gloves when gardening – even if you don't have a cat – in case the soil is contaminated with faeces. Wash your hands and gloves after gardening. If you do come into contact with cat faeces, make sure that you wash your hands thoroughly. Follow the general hygiene rules under 'Preparing food' (page 26).

Sheep

Lambs and sheep can be a source of an organism called *Chlamydia psittaci*, which is known to cause miscarriage in ewes. They also carry toxoplasma. Avoid lambing or milking ewes and all contact with newborn lambs. If you experience flu-like symptoms after coming into contact with sheep, tell your doctor.

Pigs

Research is going on to see if pigs can be a source of hepatitis E infection. This infection is dangerous in pregnant women, so avoid contact with pigs and pig faeces. There is no risk of hepatitis E from eating cooked pork products.

INHERITED CONDITIONS

Some diseases or conditions are inherited from one or both parents. These include cystic fibrosis, haemophilia, muscular dystrophy, sickle cell disorders and thalassaemia. If you, your baby's father or any of your relatives has an inherited condition or if you already have a baby with a disability, talk to your doctor. You may be able to have tests early in pregnancy to check whether your baby is at risk or affected (see page 49). Ask your GP or midwife to refer you to a genetic counsellor (a specialist in inherited diseases) for advice. Ideally, you should do this before you get pregnant or in the early weeks of pregnancy.



WORK HAZARDS

If you work with chemicals, lead or X-rays, or in a job with a lot of lifting, you may be risking your health and the health of your baby. If you have any worries about this, you should talk to your doctor, midwife, occupational health nurse, union representative or personnel department.

If it is a known and recognised risk, it may be illegal for you to continue, and your employer must offer you suitable alternative work on the same terms and conditions as your original job. If no safe alternative is available, your employer should suspend you on full pay (give you paid leave) for as long as necessary to avoid the risk. If your employer fails to pay you during your suspension, you can bring a claim in an employment tribunal (within three months). This will not affect your maternity pay and leave. See also pages 168–169.

Coping at work

You might get extremely tired – particularly in the first few and last few weeks of your pregnancy. Try to use your lunch break to eat and rest, not to do the shopping. If travelling in rush hour is exhausting, ask your employer if you can work slightly different hours for a while.

Don't rush home and start another job cleaning and cooking. If you have a partner, ask them to take over. If you are on your own, keep housework to a minimum, and go to bed early if you can.

Your rights to antenatal care, leave and benefits are set out in Chapter 17.

Computer screens

The most recent research shows no evidence of a risk from visual display units on computer terminals and word processors.

FLYING AND TRAVEL

Flying is not harmful for you or your baby, but some airlines will not let you fly towards the end of your pregnancy, and you should check conditions with them.



Long distance travel (longer than five hours) carries a small risk of thrombosis (blood clots) in pregnant women. If you fly, drink plenty of water to stay hydrated and do the recommended calf exercises.

You can buy a pair of support stockings in the pharmacy over the counter, which will reduce leg swelling.

Before you travel, think about your destination. Could you get medical help if you needed it? Are any immunisations needed which might be harmful to the pregnancy?

If you are travelling to Europe, make sure that you have a European Health Insurance Card (formerly known as E111), which entitles you to free treatment while abroad. You can get this from:

- a post office
- by calling 0845 606 2030, or
- from www.ehic.org



Safety on the move

Road accidents are among the most common causes of injury in pregnant women. To protect yourself and your baby, always wear your seatbelt with the diagonal strap across your body between your breasts and with the lap belt over your upper thighs. The straps should lie above and below your bump, not over it.



ANTENATAL CARE

4



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Antenatal care is the care that you receive from healthcare professionals during your pregnancy. You will be offered a series of appointments with a midwife, or sometimes with a doctor (an obstetrician). They will check that you and your baby are well, give you useful information about being pregnant and what to expect as well as answering any questions you may have.

As soon as you know you are pregnant, you should get in touch with a midwife or your GP to organise your antenatal care. It's best to see them as early as possible. Let your midwife know if you have a disability that means you have special requirements for your antenatal appointments or labour. If you don't speak English, let your midwife know and arrangements will be made for an interpreter.

It is important to tell your midwife or doctor if:

- there were any complications or infections in a previous pregnancy or delivery, such as pre-eclampsia or premature birth
- you are being treated for a chronic disease such as diabetes or high blood pressure
- you or anyone in your family has previously had a baby with an abnormality, for example spina bifida
- there is a family history of an inherited disease, for example sickle cell or cystic fibrosis.



If you are working, you have the right to paid time off for your antenatal care (see page 170).

Information

An important part of antenatal care is getting information that will help you to make informed choices about your pregnancy. Your midwife or doctor should give you information in writing or some other form that you can easily use and understand. Your midwife or doctor should provide you with information in an appropriate format if you:

- have a physical, learning or sensory disability
- do not speak or read English.

You may have lots of things you want to ask the midwife. It's a good idea to write your questions down, so you don't forget.



ANTENATAL APPOINTMENTS

If you are expecting your first child, you are likely to have up to 10 appointments. If you have had a baby before, you should have around seven appointments. In certain circumstances, for example if you have or develop a medical condition, you may have more appointments.

Your appointments may take place at your home, in a Children's Centre, in your GP's surgery or in hospital. You may be asked to go to hospital for your scans.

Your antenatal appointments should take place in a setting where you feel able to discuss sensitive problems that may affect you (such as domestic violence, sexual abuse, mental illness or recreational drug use).

Early in your pregnancy your midwife or doctor should give you information about how many appointments you are likely to have and when they will happen. You should have a chance to discuss the schedule with them. The table on pages 42–43 gives a brief guide to what usually happens at each antenatal appointment.



If you cannot keep an antenatal appointment, please let the clinic or midwife know and make another appointment.

What should happen at the appointments

The aim is to check on you and your baby's progress and to provide clear information and explanations about your care. At each appointment you should have the chance to ask questions and discuss any concerns or issues with your midwife or doctor.

Each appointment should have a specific purpose. You will need longer appointments early in pregnancy to allow plenty of time for your midwife or doctor to assess you, discuss your care and give you information. Wherever possible, the appointments should include any routine tests.

Help and support

If you have any questions or worries, talk to your midwife or doctor. Talking is as much a part of antenatal care as tests and examinations.



Antenatal appointments schedule



Appointment	What should happen
First contact with your midwife or doctor	<p>This is the appointment when you tell your midwife or doctor that you are pregnant. They should give you information about:</p> <ul style="list-style-type: none"> • folic acid and vitamin D supplements • nutrition, diet and food hygiene • lifestyle factors, such as smoking, drinking and recreational drug use • antenatal screening tests. <p>It is important to tell your midwife or doctor if:</p> <ul style="list-style-type: none"> • there were any complications or infections in a previous pregnancy or delivery, such as pre-eclampsia or premature birth • you are being treated for a chronic disease such as diabetes or high blood pressure • you or anyone in your family has previously had a baby with an abnormality, for example spina bifida • there is a family history of an inherited disease, for example sickle cell or cystic fibrosis.
Booking appointment (8–12 weeks)	<p>Your midwife or doctor should give you information about:</p> <ul style="list-style-type: none"> • how the baby develops during pregnancy • nutrition and diet • exercise and pelvic floor exercises • antenatal screening tests • your antenatal care • breastfeeding, including workshops • antenatal education • maternity benefits • planning your labour • your options for where to have your baby. <p>Your midwife or doctor should:</p> <ul style="list-style-type: none"> • give you your hand-held notes and plan of care • see if you may need additional care or support • plan the care you will get throughout your pregnancy • identify any potential risks associated with any work you may do • measure your height and weight and calculate your body mass index • measure your blood pressure and test your urine for protein • find out whether you are at increased risk of gestational diabetes or pre-eclampsia • offer you screening tests and make sure you understand what is involved before you decide to have any of them • offer you an ultrasound scan at eight to 14 weeks to estimate when your baby is due • offer you an ultrasound scan at 18 to 20 weeks to check the physical development of your baby and screen for possible abnormalities.
8–14 weeks (dating scan)	<p>Ultrasound scan to estimate when your baby is due, check the physical development of your baby and screen for possible abnormalities.</p>
16 weeks	<p>Your midwife or doctor should give you information about the ultrasound scan you will be offered at 18 to 20 weeks and help with any concerns or questions you have. Your midwife or doctor should:</p> <ul style="list-style-type: none"> • review, discuss and record the results of any screening tests • measure your blood pressure and test your urine for protein • consider an iron supplement if you are anaemic.
18–20 weeks (anomaly scan)	<p>Ultrasound scan to check the physical development of your baby. (Remember, the main purpose of this scan is to check that there are no structural abnormalities.)</p>



25 weeks*	Your midwife or doctor should: <ul style="list-style-type: none"> • check the size of your uterus • measure your blood pressure and test your urine for protein.
28 weeks	Your midwife or doctor should: <ul style="list-style-type: none"> • use a tape to measure the size of your uterus • measure your blood pressure and test your urine for protein • offer more screening tests • offer your first anti-D treatment if you are rhesus negative.
31 weeks*	Your midwife or doctor should: <ul style="list-style-type: none"> • review, discuss and record the results of any screening tests from the last appointment • use a tape to measure the size of your uterus • measure your blood pressure and test your urine for protein.
34 weeks	Your midwife or doctor should give you information about preparing for labour and birth, including how to recognise active labour, ways of coping with pain in labour and your birth plan. Your midwife or doctor should: <ul style="list-style-type: none"> • review, discuss and record the results of any screening tests from the last appointment • use a tape to measure the size of your uterus • measure your blood pressure and test your urine for protein • offer your second anti-D treatment if you are rhesus negative.
36 weeks	Your midwife or doctor should give you information about: <ul style="list-style-type: none"> • feeding your baby • caring for your newborn baby • vitamin K and screening tests for your newborn baby • your own health after your baby is born • the 'baby blues' and postnatal depression. Your midwife or doctor should: <ul style="list-style-type: none"> • use a tape to measure the size of your uterus • check the position of your baby • measure your blood pressure and test your urine for protein.
38 weeks	Your midwife or doctor will discuss the options and choices about what happens if your pregnancy lasts longer than 41 weeks. Your midwife or doctor should: <ul style="list-style-type: none"> • use a tape to measure the size of your uterus • measure your blood pressure and test your urine for protein.
40 weeks*	Your midwife or doctor should give you more information about what happens if your pregnancy lasts longer than 41 weeks. Your midwife or doctor should: <ul style="list-style-type: none"> • use a tape to measure the size of your uterus • measure your blood pressure and test your urine for protein.
41 weeks	Your midwife or doctor should: <ul style="list-style-type: none"> • use a tape to measure the size of your uterus • measure your blood pressure and test your urine for protein • offer a membrane sweep • discuss the options and choices for induction of labour.

* Extra appointment if this is your first baby

EARLY ANTENATAL APPOINTMENTS

In early pregnancy (up until 20–24 weeks), your antenatal appointments will take longer than those in mid-pregnancy. This is because your midwife or doctor will need time to assess you and your baby, discuss your care and give you information. At each appointment you should have the chance to ask questions and discuss any concerns or issues.

Your first appointment with your midwife or GP

As soon as you think you are pregnant, you should make an appointment to see your midwife or GP. The earlier you do this, the better. At this appointment you will be given information about:

- folic acid and vitamin D supplements
- nutrition and diet
- food hygiene
- lifestyle factors that may affect your health or the health of your baby, such as smoking, recreational drug use and alcohol consumption
- antenatal screening tests (see page 49 for more about these tests).

Your booking appointment

Most women have their 'booking appointment' between the 8th and 12th week of pregnancy. This can take a couple of hours. You will see a midwife and sometimes a doctor. You should also be offered an ultrasound scan.



You should be given information about:

- how the baby develops during pregnancy
- nutrition and diet
- exercise and pelvic floor exercises
- antenatal screening tests
- your antenatal care



- breastfeeding, including workshops
- antenatal education
- maternity benefits
- planning your labour
- your options for where to have your baby.

More information

See the NHS Choices pregnancy planner at www.nhs.uk/pregnancyplanner

Weight and height

You will be weighed at the booking appointment, but you probably will not be weighed regularly during your pregnancy. Your height will be measured along with your weight so that your midwife can calculate your BMI (body mass index). Most women put on between 10 and 12.5kg (22–28lbs) in pregnancy, most of it after the 20th week. Much of the extra weight is due to the baby growing, but your body will also be storing fat ready to make breastmilk after the birth. Eating sensibly and taking regular exercise can help. See Chapter 3 for what you should eat and for advice about exercise.

In some areas, height, weight and BMI are used to produce a personalised growth chart for your baby's development. However, other areas will use an average growth chart instead.



Questions at the booking appointment

You will be asked a lot of questions to build up a picture of you and your pregnancy. This is so that you are given the support you need and any risks are spotted early. You will probably want to ask a lot of questions yourself.

You may be asked about:

- the date of the first day of your last period, to help work out when your baby is due
- your health
- any previous illnesses and operations
- any previous pregnancies or miscarriages
- your and your baby's father's origins. This is to find out if your baby is at risk of certain inherited conditions, or if there are other factors, such as a history of twins
- your work or your partner's work and what kind of accommodation you live in, to see if there is anything about your circumstances that might affect your pregnancy
- how you are feeling and if you have been feeling depressed.

At the end of your booking appointment, you should understand the plan of care for your pregnancy and have your hand-held notes to carry with you at all times.

Your booking appointment is an opportunity to tell your midwife or doctor if you are in a vulnerable situation or if you need extra support. This could be because of domestic violence, sexual abuse or female genital mutilation.

If you are going to have your baby with midwifery care in a midwifery unit, in hospital or at home

You will probably see your own midwife for most of your antenatal care. You may be offered a visit at the hospital for an initial assessment and perhaps for an ultrasound scan or for special tests. Sometimes your midwife may visit you at home.

If you are going to have your baby in hospital

Antenatal care varies around the country. In some areas, the booking appointment is at the hospital, then all or most of the remaining appointments are with a midwife or GP. However, if there are complications, all appointments will be at the hospital. In other areas, all care is given by a midwife or GP unless there are complications, which mean a referral to the hospital antenatal clinic.

REGULAR CHECKS AT EVERY ANTENATAL APPOINTMENT

Your urine and blood pressure will be checked at every antenatal appointment.

Urine

Your urine is checked for a number of things, including protein or 'albumin'. If this is in your urine, it may mean that you have an infection that needs to be treated. It may also be a sign of pre-eclampsia (see 'High blood pressure and pre-eclampsia' on page 67).

Blood pressure



A rise in blood pressure later in pregnancy could be a sign of pre-eclampsia (see page 67). It is very common for your blood pressure to be lower in the middle of your pregnancy than at other times. This is not a problem, but may make you feel light-headed if you get up quickly. Talk to your midwife if you are concerned.



APPOINTMENTS IN LATER PREGNANCY

From 20–24 weeks, your antenatal appointments will become more frequent. If your pregnancy is uncomplicated and you are well, you may not be seen as often.

Your later appointments are usually quite short. Your midwife or doctor will:

- check your urine, blood pressure, and sometimes your weight
- feel your uterus to check your baby's position
- measure your uterus to check your baby's growth
- listen to your baby's heartbeat if you want them to.



You can also ask questions or talk about anything that is worrying you. You should be given information about:

- your plan of birth
- how to prepare for labour and birth
- how to tell if you are in active labour
- induction of labour if your baby is late
- the 'baby blues' and postnatal depression
- feeding your baby
- screening tests for newborn babies
- looking after yourself and your new baby.

Checking your baby's development and well-being

At each antenatal appointment from 24 weeks, your midwife or doctor should check your baby's growth. To do this, they will measure the distance from the top of your uterus to your pubic bone. The measurement will be recorded in your notes.

In the last weeks of pregnancy, you may also be asked to keep track of your baby's movements. If your baby's movements become less frequent, slow down or stop, contact your midwife or doctor immediately.

You will be offered an ultrasound scan if your midwife or doctor has any concerns about your baby's growth.



BLOOD TESTS

As part of your antenatal care, you will be offered a number of blood tests. Some are offered to all women and some are only offered if it is thought that you are at risk of a particular infection or inherited condition. All of the tests are done to help make your pregnancy safer or to check that your baby is healthy. Talk to your midwife or doctor so that you understand why the blood tests are being offered and so that you can make an informed choice about whether or not you want them. Your midwife or doctor should also give you information about the tests. Below is an outline of all the tests that can be offered.

Your blood group and rhesus factor

Your blood will be tested to check your blood group and to see whether you are rhesus negative or positive. Some women are rhesus negative. This is usually not a worry for a first pregnancy but it may affect the next child.

People who are rhesus positive have a substance known as D antigen on the surface of their red blood cells. Rhesus negative people do not. A woman who is rhesus negative can carry a baby who is rhesus positive if the baby's father is rhesus positive. During pregnancy or birth, small amounts of the baby's blood can enter the mother's bloodstream. This can cause the mother to produce antibodies. This usually doesn't affect the existing pregnancy, but the woman becomes 'sensitised'. This means that if she gets pregnant with another rhesus positive baby, the immune response will be quicker and much greater. The antibodies produced by the

mother can cross the placenta and attach to the D antigen on her baby's red blood cells. This can be harmful to the baby as it may result in a condition called haemolytic disease of the newborn, which can lead to anaemia and jaundice.

Prevention of rhesus disease

Anti-D injections prevent rhesus negative women producing antibodies against the baby and reduce the risk of a rhesus negative woman becoming sensitised.

Rhesus negative mothers who are not sensitised are offered anti-D injections at 28 and 34 weeks as well as after the birth of their baby. This is quite safe for both the mother and her baby.

Anaemia

Anaemia makes you tired and less able to cope with any loss of blood when you give birth. If tests show you are anaemic, you will probably be given iron and folic acid.



Immunity to rubella (German measles)

If you get rubella in early pregnancy, it can seriously damage your unborn baby. Your midwife or doctor will talk to you about what happens if your test results show low or no immunity. You will be offered a rubella immunisation after your baby is born. For more information about rubella, visit www.immunisation.nhs.uk

Syphilis

You will be tested for this sexually transmitted infection because if left untreated, it can lead to miscarriage and stillbirth.

Hepatitis B

This is a virus that can cause serious liver disease. If you have the virus or are infected during pregnancy, it may infect your baby (see page 37). Your baby will not usually be ill but has a high chance of developing long-term infection and serious liver disease later in life. Your baby can start a course of immunisation at birth to help prevent infection. If you have hepatitis B, you will be referred to a specialist.

Hepatitis C

This virus can cause serious liver disease and there is a small risk that it may be passed to your baby if you are infected. This cannot be prevented at present. Tests for hepatitis C are not usually offered routinely as part of antenatal care. If you think you may be at risk (see page 37), talk to your midwife or GP. They can arrange a test. If you are infected, your baby can be tested within a few days of birth. If you have hepatitis C, you will be referred to a specialist.

HIV

This is the virus that causes AIDS. If you are infected you can pass the infection to your baby during pregnancy, at delivery, or after birth by breastfeeding. As part of your routine antenatal care, you will be offered a confidential test for HIV infection. If you are HIV positive, both you and your baby can have treatment and care that reduce the risk of your baby becoming infected. If your test result is negative, the fact that you had the test as part of your antenatal care should not affect your ability to get insurance.

If you are HIV positive

If you are HIV positive, your doctor will need to discuss the management of your pregnancy and delivery with you.

- There is a one in four chance of your baby being infected if you and your baby don't have treatment.
- Treatment can significantly reduce the risk of transmitting HIV from you to your baby. 20% of HIV-infected babies develop AIDS or die within the first year of life, so it's important to reduce the risk of transmission.
- Your labour will be managed to reduce the risk of infection to your baby. This may include an elective caesarean delivery (see page 98).
- Your baby will be tested for HIV at birth and at intervals for up to two years. If your baby is found to be infected with HIV, paediatricians will be able to anticipate certain illnesses that occur in infected babies, and treat them early. All babies born to HIV positive mothers will appear to be HIV positive at birth, because they have antibodies from their mother's infection. If the baby is not affected, the test will later become negative because the antibodies will disappear.
- You will be advised not to breastfeed because HIV can be transmitted to your baby in this way.

Help and support

If you think that you are at risk of getting HIV or know you are HIV positive, talk to your midwife or doctor about HIV testing and counselling. You can also get free confidential advice from the National AIDS Helpline on 0800 567 123 or you can talk in confidence to someone at Positively Women (see page 185).

Sickle cell and thalassaemia disorders

Sickle cell and thalassaemia disorders are inherited blood conditions that mainly affect the way oxygen is carried around the body. You will be offered a blood test early in pregnancy for thalassaemia and asked for information about your and your baby's father's family origin to decide if any other tests are required. The information you give will help your midwife or doctor to offer the correct tests and will also help to give you the correct results of the test. It is very important that you tell the midwife, doctor or person doing the test if you think you or your baby's father have an ancestor who came from outside northern Europe (for example, someone who is Italian, Maltese, Portuguese, Spanish, Indian, Chinese, African or African-Caribbean).

Healthy people can be carriers of sickle cell or thalassaemia without knowing it and can pass it on to their children. It's possible for you or your baby's father to be carriers of these disorders without it affecting your baby at all. Carriers cannot develop the disorders, but if both of you are carriers there is a risk that your baby could have a sickle cell or thalassaemia disorder. Your midwife or doctor will discuss the implications for your baby. For further information contact the Sickle Cell Society (www.sicklecellsociety.org) or the UK Thalassaemia Society (www.ukts.org) for more details.

Cystic fibrosis

Cystic fibrosis is an inherited disease that affects vital organs in the body, especially the lungs and digestive system, by clogging them with thick sticky mucus. The sweat glands are usually also affected. The disease is inherited and both parents must be carriers of the gene variation for their baby to be born with cystic fibrosis. Testing is offered if there is a family history of cystic fibrosis.

Tay-Sachs disease

Testing for Tay-Sachs disease should be offered if you or your partner is of Ashkenazi Jewish origin and if you consider yourself or your partner to be at risk.

Cervical cancer

Cervical smears detect early changes in the cervix (the neck of the uterus), which could later lead to cancer if left untreated. Routine smears are only offered to women over 25. If you are due to have a cervical smear (if you have not had one in the last three years), you will probably be told to wait until three months after your baby is born unless you have a history of abnormal smears. This is based on guidance by the NHS cervical screening programme. For more information, go to www.cancerscreening.nhs.uk

Herpes

If you, or your partner, have ever had genital herpes, or you get your first attack of genital blisters or ulcers during your pregnancy, let your midwife or doctor know. Herpes can be dangerous for your newborn baby and it may need treatment.



ULTRASOUND SCANS

Most hospitals will offer women at least two ultrasound scans during their pregnancy. The first is usually around eight to 14 weeks and is sometimes called the dating scan because it can help to determine when the baby is due. The second scan usually takes place between 18 and 20 weeks and is called the anomaly scan because it checks for structural abnormalities.

Ultrasound scans use sound waves to build up a picture of your baby in your uterus. They are completely painless, have no known serious side effects on mothers or their babies, and may be carried out for medical need at any stage of pregnancy. If you have any concerns about having a scan, talk it over with your midwife, GP or obstetrician.



What do scans tell us?

- Check your baby's measurements. This gives a better idea of when your baby was conceived and when it is likely to be born. This can be useful if you are unsure about the date of your last period or if your menstrual cycle is long, short or irregular. Your due date may be adjusted depending on the ultrasound measurements.
- Check whether you are carrying more than one baby.
- Detect some abnormalities, particularly in your baby's head or spine.
- Show the position of your baby and your placenta. Sometimes a caesarean section is recommended – for example if your placenta is low lying in late pregnancy.
- Check that your baby is growing and developing as expected (this is particularly important if you are carrying twins or more).



At the scan

You may be asked to drink a lot of fluid before you have the scan. A full bladder pushes your uterus up and this gives a better picture. You then lie on your back and some jelly is put on your abdomen. An instrument is passed backwards and forwards over your skin and high-frequency sound is beamed through your abdomen to the uterus and pelvis.

The sound is reflected back and creates a picture that is shown on a screen. It can be very exciting to see a picture of your own baby moving about inside you.

Ask for the picture to be explained to you if you cannot make it out. It should be possible for your partner to come with you and see the scan. Although scans are medical procedures, many couples feel that they help to make the baby real for them both. Ask if it's possible to have a copy of the picture. There may be a small charge for this.



Fetal movement

You will usually start feeling some movements between 16 and 22 weeks. Later in pregnancy your baby will develop its own pattern of movements – which you will soon get to know.

These movements will range from kicks and jerks to rolls and ripples and you should feel them every day. At each antenatal appointment, your midwife will talk to you about the pattern of movements. A change, especially a reduction in movements, may be a warning sign that your baby needs further tests. Try to become familiar with your baby's typical daily pattern and contact your midwife or maternity unit immediately if you feel that the movements have changed.

TESTS TO DETECT ABNORMALITIES

You will be offered screening tests that can detect structural abnormalities like spina bifida, which is a defect in the development of the spine, or some chromosomal disorders like Down's syndrome, which is caused by an abnormal number of chromosomes. Different maternity services may use different tests, but all tests carried out in the NHS will meet national standards. Discuss the tests and what they mean with your midwife.

Screening tests can:

- reassure you that your baby has no detected structural abnormalities
- provide you with an opportunity to see your baby during the scan
- give you time to prepare for the arrival of a baby with special needs
- allow you to consider the termination of an affected baby.

Tests can also provide valuable information for your care during the pregnancy. However, no test can guarantee that your baby will be born without an abnormality. No test is 100% accurate and some abnormalities may remain undetected.

Deciding whether to have tests

You may not want to have a screening test if you think that you would continue your pregnancy whatever the results. If you do have a screening test and it suggests an increased chance of a chromosomal abnormality, you will be offered diagnostic tests, which will give a more definite diagnosis. These diagnostic tests carry a small risk of miscarriage, so you may decide not to have them. Discussing the issues with your partner, midwife, doctor and friends may help you in deciding what is right for you.

Haemophilia and muscular dystrophy

Some disorders, such as haemophilia and muscular dystrophy, are only found in boys (although girls may carry the disorder in their chromosomes and pass it on to their sons). Tell your midwife or doctor if these or other genetic disorders run in your family, as it may then be important to know your baby's sex.

TESTS FOR DOWN'S SYNDROME AND OTHER GENETIC DISORDERS

These tests are offered to all pregnant women. There are different ways of carrying out screening.

Combined screening

Combined screening involves a blood test and an ultrasound scan. All women should have dating and nuchal translucency scans between eight and 14 weeks. These scans may be combined. The blood test

measures two pregnancy-associated blood chemicals. At the scan, the radiographer measures the thickness of the nuchal translucency at the back of your baby's neck. This information is used to calculate your individual statistical chance of having a baby with Down's syndrome. This nuchal translucency scan can be used in multiple pregnancies. For more information about screening for anomalies, visit www.fetalanomaly.screening.nhs.uk/publicationsandleaflets

Serum screening

Serum screening is a blood test that screens for Down's syndrome, usually at about 16 weeks into your pregnancy. It measures three or four pregnancy-associated blood chemicals to give your individual statistical chance of having a baby with Down's syndrome. Serum screening on its own is not recommended for twin and other multiple pregnancies.

Screening results

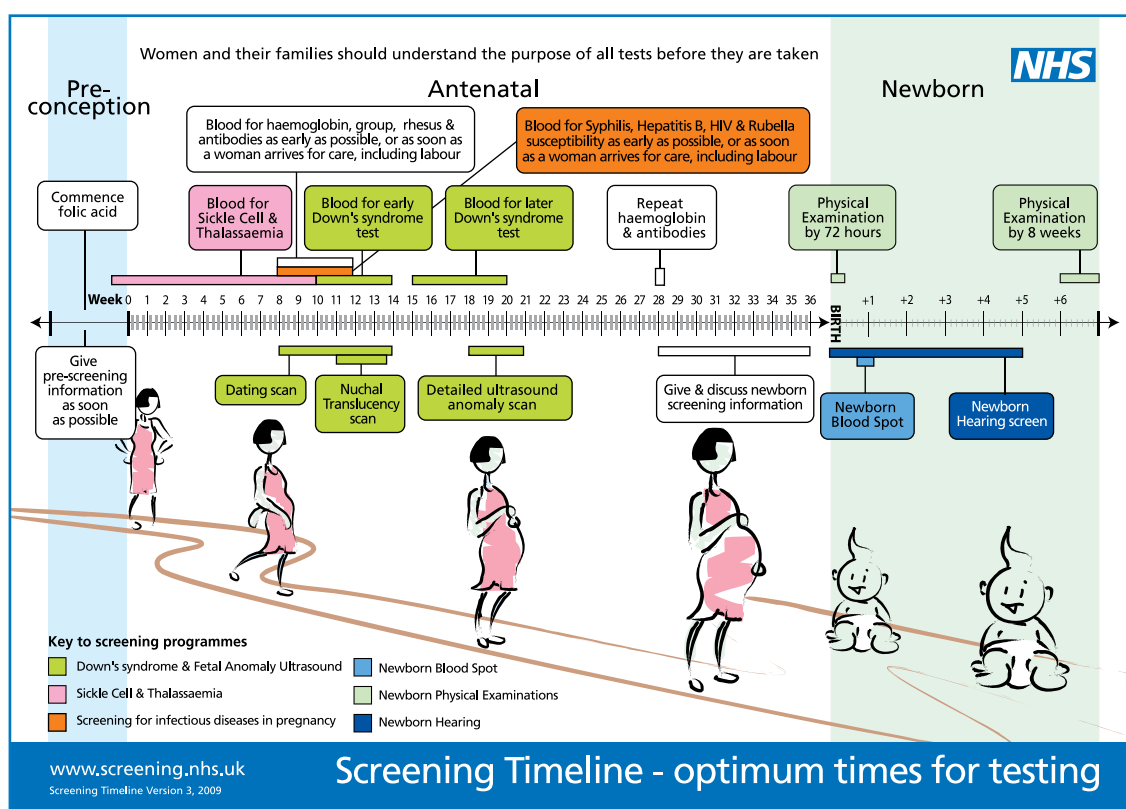
Some maternity services give the result as 'lower risk/screen negative' or 'higher risk/screen positive'.

If the screening test shows the risk of the baby having Down's syndrome is lower than the recommended national cut-off, this is known as having a 'low-risk' result. A low-risk result means that you are at a low-risk of having a baby with Down's syndrome, but it does not mean there is no risk.

If the result shows the risk of the baby having Down's syndrome is greater than the recommended national cut-off, this is known as an 'increased risk' or 'higher risk' result. An increased risk means you will be offered diagnostic test but it does not mean that your baby definitely has the condition. The diagnostic procedure you will be offered is either chorionic villus sampling (CVS) (see next page) or amniocentesis to give you a definite answer about Down's syndrome. Your midwife or doctor will explain the result to you and help you decided whether you want to have further tests.

More information

- www.library.nhs.uk
- www.screening.nhs.uk



Amniocentesis

Amniocentesis can be offered from 15 weeks of pregnancy if:

- you have a positive or higher risk Down's syndrome screening result
- an ultrasound scan detects an abnormality that is associated with a genetic disorder
- your past history or family history suggests that there may be a risk of your baby having a genetic or chromosomal disorder such as Down's syndrome, sickle cell disorder or thalassaemia.

What happens

Using ultrasound as a guide, a fine needle is passed through the wall of the abdomen into the amniotic fluid that surrounds your baby. Within the fluid are cells that contain the same chromosomes as your baby. A small sample of this fluid is drawn off and sent to a laboratory for testing. Most women feel only mild discomfort.

Usually, the fluid will be tested for Down's syndrome and other serious syndromes. The results should be available within three working days. If all the chromosomes have to be looked at, it can take up to three weeks. This test will reveal your baby's sex, so tell your midwife or doctor whether, at this stage, you want to know if your baby is a boy or a girl.

The risks

Amniocentesis has a 0.5–1% risk of miscarriage. At most, one test in 100 will result in pregnancy loss. When deciding whether or not to go ahead with this test, try to balance the risk of miscarriage against the value of the result to you.

DIAGNOSTIC TESTS FOR DOWN'S SYNDROME AND OTHER GENETIC DISORDERS

These tests will give you a definite diagnosis of Down's syndrome and sometimes other abnormalities.

Your midwife or doctor will explain what is involved and you will usually be offered counselling.

Chorionic villus sampling (CVS)

CVS can be carried out at around 11 weeks. It can give you an earlier diagnosis if you are at risk of having a child with an inherited disorder, such as cystic fibrosis, sickle cell disorder, thalassaemia or muscular dystrophy.

What happens?

The test takes 10 to 20 minutes and may be a little uncomfortable. Using ultrasound as a guide, a fine needle is passed through the abdomen into the uterus.

Sometimes a fine tube is passed through the vagina and cervix into the uterus instead. A tiny piece of the developing placenta, known as chorionic tissue, is taken. The chromosomes in the cells of this tissue are examined. As with amniocentesis, a rapid result can be obtained, but if all the chromosomes are going to be checked the results may take up to two weeks.

The risks

CVS has a 1–2% risk of miscarriage. This is slightly higher than amniocentesis.

IF A TEST DETECTS AN ABNORMALITY

It is always difficult when you are told there is something wrong with your baby, especially if you are faced with a painful decision about the future of your pregnancy. Your midwife or doctor will make sure you see the appropriate health professionals to help you get all the information and support you need so you can make the choices that are right for you and your family.

Help and support

Antenatal Results and Choices (ARC) (see page 186) helps parents with all issues associated with antenatal testing and its implications. They can give you more information or put you in touch with parents who decided to continue with a pregnancy in which an abnormality had been detected or those who decided to have a termination. Go to www.arc-uk.org for more information.





MAKING THE MOST OF ANTENATAL CARE

Having regular antenatal care is important for your health and the health of your baby. Most antenatal services are now provided in easily accessible community settings. Waiting times in clinics can vary, and this can be particularly difficult if you have young children with you. Try to plan ahead to make your visits easier. Here are some suggestions:

- In some clinics you can buy refreshments. If not, take a snack with you if you are likely to get hungry.
- Write a list of questions you want to ask and take it with you to remind you. Make sure you get answers to your questions or the opportunity to discuss any worries.
- If your partner is free, they may be able to go with you. This can help them feel more involved in the pregnancy.



Your hand-held antenatal notes

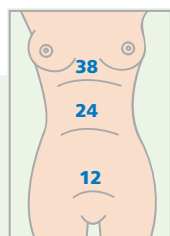
At your first antenatal visit, your midwife will enter your details in a record book and add to them at each visit. You should be asked to keep your maternity notes at home with you and to bring them along to all your antenatal appointments. Take your notes with you wherever you go. Then, if you need medical attention while you are away from home, you will have the information that is needed with you.

The chart on the right gives a sample of the information your card or notes may contain, but each clinic has its own system. Always ask your midwife or doctor to explain anything they write on your card.

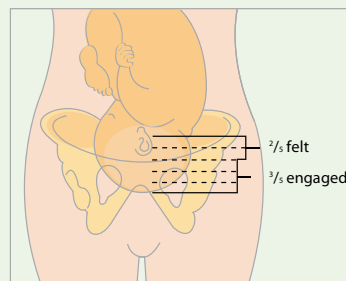
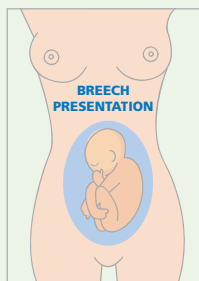
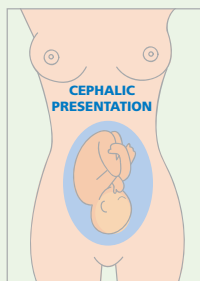
- 1 Date.** This is the date of your antenatal visit.
- 2 Weeks.** This refers to the length of your pregnancy in weeks from the date of your last menstrual period.
- 3 Weight.** This is your weight.
- 4 Urine.** These are the results of your urine tests for protein and sugar. '+' or 'Tr' means a quantity (or trace) has been found. 'Alb' stands for 'albumin', a name for one of the proteins detected in urine. 'Nil' or a tick or 'NAD' all mean the same: nothing abnormal has been discovered. 'Ketones' may be found if you have not eaten recently or have been vomiting.

DATE	WEEKS	WEIGHT	URINE ALB SUGAR	BP
1	2	3	4	5
15/6/09	13	58kg	Nil	110/60
20/7/09	18	59.2kg	Nil	125/60
21/8/09	22	61kg	Nil	135/65
18/9/09	26+	64kg	Nil	125/75
28/10/09	30	66kg	Nil	125/70
27/11/09	34	–	Nil	115/75

- 5 Blood pressure (BP).** This should stay at about the same level throughout your pregnancy. If it goes up a lot in the last half of your pregnancy, it may be a sign of pre-eclampsia (see page 67).



- 6 Height of fundus.** By gently pressing on your abdomen, the midwife or doctor can feel your uterus. Early in pregnancy the top of the uterus, or 'fundus', can be felt low down, below your navel. Towards the end it is well up above your navel, just under your breasts. The figure should be roughly the same as the figure in the 'weeks' column. If there is a big difference (more than two weeks), ask your midwife what action is appropriate.



- 7 Presentation.** This refers to which way up your baby is. Up to about 30 weeks, your baby moves about a lot. Then they usually settle into a head-downward position, ready to be born head first. This is recorded as 'Vx' (vertex) or 'C' or 'ceph' (cephalic). Both words mean the top of the head. If your baby stays with its bottom downwards, this is a breech ('Br') presentation. 'PP' means presenting part, which is the part (head or bottom) of your baby that is coming first. 'Tr' (transverse) means your baby is lying across your abdomen.

- 8 Relation to brim.** At the end of pregnancy, your baby's head (or bottom, or feet if they are in the breech position) will start to move into your pelvis. Professionals 'divide' the baby's head into 'fifths' and describe how far it has moved down into the pelvis by judging how many 'fifths' of the head they can feel above the brim (the bone at the front). They may say that the head is 'engaged' – this is when 2/5 or less of your baby's head can be felt ('palpated') above the brim. This may not happen until you are in labour. If all of your baby's head can be felt above the brim, this is described as 'free' or '5/5 palpable'.

HEIGHT FUNDUS	PRESENTATION	RELATION OF PP TO BRIM	FH	OEDEMA	Hb	NEXT	SIGN.	NOTES
6	7	8	9	10	11			
15	–	–	–	–	12.0	20/7	JS	u/s arranged for 17/7 to check maturity
18–20	–	–	FMF	–	–	21/8	JS	
20	–	–	–	–	–	18/9	JS	taking iron
24–26	–	–	H	–	11.2	28/10	JS	Health in Pregnancy Grant
30	ceph	5/5	FHH	–	–	27/11	JS	MAT B1 given, Hb taken
34	ceph	4/5	FHH	–	11.0	15/12	JS	

- 9 Fetal heart (FH).** 'FHH' or just 'H' means 'fetal heart heard'. 'FMF' means 'fetal movement felt'.
- 10 Oedema.** This is another word for swelling, often of the feet and hands. Usually it is nothing to worry about, but tell your midwife or doctor if it suddenly gets worse as this may be a sign of pre-eclampsia (see page 67).
- 11 Hb.** This stands for 'haemoglobin'. It is tested in your blood sample to check if you are anaemic.

YOUR ANTENATAL TEAM

While you are pregnant you should normally see a small number of healthcare professionals, led by your midwife or doctor, on a regular basis. They want to make you feel happy with all aspects of the care you receive, both while you are pregnant and when you have your baby.

Many mothers would like to be able to get to know the people who care for them during pregnancy and the birth of their baby. The NHS is working to achieve this but you may still find that you see a number of different carers. The professionals you see should introduce themselves

and explain who they are, but if they forget, don't hesitate to ask. It may help to make a note of who you have seen and what they have said in case you need to discuss any point later on.



The people you are most likely to meet are listed below

- **A midwife** is specially trained to care for mothers and babies throughout pregnancy and labour and after the birth. Midwives provide care for the majority of women at home or in hospital. Increasingly, midwives will be working both in hospitals and in the community, so that the same midwife can provide antenatal care and be present at the birth. You should know the name of the midwife who is responsible for your care.

A midwife will look after you during labour and, if everything is straightforward, will deliver your baby. If any complications develop during your pregnancy or delivery, you will also see a doctor. You may also meet student midwives and student doctors. After the birth, you and your baby will be cared for by midwives and maternity support workers.

Care from your midwife

- **An obstetrician** is a doctor specialising in the care of women during pregnancy and labour and after the birth.



Your midwife or GP will refer you for an appointment with an obstetrician if they have a particular concern, such as previous complications in pregnancy or chronic illness. You can request to see an obstetrician if you have any particular concerns.

- **An anaesthetist** is a doctor who specialises in providing pain relief and anaesthesia. If you decide to have an epidural, it will be set up by an anaesthetist.



If you require a caesarean section or an instrumental delivery (e.g. using forceps or ventouse), an anaesthetist will provide the appropriate anaesthesia. In many hospitals your midwife can arrange for you to talk to an anaesthetist about analgesia or anaesthesia if you have medical or obstetric problems. Before or during labour you will be able to speak to your anaesthetist.



- **A paediatrician** is a doctor specialising in the care of babies and children. A paediatrician may check your baby after the birth to make sure all is well and will be present when your baby is born if you have had a difficult labour. If your baby has any problems, you will be able to talk this over with the paediatrician. If your baby is born at home or your stay in hospital is short, you may not see a paediatrician at all. Your midwife or GP will check that all is well with you and your baby.

- **A sonographer** is specially trained to carry out ultrasound scans. A sonographer will perform your dating and nuchal translucency or anomaly scan. Some women are scanned at other points in their pregnancy.



- **An obstetric physiotherapist** is specially trained to help you cope with physical changes during pregnancy, childbirth and afterwards. Some provide antenatal education and teach antenatal exercises, relaxation and breathing, active positions and other ways you can keep yourself fit and healthy during pregnancy and labour. After the birth, they advise on postnatal exercises to tone up your muscles. Your midwife can help you with these exercises.



- **Health visitors** are specially trained nurses who offer help and support with the health of the whole family. You may meet your health visitor before the birth of your baby and you will be visited by a member of the team in the first few weeks after your baby is born. You may continue to see your health visitor or a member of the health visiting team at home or at your child health clinic, Children's Centre, health centre or GP's surgery.



- **Dieticians** may be available to advise you about healthy eating or special diets, for example if you develop gestational diabetes.

Research

You may be asked to participate in a research project during your antenatal care or labour or after you have given birth. This may be to test a new treatment or to find out your opinions on an aspect of your care. Such projects are vital if professionals are to improve maternity care. The project should be fully explained to you and you are free to say no.

Students

Some of the health professionals you see will have students with them. The students will be at various stages of their training but will always be supervised. You can say no, but if you let a student be present it will help their education and may even add to your experience of pregnancy and labour.



ANTENATAL EDUCATION

Antenatal education (sometimes called antenatal classes) can help to prepare you for your baby's birth as well as for looking after and feeding your baby. It can help you to keep yourself fit and well during pregnancy and give you confidence as well as information. You can find out about arrangements for labour and birth and the sorts of choices available to you (see page 74 for information about birth plans). You may also meet some of the people who will look after you during labour.

You will be able to talk over any worries and discuss your plans, not just with professionals but with other women and their partners as well. Classes are also a really good way to make friends with other parents expecting babies at around the same time as you. These friendships often help you through the first few months with a baby. Classes are usually informal and fun.

Choosing an antenatal class

Think about what you hope to gain from antenatal classes so that you can find the sort of class that suits you best. You need to start making enquiries early in pregnancy so that you can be sure of getting a place in the class you choose. You can go to more than one class. Ask your midwife, health visitor or GP about what is available in your area, or contact the NCT (see next page). Speak to your community midwife if you cannot go to classes. The midwife may have DVDs to lend you, or you may be able to hire or buy one.

The classes

During pregnancy, you may be able to go to some introductory classes on baby care. Most start about eight to 10 weeks before your baby is due. If you are expecting a multiple pregnancy, try to start your classes at around 24 weeks, because your babies are more likely to be born earlier.

Classes are normally held once a week, either during the day or in the evening, for about two hours. Some classes are for pregnant women only. Others will welcome partners or friends, either to all the sessions or to some of them. In some areas there are classes for women whose first language is not English, classes for single mothers and classes for teenagers. The kinds of topics covered in antenatal education are:

- health in pregnancy
- exercises to keep you fit during pregnancy and help you in labour
- what happens during labour and birth
- coping with labour and information about different types of pain relief
- how to help yourself during labour and birth

**relaxed
and fun**





The NCT

The NCT (also known as the National Childbirth Trust) runs a range of classes.

The groups tend to be smaller and may go into more depth, often allowing time for discussion and for practising physical skills. For details of antenatal courses, along with information on local support groups, visit www.nct.org.uk



- relaxation techniques
- how to give birth without any intervention, if that is what you want
- information on different kinds of birth and intervention
- caring for your baby, including feeding
- your health after the birth
- 'refresher classes' for those who have already had a baby
- emotions during pregnancy, birth and the early postnatal period.

Some classes will try to cover all of these topics. Others will concentrate on certain aspects, such as exercises and relaxation or caring for your baby.

The number of different antenatal classes available varies from place to place.

Children's Centres (sometimes called Sure Start Children's Centres)

Children's Centres also support families with children under the age of five. They can provide:

- easy access to antenatal care
- health services
- parenting and family support
- drop-in sessions
- outreach services
- early education and childcare, and
- links to training and employment opportunities.



For more information on Children's Centres, including finding centres in your area, visit www.surestart.gov.uk

meet other parents-to-be



CONDITIONS AND PROBLEMS IN PREGNANCY



Common minor problems	58
More serious problems	67

Your body goes through a lot of changes during pregnancy. Sometimes these changes can cause you discomfort or irritation, and you may be worried about what is happening to you. There is usually nothing to worry about, but you should mention anything that concerns you to your midwife or doctor. If you think that something may be seriously wrong, trust your own judgement and get in touch with your midwife or doctor straight away.

This chapter describes some of the minor and more serious health problems and gives advice on how to deal with them and when you should get help. These problems are listed in alphabetical order.



COMMON MINOR PROBLEMS

Backache

As your baby grows, the hollow in your lower back may become more pronounced, and this can also cause backache. During pregnancy, your ligaments become softer and stretch to prepare you for labour. This can put a strain on the joints of your lower back and pelvis, which can cause backache.

How to avoid backache

- Avoid lifting heavy objects.
- Bend your knees and keep your back straight when lifting or picking something up from the floor.
- Move your feet when turning round to avoid twisting your spine.
- Wear flat shoes that allow your weight to be evenly distributed.
- Work at a surface that is high enough so that you don't stoop.
- Try to balance the weight between two bags when carrying shopping.
- Sit with your back straight and well supported.
- Make sure you get enough rest – particularly later in pregnancy.

How to ease backache

- A firm mattress can help to prevent and relieve backache. If your mattress is too soft, put a piece of hardboard under it to make it firmer.
- Massage can help.

When to get help

If your backache is very painful, ask your doctor to refer you to an obstetric physiotherapist at your hospital. They will be able to give you some advice and may suggest some helpful exercises.

Constipation

You may become constipated very early in pregnancy because of the hormonal changes taking place in your body.

How to avoid constipation

- Eat foods that are high in fibre, like wholemeal breads, wholegrain cereals, fruit and vegetables, and pulses such as beans and lentils.
- Exercise regularly to keep your muscles toned.
- Drink plenty of water.
- Avoid iron supplements. Ask your doctor whether you can manage without them or change to a different type.

Cramp

Cramp is a sudden, sharp pain, usually in your calf muscles or feet. It is most common at night, but nobody really knows what causes it.

How to avoid cramp

Regular, gentle exercise in pregnancy, particularly ankle and leg movements, will improve your circulation and may help to prevent cramp occurring.



How to ease cramp

It usually helps if you pull your toes hard up towards your ankle or rub the muscle hard.

Feeling faint

You may often feel faint when you are pregnant. This is because of hormonal changes taking place in your body and happens if your brain is not getting enough blood and therefore enough oxygen. If your oxygen level gets too low, you may actually faint. You are most likely to feel faint if you stand still for too long or get up too quickly from a chair or out of a hot bath. It can also happen when you are lying on your back.

How to avoid feeling faint

- Try to get up slowly after sitting or lying down.
- If you feel faint when standing still, find a seat quickly and the feeling should pass. If it doesn't, lie down on your side.
- If you feel faint while lying on your back, turn on your side. It is advisable not to lie flat on your back at any time in later pregnancy or during labour.

Feeling hot

During pregnancy you are likely to feel warmer than normal. This is due to hormonal changes and to an increase in the blood supply to your skin. You are also likely to sweat more.

How to avoid feeling hot

- Wear loose clothing made of natural fibres, as these are more absorbent and 'breathe' more than synthetic fibres.
- Keep your room cool. You could use an electric fan to cool it down.
- Wash frequently to help you to feel fresh.



Headaches

Some pregnant women find they get a lot of headaches.

How to ease headaches

- Try and get more regular rest and relaxation.
- Paracetamol in the recommended dose is generally considered safe for pregnant women but there are some painkillers that you should avoid. Speak to your pharmacist, nurse, midwife, health visitor or GP about how much paracetamol you can take and for how long.



When to get help

If you often have bad headaches, tell your midwife or doctor. Severe headaches can be a sign of high blood pressure (see page 67).

Incontinence

Incontinence is a common problem. It can affect you during and after pregnancy.

Sometimes pregnant women are unable to prevent a sudden spurt of urine or a small leak when they cough, sneeze or laugh, or when moving suddenly or just getting up from a sitting position. This may be temporary, because the pelvic floor muscles relax slightly to prepare for the baby's delivery.

Some women have more severe incontinence and find that they cannot help wetting themselves.



When to get help

In many cases incontinence is curable, so if you have got a problem talk to your midwife, doctor or health visitor.

Help and support

You could also call the confidential **Continence Foundation** helpline on 0845 345 0165 (9.30am to 1pm Mon to Fri) or visit www.continence-foundation.org.uk



Indigestion and heartburn

Indigestion is partly caused by hormonal changes and in later pregnancy by your growing uterus pressing on your stomach. Heartburn is more than just indigestion. It is a strong, burning pain in the chest caused by stomach acid passing from your stomach into the tube leading to your stomach. This is because the valve between your stomach and this tube relaxes during pregnancy.

How to avoid indigestion

- Try eating smaller meals more often.
- Sit up straight when you are eating, as this takes the pressure off your stomach.
- Avoid the foods which affect you, e.g. fried or highly spiced food, but make sure you are still eating well (see pages 24–25 for information on healthy eating).

How to avoid heartburn

- Heartburn is often brought on by lying flat. Sleep well propped up with plenty of pillows.
- Avoid eating and drinking for a few hours before you go to bed.
- Your midwife or GP may prescribe an antacid if the problem is persistent.

How to ease heartburn

- Drink a glass of milk. Have one by your bed in case you wake with heartburn in the night.
- Note that you should not take antacid tablets before checking with your midwife, doctor or pharmacist that they are safe for you to take.

Itching

Mild itching is common in pregnancy because of the increased blood supply to the skin. In late pregnancy the skin of the abdomen is stretched and this may also cause itchiness.



How to avoid itching

- Wearing loose clothing may help.
- You may also want to avoid synthetic materials.

Leaking nipples

Leaking nipples are normal and usually nothing to worry about. The leaking milk is colostrum, which is the first milk your breasts make to feed your baby.

When to get help

See your midwife or doctor if the milk becomes bloodstained.

Nausea and morning sickness

Nausea is very common in the early weeks of pregnancy. Some women feel sick, and some are sick. It can happen at any time of day – or even all day long.

Hormonal changes in the first three months are probably one cause. Nausea usually disappears around the 12th to 14th weeks. It can be one of the most trying problems in early pregnancy. It comes at a time when you may be feeling tired and emotional, and when many people around you may not realise that you are pregnant.

How to avoid nausea and morning sickness

- If you feel sick first thing in the morning, give yourself time to get up slowly. If possible, eat something like dry toast or a plain biscuit before you get up.
- Get plenty of rest and sleep whenever you can. Feeling tired can make the sickness worse.
- Eat small amounts of food often rather than several large meals, but don't stop eating.
- Drink plenty of fluids.
- Ask those close to you for extra help and support.
- Distract yourself as much as you can. Often the nausea gets worse the more you think about it.
- Avoid foods and smells that make you feel worse. It helps if someone else can cook. If not, go for bland, non-greasy foods, such as baked potatoes, pasta and milk puddings, which are simple to prepare.
- Wear comfortable clothes. Tight waistbands can make you feel worse.

When to get help

If you are being sick all the time and cannot keep anything down, tell your midwife or doctor. Some pregnant women experience severe nausea and vomiting. This condition is known as *hyperemesis gravidarum* and needs specialist treatment.



Nose bleeds

Nose bleeds are quite common in pregnancy because of hormonal changes. They don't usually last long but can be quite heavy. As long as you don't lose a lot of blood, there is nothing to worry about. You may also find that your nose gets more blocked up than usual.

How to stop nose bleeds

- Sit with your head forward.
- Press the sides of your nose together between your thumb and forefinger, just below the bony part, for 10 minutes and try not to swallow the blood.
- Repeat for a further 10 minutes if this is unsuccessful.
- If the bleeding continues, seek medical advice.

Passing urine often

Needing to pass urine often may start in early pregnancy. Sometimes it continues right through pregnancy. In later pregnancy it's the result of the baby's head pressing on the bladder.

How to reduce the need to pass urine

- If you find that you have to get up in the night try cutting out drinks in the late evening, but make sure you keep drinking plenty during the day.
- Later in pregnancy, some women find it helps to rock backwards and forwards while they are on the toilet. This lessens the pressure of the uterus on the bladder so that you can empty it properly. Then you may not need to pass water again quite so soon.

When to get help

If you have any pain while passing water or you pass any blood, you may have a urine infection, which will need treatment. Drink plenty of water to dilute your urine and reduce pain. You should contact your GP within 24 hours.

The growing baby will increase pressure on your bladder. If you find this a problem, you can improve the situation by doing exercises to tone up your pelvic floor muscles (see page 35).

Ask a midwife or obstetric physiotherapist (see pages 54 and 55) for advice.

Pelvic joint pain

If during or after your pregnancy you have pain in your pelvic joints when walking, climbing stairs or turning in bed, you could have pelvic girdle pain (PGP) or symphysis pubis dysfunction (SPD). This is a slight misalignment or stiffness of your pelvic joints, at either the back or front. It affects up to one in four pregnant women to a lesser or greater extent. Some women have minor discomfort, others may have much greater immobility.

When to get help

Getting diagnosed as early as possible can help to minimise the pain and avoid long-term discomfort. Treatment usually involves gently pressing on or moving the affected joint so that it works normally again.

Ask a member of your maternity team for a referral to a manual physiotherapist, osteopath or chiropractor who is experienced in treating pelvic joint problems. They tend not to get better completely without treatment from an experienced practitioner.

Contact the Pelvic Partnership for support and information (see page 187).



coping
with the
symptoms



Piles

Piles, also known as haemorrhoids, are swollen veins around your anus (back passage) which may itch, ache or feel sore. You can usually feel the lumpiness of the piles around your anus. Piles may also bleed a little and they can make going to the toilet uncomfortable or even painful. They occur in pregnancy because certain hormones make your veins relax. Piles usually resolve within weeks after birth.

How to ease piles

- Eat plenty of food that is high in fibre, like wholemeal bread, fruit and vegetables, and drink plenty of water. This will prevent constipation, which can make piles worse.
- Avoid standing for long periods.
- Take regular exercise to improve your circulation.
- You may find it helpful to use a cloth wrung out in ice water.
- Push any piles that stick out gently back inside using a lubricating jelly.
- Ask your midwife, doctor or pharmacist if they can suggest a suitable ointment.



Skin and hair changes

Hormonal changes taking place in pregnancy will make your nipples and the area around them go darker. Your skin colour may also darken a little, either in patches or all over. Birthmarks, moles and freckles may also darken. Some women develop a dark line from their belly buttons down to the top of their pubic hair. These changes will gradually fade after the baby has been born, although your nipples may remain a little darker.

If you sunbathe while you are pregnant, you may find that you tan more easily. Protect your skin with a good, high-factor sunscreen. Don't stay in the sun for very long.

Hair growth is also likely to increase in pregnancy. Your hair may also be greasier. After the baby is born, it may seem as if you are losing a lot of hair. In fact, you are simply losing the extra hair that you grew during pregnancy.





It might be more comfortable to lie on one side with a pillow under your tummy and another between your knees.

Sleep

Late in pregnancy it can be very difficult to get a good night's sleep. It can be uncomfortable lying down or, just when you get comfortable, you find that you have to get up to go to the toilet.

Some women have strange dreams or nightmares about the baby and about the birth. Talking about them can help you.

Stretch marks



These are pink or purplish lines which usually occur on your abdomen or sometimes on your upper thighs or breasts. Some women get them, some don't. It depends on your skin type. Some people's skin is more elastic. You are more likely to get stretch marks if your weight gain is more than average. It is very doubtful whether oils or creams help to prevent stretch marks. After your baby is born, the marks should gradually pale and become less noticeable.

Swollen ankles, feet and fingers

Ankles, feet and fingers often swell a little in pregnancy because your body is holding more water than usual. Towards the end of the day, especially if the weather is hot or if you have been standing a lot, the extra water tends to gather in the lowest parts of your body.

Suggestions for swollen ankles, feet and fingers

- Avoid standing for long periods.
- Wear comfortable shoes.
- Put your feet up as much as you can. Try to rest for an hour a day with your feet higher than your heart.
- Do foot exercises (see page 35).

put
your feet
up and rest



Teeth and gums

Bleeding gums are caused by a build-up of plaque (bacteria) on your teeth. During pregnancy, hormonal changes in your body can cause plaque to make your gums more inflamed. They may become swollen and bleed more easily. When your baby is born your gums should return to normal.

How to keep teeth and gums healthy

- Clean your teeth and gums carefully. Ask your dentist to show you a good brushing method to remove all the plaque.
- Avoid having sugary drinks and foods too often. Try to eat them at mealtimes only.
- Go to the dentist for a check-up. NHS dental treatment is free while you are pregnant and for a year after your baby's birth.
- Ask your dentist if any new or replacement fillings should be delayed until after your baby is born.



Tiredness

In the early months of pregnancy you may feel tired or even desperately exhausted. The only answer is to try to rest as much as possible. Make time to sit with your feet up during the day and accept any offers of help from colleagues and family.

Towards the end of pregnancy you may feel tired because of the extra weight you are carrying. Make sure that you get plenty of rest.



free
NHS
dental
treatment

Vaginal discharge

Almost all women have more vaginal discharge in pregnancy. It should be clear and white and should not smell unpleasant. If the discharge is coloured or smells strange, or if you feel itchy or sore, you may have a vaginal infection. The most common infection is thrush, which your doctor can treat easily. You can help to prevent thrush by wearing loose cotton underwear.

When to get help

Tell your midwife or doctor if the discharge is coloured, smells strange, or if you feel itchy or sore.

Tell your midwife or doctor if vaginal discharge, of any colour, increases a lot in later pregnancy.

Varicose veins

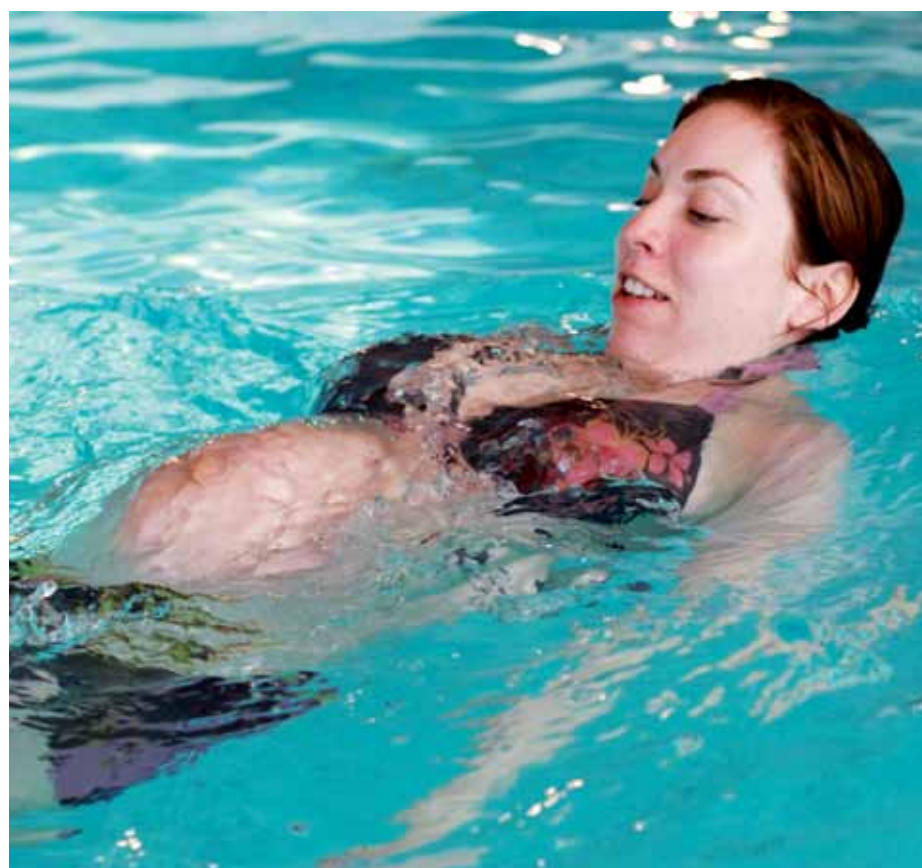
Varicose veins are veins which have become swollen. The veins in the legs are most commonly affected. You can also get varicose veins in the vulva (vaginal opening). They usually get better after delivery.

If you have varicose veins

- Try to avoid standing for long periods of time.
- Try not to sit with your legs crossed.
- Try not to put on too much weight, as this increases the pressure.
- Sit with your legs up as often as you can to ease the discomfort.
- Try support tights, which may also help to support the muscles of your legs.
- Try sleeping with your legs higher than the rest of your body – use pillows under your ankles or put books under the foot of your bed.
- Do foot exercises (see page 35) and other antenatal exercises such as walking and swimming, which will help your circulation.



exercise helps your circulation



Help and support

Contact **Netmums**, a unique local network and source of discussion – www.netmums.com



MORE SERIOUS PROBLEMS

High blood pressure and pre-eclampsia

During pregnancy your blood pressure will be checked at every antenatal appointment. This is because a rise in blood pressure can be the first sign of a condition known as pre-eclampsia – also called pregnancy-induced hypertension (PIH) or pre-eclamptic toxæmia (PET). It can run in families and affects 10% of pregnancies. Your urine is checked for protein at every visit, as this is a sign of pre-eclampsia.

The symptoms

Some of the symptoms of pre-eclampsia are:

- bad headaches
- problems with vision, such as blurred vision or lights flashing before the eyes
- bad pain just below the ribs
- vomiting
- sudden swelling of the face, hands or feet.

However, you can have severe pre-eclampsia without any symptoms at all.

Although most cases are mild and cause no trouble, it can be serious for both mother and baby. It can cause fits in the mother (called eclampsia) and affects the baby's growth. It is life-threatening if left untreated. That is why routine antenatal checks are so important.

Pre-eclampsia usually happens towards the end of pregnancy, but it may happen earlier. It can also happen after the birth. It is likely to be more severe if it starts earlier in pregnancy. Treatment may start with

rest at home, but some women need admission to hospital and medicines that lower high blood pressure. Occasionally, pre-eclampsia is a reason to deliver the baby early – this may be either by induction of labour or by caesarean section.

When to get help

If you get any of the symptoms described here, or have any reason to think that you have pre-eclampsia, contact your midwife, doctor or the hospital immediately.

Placenta praevia

Placenta praevia (or a low-lying placenta) is when the placenta is attached in the lower part of the uterus, near to or covering the cervix.

The position of your placenta is recorded at your 18 to 21-week ultrasound scan. If it is significantly low you will be offered an extra ultrasound scan later in your pregnancy (usually at around 32 weeks) to recheck its position. For 9 out of 10 women the placenta has moved into the upper part of the uterus by this time.

If the placenta is still low in the uterus, there is a higher chance that you could bleed during your pregnancy or at the time of birth. This bleeding can be very heavy and put you and your baby at risk. You may be advised to come into hospital at the end of your pregnancy so that emergency treatment can be given very quickly if you do bleed. If the placenta is near or covering the cervix, the baby cannot get past it to be born vaginally and a caesarean section will be recommended.



Severe itching and obstetric cholestasis

Severe itching can be a sign of a condition called obstetric cholestasis. This is a potentially dangerous liver disorder that seems to run in families, although it can occur even if there is no family history. The main symptom is severe generalised itching without a rash, most commonly in the last four months of pregnancy. Obstetric cholestasis can lead to premature birth, stillbirth or serious health problems for your baby. It can also increase the risk of maternal haemorrhage after the delivery.

When to get help

You should see your doctor if:

- the itching becomes severe – particularly if it affects your hands and feet
- you develop jaundice (yellowing of the whites of the eyes and skin)
- you get itching and a severe rash.



Slow-growing babies

Many of the tests in pregnancy check that your baby is growing. If you have previously had a very small baby, or if you smoke heavily, the midwives and doctors will already be monitoring your pregnancy closely. Blood pressure checks may also pick up signs that there are complications. If there is concern about your baby's health, further tests might be carried out and your baby will be monitored more frequently.

When to get help

In the last weeks of pregnancy, you should keep track of your baby's movements. If you notice your baby's movements becoming less frequent or stopping, it may be a sign that your baby is unwell. You should contact your midwife or doctor immediately.

If tests show that your baby is not growing well in the uterus, your midwife and doctor may recommend early delivery by induction of labour or caesarean section (see page 98).



Seek medical help

You should contact your GP if you have a sudden 'acute' illness like diarrhoea, vomiting, abdominal pain or a high fever.

Vaginal bleeding

Bleeding from the vagina at any time in pregnancy can be a dangerous sign. Some causes of vaginal bleeding are more serious than others, so it's important to find the cause straight away.

Bleeding after sex

The cells on the surface of the cervix often change in pregnancy and make it more likely to bleed – particularly after sex. This is called a cervical ectropion. Vaginal infections can also cause a small amount of vaginal bleeding.

Ectopic pregnancy

In early pregnancy, bleeding may be a sign of an ectopic pregnancy or a miscarriage (see page 151), although many women who bleed at this time go on to have normal and successful pregnancies.

Bleeding in late pregnancy

The most common sort of bleeding in late pregnancy is the small amount of blood mixed with mucus that is known as a 'show'. This is a sign that the cervix is changing and becoming ready for labour to start. It may happen a few days before contractions start or during labour itself.

Help and support

Always contact your midwife or doctor immediately if you have vaginal bleeding at any stage of pregnancy.



More information

For more information see the Royal College of Obstetricians and Gynaecologists' guideline *Thromboprophylaxis during pregnancy, labour and after vaginal delivery* at www.rcog.org.uk/womens-health/clinical-guidance/thromboprophylaxis-during-pregnancy-labour-and-after-vaginal-deliver

Deep vein thrombosis

Deep vein thrombosis is a serious condition where clots develop, often in the deep veins of the legs. It can be fatal if the clot travels from the legs to the lungs. The risk may increase if you are on a long-haul flight (over five hours), where you sit still for a long time.

When to get help

If you develop swollen and painful legs or have breathing difficulties, go to your GP or your nearest accident and emergency department immediately.

Vasa praevia

Vasa praevia is a rare condition (occurring in about 1 in 3,000 to 1 in 6,000 births). It occurs when the blood vessels of the umbilical cord run through the membranes covering the cervix. Normally the blood vessels would be protected within the umbilical cord. When the membranes rupture and the waters break, these vessels may be torn, causing vaginal bleeding. The baby can lose a life-threatening amount of blood and die. It is very difficult to diagnose but it may occasionally be spotted before birth by an ultrasound scan. Vasa praevia should be suspected if there is bleeding and the baby's heart rate changes suddenly after rupture of the membranes. It is linked with placenta praevia (see page 67).

Problems in early pregnancy

Most women feel well in early pregnancy but it can be uncomfortable. Some women describe a pain low down in the abdomen similar to a period pain. This does not necessarily mean that something is wrong, but if the pain is more than discomfort or if there is any bleeding, your midwife or GP should refer you for a scan in the early pregnancy assessment unit. This scan will show whether the pregnancy is growing in the uterus. Sometimes you need a second scan to check that all is well.

CHOOSING WHERE TO HAVE YOUR BABY



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You can give birth at home, in a unit run by midwives or in a hospital. This chapter gives information about each of these options so that you can choose what is best for you.

SAFETY

Giving birth is generally very safe, wherever you choose to have your baby. There is not much evidence that compares how safe different places are. However, women who have their baby in a unit run by midwives or at home are less likely to need assistance, for example through the use of forceps or a ventouse.

If you choose to have your baby at home or in a unit run by midwives, you should be given information about what would happen if you need to be transferred to hospital during labour and how long this would take. You should also be aware that if something goes seriously wrong during your labour (which is rare) it could be worse for you and your baby than if you were in hospital with access to specialised care. You may be advised to give birth in hospital if you have, or develop, certain medical conditions.

MAKING AN INFORMED DECISION

It is important that you and your partner make an informed choice about where you would like to give birth.

It is your choice, and even after you have decided where you want to have your baby you can still change your mind. Your midwife will discuss the options that are available to you locally, though you are free to choose any maternity services if you are prepared to travel.



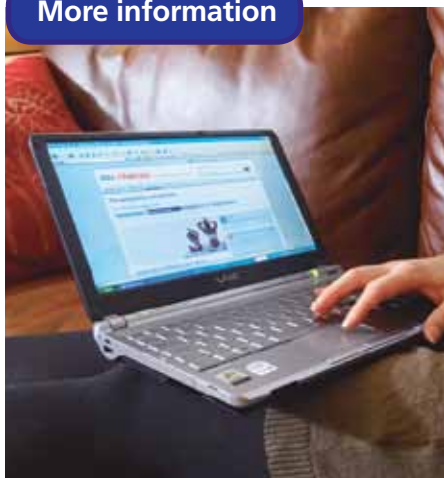
As well as getting information from your midwife, you can get information from:

- local maternity units
- Children's Centres
- your GP surgery
- the NCT, which can put you in touch with local mothers (see page 57)
- Maternity Services Liaison Committees (www.csip.org.uk/~mslc)
- a supervisor of midwives (see page 74).

You may also want to seek the views of your friends and family.

See also Chapter 4 on antenatal care and Chapter 8 on labour and birth.

More information



www.nhs.uk/pregnancyplanner

www.birthchoiceuk.com

www.drfooster.co.uk/Guides/BirthGuide/

www.nct.org.uk/home



HOME BIRTHS

If you have a straightforward pregnancy and both you and the baby are well, you might choose to give birth at home. In England, approximately 1 in 50 babies is born at home.

If you give birth at home, you will be supported by a midwife, who will support you while you are in labour. If you need any help or your labour is not progressing as well as it should, your midwife will make arrangements for you to be transferred to hospital.

The advantages of giving birth at home include the following:

- You can give birth in familiar surroundings where you may feel more relaxed and able to cope.
- You don't have to interrupt your labour to go into hospital.
- You will not need to leave your other children.
- You will not have to be separated from your partner after the birth.
- You are more likely to be looked after by a midwife who you have got to know during your pregnancy.

The things you should consider include the following:

- You may need to transfer to a hospital if there are any complications.
- Epidurals are not available at home.
- Your doctor or midwife may recommend that you give birth in hospital, for example if you are expecting twins or if your baby is breech. Your midwife or doctor will explain why they think hospital is safer for you and your baby.

Planning a home birth

Ask your midwife whether or not a home birth is suitable for you and your baby or available to you. If it is, your midwife will arrange for members of the midwifery team to support and help you.

Here are some of the questions that you might want to ask:

- How long would it take if you needed to be transferred to hospital?
- Which hospital would you be transferred to?
- Would a midwife be with you all the time?
- How do you obtain a birthing pool?



MIDWIFERY UNITS OR BIRTH CENTRES

Birth centres and midwifery units are home-from-home places where you can go to have your baby. These units can be part of a general hospital maternity unit, in a smaller community hospital or completely separate.

The advantages of giving birth at a midwifery unit include the following:

- You can give birth in surroundings where you may feel more relaxed and able to cope with labour.
- You are more likely to be looked after by a midwife who you have got to know during your pregnancy.

The things you should consider include the following:

- You may need to transfer to a hospital if there are any complications.
- Epidurals are not available in a midwifery unit.
- Your doctor or midwife may recommend that it is safer for you and your baby to give birth in hospital.



Planning a birth in a midwifery unit or birth centre

Midwifery care is available at home, in a midwifery unit and in hospital. Ask your midwife if there are any midwifery units or birthing centres in your area. There may be others that you can use if you are prepared to travel.

Here are some of the questions that you might want to ask:

- How long would it take if you needed to be transferred to hospital?
- Which hospital would you be transferred to?
- Will a midwife be with you all the time?
- Can you visit the unit before you give birth?
- What facilities are available? Are there birthing pools, for example?

the choices

that are right for you



BIRTH IN HOSPITAL

Most women give birth in an NHS hospital maternity unit. If you choose to give birth in hospital, you will be looked after by a midwife but doctors will be available if you need their help. You will still have choices about the kind of care you want. Your midwife and doctors will provide information about what your hospital can offer.



The advantages of giving birth in hospital include the following:

- You have direct access to obstetricians, anaesthetists and neonatologists.
- You can access other specialist services, such as epidurals for relief of pain.
- There will be a special care baby unit if there are any problems.

The things you should consider include the following:

- You may go home directly from the labour ward or you may be moved to a postnatal ward.
- In hospital, you may be looked after by a different midwife from the one who looked after you during pregnancy.



Planning a hospital birth

Your midwife can help you decide at which hospital you want to have your baby. If there is more than one hospital in your locality you can choose which one to go to. Find out more about the care provided in each so that you can decide which will suit you best.

Here are some of the questions that you might want to ask:

- Are tours of maternity facilities for birth available before the birth?
- When can I discuss my birth plan?
- Are TENS machines available (see page 89) or do I need to hire one?
- What equipment is available – e.g. mats, a birthing chair or beanbags?
- Are there birthing pools?
- Are partners, close relatives or friends welcome in the delivery room?
- Are birthing partners ever asked to leave the room? Why?
- Can I move around in labour and find my own position for the birth?
- What services are provided for sick babies?
- Who will help me breastfeed my baby?
- Who will help me if I choose to formula feed?
- How long will I be in hospital?
- What are the visiting hours?



BIRTH PLANS

A birth plan is a record of what you would like to happen during your labour and after the birth. To see an example of a birth plan, visit the online pregnancy planner at www.nhs.uk/birthplan. You don't have to create a birth plan, but if you want to, your midwife will be able to help.



If you don't have access to a computer, ask your midwife to print out a copy of a birth plan from the NHS Choices website. Discussing a birth plan with your midwife will give you the chance to ask questions and find out more about what happens when you are in labour. It also gives your midwife the chance to get to know you better and understand your feelings and priorities.

You will probably want to think about or discuss some things

more fully with the baby's father and friends and relatives. And you can change your mind at any time.

Your birth plan is personal to you. It will depend not only on what you want, but also on your medical history, your own circumstances and what is available at your maternity service. What may be safe and practical for one pregnant woman may not be a good idea for another.

You may be given a special form for a birth plan, or there may be room in your notes. It's a good idea for you to keep a copy of your birth plan with you. The maternity team who care for you during labour will discuss it with you so that they know what you want. But remember, you need to be flexible if complications arise with you or the baby. The maternity team will be able to give advice on your particular circumstances. Don't hesitate to ask questions if you need to.

Read the chapters on labour and birth (page 85) and the first days with your new baby (page 120) before talking to your midwife, to see if there is anything you feel strongly about and want to include.

What is a midwife?



A midwife is a healthcare professional who is qualified to care for women during pregnancy, labour and after the baby is born. They also care for newborn babies until they are 28 days old, if necessary. Midwives provide care for all women and involve other members of the team, including doctors when necessary.

Midwives help women prepare for birth through antenatal education and provide advice about common problems. A nursing qualification is not necessary to become a midwife, although some midwives have one.

What is a supervisor of midwives?

A supervisor of midwives is an experienced midwife who has had extra training and education to assist and support midwives in providing the best quality maternity care. Supervisors of midwives aim to make sure that you receive the best guidance and information about the right type of care for you. They are there to help and support you if you are having any problems with your care, or if you feel that your wishes and requests are not being considered.

The telephone number for your supervisor of midwives should be in your pregnancy information details (or hand-held notes), or you can call your hospital's labour ward/birthing room or your local birth centre. Discussing issues with the supervisor of midwives will not affect your care or influence how you are further supported in your pregnancy, birth and aftercare.

PALS

The Patient Advice and Liaison Service, known as PALS, has been introduced to ensure that the NHS listens to patients, their relatives, carers and friends and answers and resolves their concerns as quickly as possible. If you have any suggestions or complaints about your care, make contact with the PALS service based in hospitals in the first instance. For more information visit www.pals.nhs.uk



FEELINGS AND RELATIONSHIPS

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From the minute you know you are pregnant, your feelings change: feelings about yourself, about the baby and about your future. Your relationships change: with your partner, other children and also with your parents and friends. Coping with these changes is not always easy.

This chapter is about some of the worries that may come up in pregnancy and suggestions on how to handle them. What is a problem for one person may not be a problem for you, and what is helpful advice for some people may not be right for you. So take from these pages what you find useful.

FEELINGS

When you are pregnant it can sometimes seem as though you have to be happy all of the time. You may find that people expect you to look forward to the baby, be excited and to 'bloom' all the time. You too may think that this is the way you ought to feel. In fact, you are likely to have ups and downs, just like any other nine months in your life.

Hormonal changes and tiredness

Hormonal changes taking place in your body can make you feel tired, nauseous, emotional and upset – particularly in the first three months. You may find that you cry more easily, sometimes for no reason, and lose your temper more. Being tired and run down can make you feel low. Try to look after your physical health and get plenty of sleep (see Chapter 3 on your health in pregnancy).



Help and support



If you are feeling very anxious – for whatever reason – talk to your midwife or doctor as soon as possible.



DEPRESSION AND MENTAL HEALTH PROBLEMS

It's normal to have some worries while you are pregnant and to feel a bit down from time to time. But it is a cause for concern if you are feeling down most of the time. Whatever the reason for your unhappiness, or even if there doesn't seem to be any reason at all, explain how you feel to your midwife, doctor or health visitor (see page 54 to find out who is who). Make sure that they understand that you are talking



about something more than just feeling low. Some women do get depressed during pregnancy and you may need treatment to help you deal with it.

If you have had a mental health problem in the past, then you might be at risk of becoming ill with a depressive illness during pregnancy and childbirth. It is important that you tell your midwife at the start of your pregnancy about any previous illness. If your mood changes throughout the pregnancy then let someone know how you are feeling; don't suffer alone – you can be helped.

Anxiety

It is quite normal to feel anxious and worried when you are pregnant – especially if this is your first pregnancy. There are a number of things that you may feel anxious about. You may find antenatal tests stressful – because of the possibility that something may be wrong.

You may be worried about practical things like money, work or where you are going to live. You may be anxious about whether you will cope as a parent, or about whether you are ready to be a parent. Some of these anxieties could be shared by your partner, friends or family. It is a good idea to talk through these feelings together.

Dreams

It is normal to have dreams about your baby. Sometimes your dreams may reflect your anxieties. This is often because you are thinking much more about your pregnancy and the changes that are happening in your body. Talk to your midwife if you are worried by this.

Ways of coping

- Sometimes it helps to share anxieties with other pregnant women.
- Discuss any worries, concerns or anxieties you have with someone you feel you can talk to. This could be your midwife, your partner, your friends or family.

**discuss
your
feelings**





Antenatal education will also help to prepare you for labour and the birth and to know what to expect (see page 56).

You will have an opportunity to discuss this in more detail with your midwife, and to draw up a birth plan, during the later months of pregnancy (see page 74).



Talk to your partner or someone close to you. They may be feeling anxious too – particularly if they are going to be with you in labour. Together, you can then work out ways that will help you to cope.

**antenatal
education
will help
prepare
you**

WORRYING ABOUT THE BIRTH

Many women worry about whether they can cope with the pain they will experience during labour and while giving birth. It is difficult to imagine what a contraction is like and no one can really tell you – though they may try! Exploring ways of coping with labour may help you to feel more confident and more in control.

You can begin by reading the chapter on labour and birth (page 85) with your partner or a friend or relative who will be with you for the birth. Ask your midwife or doctor for any further information, and look on the internet (www.nhs.uk/pregnancy).

CONCERNS ABOUT DISABILITIES

At some time during pregnancy, most expectant parents worry that there may be something wrong with their baby. Some people find that talking openly about their fears helps them to cope. Others prefer not to think about the possibility that something could be wrong.

Some women worry because they are convinced that if something does go wrong it will be their fault. You can increase your baby's chances of being born healthy by following the advice outlined in Chapter 3. But there are certain problems which cannot be prevented. This is either because the causes are not known or because they are beyond your control.

Of all the babies born in the UK, 97% are healthy and 1% of babies will be born with abnormalities that can be partly or completely corrected, such as extra fingers or toes. About 2%, however, will suffer from some more severe disability. Regular antenatal care and careful observation during labour helps to pick up any potential problems and allow appropriate action to be taken.

If you are particularly concerned – perhaps because you or someone in your family has a disability – talk to your midwife or doctor as soon as possible.

They may be able to reassure you or offer you helpful information about tests which can be done during pregnancy (see Chapter 4).

If you have previously had a baby with an abnormality or disability, talk to your midwife or doctor and see if you need any additional care during this pregnancy.

COUPLES

Pregnancy will bring about big changes to your relationship, especially if this is your first baby. Some people cope with these changes easily, others find it harder. Everybody is different.

It is quite common for couples to find themselves having arguments every now and then during

pregnancy, however much they are looking forward to the baby. Some arguments may be nothing to do with the pregnancy, but others may be because one of



you is worried about the future and how you are going to cope. It's important to realise that during pregnancy there are understandable reasons for the odd difficulty between you, and good reasons for feeling closer and more loving.

One practical question you will need to discuss is how you will cope with labour, and whether your partner wants to be there. Many fathers do want to be present at their

baby's birth. The chapter on labour and birth (page 85) gives some suggestions for ways in which fathers can help, and what it can mean for them to share this experience.

If your relationship is particularly problematic, or is abusive, do get help. For sources of confidential support, like Relate or Women's Aid, refer to the list of useful organisations featured at the back of the book (see page 182).

It may be that you do not have a partner in this pregnancy and you need extra support from family or friends. You may wish to talk to your midwife about services that may be available. See 'Single parents' opposite.



SEX IN PREGNANCY

It is perfectly safe to have sex during pregnancy. Your partner's penis cannot penetrate beyond your vagina, and the baby cannot tell what is going on! However, it is

normal for your sex drive to change and you should not worry about this, but do talk about it with your partner.

Later in pregnancy, an orgasm – or even sex itself – can set off contractions (known as Braxton Hicks contractions – see page 87). You will feel the muscles of your uterus go hard. There is no need for alarm, as this is perfectly normal. If it feels uncomfortable, try your relaxation techniques or just lie quietly till the contractions pass.

Your midwife or doctor will probably advise you to avoid sex if you have any heavy bleeding in pregnancy, since this risks infection in the baby – especially if your waters have broken (see page 87).

Some couples find having sex very enjoyable during pregnancy,

while others simply feel that they don't want to have sex. You can find other ways of being loving or of making love. The most important thing is to talk about your feelings with each other.

While sex is safe for most couples in pregnancy, it may not be all that easy. You will probably need to find different positions. This can be a time to explore and experiment together. Even early in pregnancy it can become uncomfortable to have sex with your partner on top. This can be because of your bump or because your breasts are tender. It can also be uncomfortable if your partner penetrates you too deeply. So it may be better to lie on your sides.



Help and support

thecoupleconnection.net

thecoupleconnection.net is an innovative new service developed by One Plus One, the UK's leading relationships research organisation. thecoupleconnection.net has been designed to help couples to cope with changes and to strengthen their relationships. Visit www.thecoupleconnection.net



SINGLE PARENTS

If you are pregnant and on your own, it is important that there are people who can support you. Sorting out problems, whether personal or medical, is often difficult when you are by yourself, and it's better to find someone to talk to rather than to let things get you down. You may find it encouraging to meet other mothers who have also gone through pregnancy on their own.

Don't feel that, just because you don't have a partner, you have to go to antenatal visits and cope

with labour on your own. You have as much right as anyone else to take whoever you like – a friend, sister, or perhaps your mum. Involve your 'labour partner' in antenatal classes if you can, and let them know what you want from them. Ask your midwife if there are antenatal classes in your area that are run especially for single women.

Think about the people who can help and support you. If there is no one who can give you support, it might help to discuss your situation with a social worker. Your midwife can refer you or you can contact the social services department of your local council directly.

Help and support



One Parent Families/Gingerbread

One Parent Families/Gingerbread (see page 184) is a self-help organisation for one-parent families that has a network of local groups which can offer you information and advice. They will be able to put you in touch with other mothers in a similar situation.

If money is an immediate concern, see the chapter on rights and benefits (page 156) for information on what you can claim and your employment rights. Your local Jobcentre Plus or Citizens Advice Bureau (CAB) will be able to give you more advice. If you have housing problems, contact your local CAB or your local housing advice centre. Ask your local authority at the town hall for the address.

Lone Parent Helpline

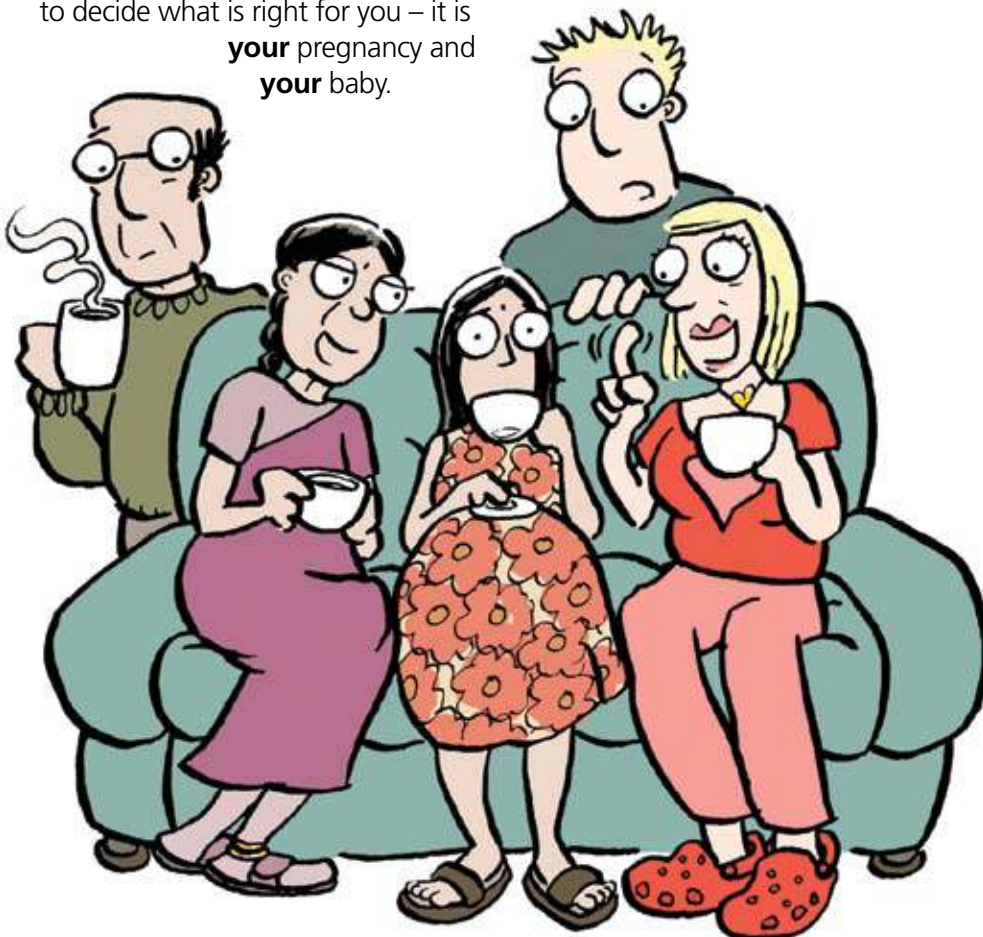
Call free on **0800 018 5026** (9am–5pm, Mon–Fri; 9am–8pm, Wed).

FAMILY AND FRIENDS

Pregnancy is a special time for you and your partner, but there may be a lot of people around you who are interested in your baby, such as your parents, sisters, brothers and friends.

People can offer a great deal of help in all sorts of ways, and you will probably be very glad of their interest and support. Sometimes it can feel as if they are taking over. If so, it can help everyone if you explain gently that there are some decisions that only you and your partner can take, and some things that you would prefer to do on your own.

You may also find that being pregnant puts you on the receiving end of a lot of advice, and perhaps a bit of criticism too. Sometimes the advice is helpful, sometimes not. Sometimes the criticism can really hurt. The important thing is to decide what is right for you – it is **your** pregnancy and **your** baby.



More information

Families Information Service

Your local Families Information Service (which may be called something else in your local area) can provide information about registered childcare, free early education places and other services available in your area.

You can contact them on **0800 2 346 346**. You can also search **www.childcarelink.gov.uk** for your local Families Information Service or look on your local authority's website for more details.

WORK

If you work, and you like the people you work with, you may have mixed feelings when you go on maternity leave. Try to make the most of these few weeks to enjoy doing the things you want to do at your own pace. It is also a good opportunity to make some new friends. You may meet other mothers at antenatal classes (see page 56) or you may get to know more people living close by.

You may have decided that you are going to spend some time at home with your baby, or you may be planning to return to work, either full or part-time, fairly soon after the birth. If you think that you will be going back to work, you need to start thinking about who will look after your baby in advance. It is not always easy to find satisfactory childcare arrangements, and it may take you some time.

You may have a relative willing to look after your child. If not, you should contact your Families Information Service for a list of registered childminders and nurseries. You may also want to think about organising care in your own home, either on your own or sharing with other parents.

Care in your own home does not need to be registered, but you should make sure that your carer is experienced and trained to care for babies. However, if you are to claim financial help with the costs, either through tax credits or tax relief on help from your employer, the carer must be approved through the government's Childcare Approval Scheme. You can find out more at www.childcareapprovalscheme.co.uk



MOOD CHANGES THAT CAN DEVELOP AFTER THE BIRTH OF A BABY

If you experience any of the following mood changes, do not feel ashamed of how you are feeling. You are not alone: asking for and accepting help is the first stage of recovery – particularly for the more serious conditions. If you think you are in any way depressed, talk to a healthcare professional as soon as you can. Your midwife, health visitor and GP are all trained to help you, and many voluntary organisations offer advice (see the list of useful organisations on page 182).

The baby blues

As many as 8 out of 10 women get what is commonly called 'the baby blues'. It normally begins within a few days of the baby's birth.

How does it affect you?

Common reactions are to burst into tears for no obvious reason, or to feel on top of the world one minute and miserable the next. It is not unusual to feel anxious or tense, lacking in confidence or worried.

Remember that having a baby can turn your world upside down. In the first few weeks and months you are likely to feel emotionally and physically drained. Becoming a parent for the first time can feel like an overwhelming responsibility and it is very easy to feel inadequate when other parents around you seem to be coping well. You may expect to love your baby immediately, but this can take a while and is not always instinctive, and does not mean that you are not a 'good' or 'natural' mother. Many women experience these feelings.

AFTER THE BIRTH

Having a baby and becoming a parent are major events for both you and your partner. Becoming a parent usually brings changes to your home life, social life and relationships. Parents of a new baby experience a variety of emotions after the birth. You will feel happy and proud of yourself, or possibly relieved that it is all over.



Whether this is your first, second or third baby, the first few weeks of parenthood are both physically and emotionally tiring. It can be difficult to find time for yourself, your partner or your family when you have the 24-hour demands of a new baby to deal with. Meeting the needs of a baby can be rewarding, but in the weeks and months following the birth of a baby you can feel stressed.

It is likely that during the first few weeks and months of parenthood you will feel a mixture of emotions. Your health visitor will be available to talk to you, but it is important that you talk honestly to your partner, friends or family about how you feel.

Being a parent means constantly experiencing new events and carrying out new tasks. You will have to learn a new set of skills to cope with these situations. Women do not automatically know how to be a mother and men do not automatically know how to be a father. It is something that you learn over time.



If you have twins or triplets, you are more likely to experience postnatal and longer-term depression. This is mainly because of the additional stress of caring for more than one baby. Getting out of the house can be difficult and this can make you feel isolated. Tamba (see page 188) can help you to make contact with other mothers through local twins clubs and through their helpline, Tamba Twinline (0880 138 0509).

When you have a baby your life changes, so don't be too hard on yourself – you are only human. We all learn to be a parent when we actually have a baby, not before. Give yourself plenty of time to adjust to your new life. Find time to rest and eat a good diet, as this will help you to become and stay physically and emotionally healthy.

Talk to someone you can trust such as your partner, your mum, a friend, or to your midwife or health visitor, about how you are feeling. It can help a lot just to confide in someone else. Once they know how you are feeling, they will be able to give you support.

If you become more unhappy or upset, or if your low mood lasts more than a week, then you are probably experiencing something other than the baby blues. In these circumstances, you should talk to your midwife, health visitor or doctor – especially if you have had depression before.

Postnatal depression

Postnatal depression affects 1 in 10 women following the birth of their baby. It usually begins in the first six months after childbirth, although for some women the depression begins in pregnancy. It can occur at any time within the first year of the birth of your baby.

How does it affect you?

If you get postnatal depression, you can feel as if you are taken over by a feeling of hopelessness. You may feel angry, but more often you will feel too exhausted to be angry or even to cope with the simplest tasks.

Postnatal depression is serious, and if it is left untreated it can last for longer than a year. However, early diagnosis and treatment of postnatal depression will result in a faster recovery. Quite often a partner or close family friend will recognise that there is something wrong before you do.

If you think you are depressed, contact your GP, midwife or health visitor and explain how you are feeling. Your partner or a friend could contact them for you if you want. You can also contact the Association for Post-Natal Illness (see page 186) for more information.

Postnatal post traumatic stress disorder and birth trauma

Post traumatic stress disorder symptoms may occur on their own or with postnatal depression. The reasons women develop this are unclear, but women often describe feeling 'out of control' and very afraid during the birth. This condition can be caused by:

- a fear of dying or your baby dying, or
- life-threatening situations.

How does it affect you?

The symptoms include flashbacks, nightmares, panic attacks, numbed emotions, sleeping problems, irritable, angry and irrational behaviour.

If you get any of these symptoms, you need to talk to someone about how you are feeling; your midwife, GP or health visitor will be able to advise where to get help.

Puerperal psychosis

This is a much more rare and serious condition, which affects about 1 in 500 new mothers. Women with a family history of mental illness or who have suffered from puerperal psychosis in previous pregnancies are at a higher risk of developing this illness.

Symptoms include hallucinations (seeing or hearing things that others cannot), delusions (incredible beliefs such as thinking you must save the world) and mania (extremely energetic and bizarre activity like washing and ironing clothes in the middle of the night).

How does it affect you?

The symptoms of this illness can be very severe and sometimes very frightening for you, your partner, and your family. In fact, your partner may be the first to notice that you are unwell. It is important that your partner or someone close to you knows the symptoms to look out for. They will appear suddenly, often within the first two weeks following the birth of the baby. Seeking help quickly will ensure that you are treated as early as possible, to help you get well again.

Women with this illness are often treated in hospital. Mother and baby units are available so that you will not be separated from your baby.

DOMESTIC ABUSE

One in four women experience domestic abuse at some point in their lives. This may be physical, sexual, emotional or psychological abuse. Of this, 30% starts in pregnancy, and existing abuse may get worse during pregnancy or after giving birth. Domestic abuse during pregnancy puts a pregnant woman and her unborn child in danger. It increases the risk of miscarriage, infection, premature birth, low birth rate, fetal injury and fetal death. Domestic abuse should not be tolerated.

If you are pregnant and being abused, there is help available. You can speak in confidence to your GP, midwife, obstetrician, health visitor or social worker. Or call the confidential National Domestic Violence Helpline number (see right) for information and support. For further sources of confidential support, refer to page 184.

Help and support

Domestic abuse

If you are in immediate danger, call 999.

For information and support call the freephone, 24-hour **National Domestic Violence Helpline**, run in partnership between Refuge and Women's Aid: **0808 2000 247**

Refuge

www.refuge.org.uk

Women's Aid

www.womensaid.org.uk



there is
help
available

Benefits and advice if your partner has died

The following leaflets are produced by the Department for Work and Pensions (www.dwp.gov.uk):

- *What to do after a death in England and Wales* (DWP1027)
- *The Social Fund* (DWP1007) (available from www.dwp.gov.uk to download only)
- *A guide to the Social Fund* (SB16)
- *Having a baby* (DWP1031)

Read Chapter 17 for advice about the following:

- Income Support
- Housing Benefit
- Working Tax Credit
- Council Tax Benefit
- Child Benefit
- Child Tax Credit
- If you were married and your partner worked, you may be entitled to Widowed Parent's Allowance, based on your partner's National Insurance contributions.
- If you were not married, you will not be classed as a widow and will therefore be dependent on your private arrangements, on Income Support or on Working Tax Credit.
- If you are on a low income you may be able to get some help with the funeral expenses from the Social Fund. It is always worth talking to your undertaker or religious adviser to see if they can help.

For more information, contact your local Jobcentre Plus or look at www.jobcentreplus.gov.uk

BEREAVEMENT

The death of someone you love can turn your world upside down, and is one of the most difficult experiences to deal with. This may be harder to cope with if you are pregnant or have just had a baby.

Family and friends can help you by spending time with you. A sympathetic arm around the shoulders can express love and support when words are not enough.

Grief is not just one feeling but a whole succession of feelings, which take time to get through and which cannot be hurried. If you need help or advice, contact your GP or midwife or any of the organisations listed on page 186.

If your partner dies

If your partner dies during your pregnancy or soon after childbirth, you will feel emotionally numb. It may not be something that you get over – more something that you eventually learn to live with.

Don't be afraid to lean on your family and friends. If your partner was going to be with you at the birth, you will need to think about who will be with you instead. Try to choose someone who knows you very well.

Financially, you may need urgent advice and support. You can get the recommended leaflets (see box) from your local Jobcentre Plus.

As well as speaking to friends, family and social services, you may like to contact Cruse (see page 186).



LABOUR AND BIRTH

8



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Going into labour is exciting, but you may also feel apprehensive, so it helps to be prepared well in advance. Knowing all about the stages of labour and what to expect can help you to feel more in control when the time comes.

GETTING READY

Whether you are having your baby at home, in hospital or at a midwifery unit, you should get a few things ready at least two weeks before your due date.

Packing your bag

If you plan to give birth in hospital or a midwifery unit, your midwife will probably give you a list of what you will need to pack. You may want to include the following:

- Something loose and comfortable to wear during labour. It should not restrict you from moving around or make you too hot. You may need about three changes of clothes.

- Two or three comfortable and supportive bras, including nursing bras if you are planning to breastfeed. Remember, your breasts will be much larger than usual.
- About 24 super-absorbent sanitary towels.
- Your wash bag with toothbrush, hairbrush, flannel, etc.
- Towels.
- Things that can help you pass the time and relax, e.g. books, magazines, MP3 player.
- A sponge or water spray to cool you down.
- Front-opening nightdresses if you are going to breastfeed.
- Dressing gown and slippers.
- Five or six pairs of pants.
- A loose, comfortable outfit to wear after you have given birth and to come home in.
- Clothes (including a hat) and nappies for the baby.
- A shawl or blanket to wrap the baby in.





Transport

Work out how you will get to hospital or the midwifery unit, as it could be at any time of the day or night. If you are planning to go by car, make sure that it's running well and that there is always enough petrol in the tank. If a neighbour has said that they will take you, make an alternative arrangement just in case they are not in. If you have not got a car, you could call a taxi. Or call your maternity unit, which can arrange for an ambulance to pick you up. Try to do so in good time.

Home births

If you are planning to give birth at home, discuss your plans and what you need to prepare with your midwife. You are likely to need the following:

- clothes (including a hat) and nappies for the baby
- about 24 super-absorbent sanitary towels.



Mobile phones

Some hospitals and midwifery units will allow you to use your mobile phone. Check with your midwife. If you cannot use your mobile, make sure that you have a phone card or change for the phone.

If labour starts early

Labour can start as early as 24 weeks. If this happens, call your midwife or hospital immediately.

Stocking up

When you come home you will not want to do much more than rest and care for your baby, so do as much planning as you can in advance:

- Stock up on basics, such as toilet paper, sanitary towels and nappies.
- Buy tinned and dried food like beans, pasta and rice.
- If you have a freezer, cook some meals in advance.



Important numbers

Keep a list of important numbers in your handbag or near your phone. There is space for you to write them down at the back of this book.

You need to include the following:

- Your hospital and midwife's phone numbers.
- Your partner and birth partner's phone numbers.
- Your own hospital reference number (it will be on your card or notes). You will be asked for this when you phone in.
- A local taxi number, just in case you need it.

THE SIGNS OF LABOUR

You are unlikely to mistake the signs of labour when the time really comes, but if you are in any doubt, don't hesitate to contact your midwife.

Regular contractions

During a contraction, your uterus gets tight and then relaxes. You may have had these throughout your pregnancy – particularly towards the end. Before labour, these are called Braxton Hicks contractions. When you are having regular contractions that last more than 30 seconds and begin to feel stronger, labour may have started. Your contractions will become longer, stronger and more frequent.

Other signs of labour

- **Backache** or the aching, heavy feeling that some women get with their monthly period.

- **The 'show'.** The plug of mucus in the cervix, which has helped to seal the uterus during pregnancy, comes away and comes out of the vagina. This small amount of sticky pink mucus is called the 'show'. It usually comes away before or in early labour. There should only be a little blood mixed in with the mucus. If you are losing more blood, it may be a sign that something is wrong, so phone your hospital or midwife straight away.
- **Your waters break.** The bag of water surrounding your baby may break before labour starts. To prepare for this, you could keep a sanitary towel (not a tampon) handy if you are going out, and put a plastic sheet on your bed. If your waters break before labour starts, you will notice either a slow trickle from your vagina or a sudden gush of water that you cannot control. Phone your midwife when this happens.
- **Nausea or vomiting.**
- **Diarrhoea.**



Pain relief in labour

Labour is painful, so it is important to learn about all the ways you can relieve pain. Whoever is going to be with you during labour should also know about the different options, as well as how they can support you. Ask your midwife or doctor to explain what is available so that you can decide what is best for you. Write down what you want in your birth plan, but remember that you should keep an open mind. You may find that you want more pain relief than you had planned, or your doctor or midwife may suggest more effective pain relief to help the delivery.



has
the time
come?

TYPES OF PAIN RELIEF

Self-help

The following techniques can help you to be more relaxed in labour, and this can help you to cope with the pain.

- Learn about labour. This can make you feel more in control and less frightened about what is going to happen. Read books like this one, talk to your midwife or doctor and attend antenatal classes if they are available in your area.
- Learn how to relax and stay calm. Try breathing deeply.
- Keep moving. Your position can make a difference. Try kneeling, walking around or rocking back and forwards.

- Have a partner, friend or relative to support you during labour. If you don't have anyone, don't worry – your midwife will give you all the support you need.
- Ask your partner to massage you (although you may find that you don't want to be touched).
- Have a bath.



Hydrotherapy

Water can help you to relax and can make the contractions seem less painful. Ask if you can have a bath or use a birth pool. The water will be kept at a temperature that is comfortable for you but it will not be above 37°C. Your temperature will be monitored closely.



'Gas and air' (Entonox)

This is a mixture of oxygen and another gas called nitrous oxide. 'Gas and air' will not remove all the pain, but it can help to reduce it and make it easier to bear. Many women like it because it's easy to use and you control it yourself.

How it works

You breathe it in through a mask or mouthpiece which you hold yourself. You will probably have a chance to practise using the mask or mouthpiece if you attend an antenatal class.

The gas takes 15–20 seconds to work, so you breathe it in just as a contraction begins. It works best if you take slow, deep breaths.

Side effects

There are no harmful side effects for you or the baby, but it can make you feel lightheaded. Some women also find that it makes them feel sick or sleepy or unable to concentrate on what is happening. If this happens, you can simply stop using it.

staying
calm
will help



TENS

TENS stands for transcutaneous electrical nerve stimulation. Some hospitals have TENS machines. If not, you can hire your own machine.

TENS has not been shown to be effective during the active phase of labour. It is probably most effective during the early stages, when many women experience lower-back pain.

TENS may be useful if you plan to give birth at home or while you are at home in the early stages of labour. If you are interested in TENS, you should learn how to use it in the later months of your pregnancy. Ask your midwife or physiotherapist.

How it works

Electrodes are taped onto your back and connected by wires to a small, battery-powered stimulator known as an 'obstetric pulsar'. Holding the pulsar, you give yourself small, safe amounts of current. You can move around while using it.



It is believed that TENS works by stimulating your body to produce more endorphins, which are the body's own natural painkillers. It also reduces the number of pain signals that are sent to the brain by the spinal cord.

Side effects

There are no known side effects for either you or the baby.

Intramuscular injections of pain-relieving drugs

Injections of drugs like pethidine or diamorphine can help you to relax, and this can lessen the pain.

How it works

You are given an intramuscular injection. It takes about 20 minutes to work and the effects last between two and four hours.

Side effects

- It can make some women feel very 'woozy', sick and forgetful.
- If it has not worn off towards the end of labour, it can make it difficult to push. You might prefer to ask for half a dose initially, to see how it works for you.
- If pethidine or diamorphine are given too close to the time of delivery, it may affect the baby's breathing. If it does, an antidote may be given.
- The drugs can interfere with breastfeeding.

Epidural analgesia

An epidural is a special type of local anaesthetic. It numbs the nerves which carry pain from the birth canal to the brain. For most women, an epidural gives complete pain relief. It can be very helpful for women who are having a long or particularly painful labour, or who are becoming very distressed.

An anaesthetist is the only person who can give an epidural. If you think you are going to want one, check whether anaesthetists are always available at your hospital.

How it works

- A drip will run fluid into a vein in your arm.
- While you lie on your side or sit up in a curled position, an anaesthetist will clean your back with antiseptic and numb a small area with some local anaesthetic.



- A very small tube will be placed into your back near the nerves that carry pain from the uterus. Drugs (usually a mixture of local anaesthetic and opioid) are then administered through this tube. It takes about 20 minutes to get the epidural set up and then another 10–15 minutes for it to work. Occasionally it doesn't work perfectly at first, and needs to be adjusted.
- After it has been set up, the epidural can be 'topped up' by an anaesthetist or midwife, or you may be given a machine which will let you top up the epidural yourself.
- Your contractions and the baby's heart will need to be continuously monitored by a machine. This means having a belt round your abdomen and possibly a clip attached to your baby's head.

Side effects

- Epidurals may make your legs heavy. It depends on the type of epidural that you have.
- An epidural should not make you feel drowsy or sick.
- Your blood pressure can drop. This is rare, as the drip in your arm will help you to maintain good blood pressure.
- Epidurals can prolong the second stage of labour. If you can no longer feel your contractions,

the midwife will have to tell you when to push. This may mean that instruments are used to help you deliver your baby. However, when you have an epidural, your midwife or doctor will wait longer before they use instruments as long as your baby is fine. Sometimes, less anaesthetic is given towards the end so that the effect wears off and you can push the baby out naturally.

- You may find it difficult to pass water, and a small tube called a catheter may be put into your bladder to help you.
- About 1 in 100 women gets a headache after an epidural. If you develop a headache afterwards, it can be treated.
- Your back might be a bit sore for a day or two, but epidurals do not cause long-term backache.
- About 1 in 2,000 mothers gets a feeling of tingling or pins and needles down one leg after having a baby. This is more likely to result from childbirth itself than from an epidural. You will be advised on when you can get out of bed.

Alternative methods of pain relief



Some women want to avoid the above methods of pain relief and choose acupuncture, aromatherapy, homeopathy, hypnosis, massage and reflexology. Most of these techniques do not provide very effective pain relief. However, if you would like to use any of these methods it is important to discuss it with your midwife or doctor and to let the hospital know beforehand. Most hospitals do not offer them for the relief of pain during labour. If you want to try one of these alternative techniques, make sure that the practitioner you use is properly trained and experienced and check with your midwife that this will be available in the maternity unit. For advice, contact the Institute for Complementary and Natural Medicine (see page 183).

Keep active

Keep active in labour for as long as you feel comfortable. This helps the progress of the birth. Don't do anything strenuous but try and move or walk around normally.

WHEN TO GO TO HOSPITAL OR YOUR MIDWIFERY UNIT

If it is your first pregnancy, you may feel unsure about when you should go into hospital. The best thing to do is call your hospital or unit for advice.



- If your waters have broken, you will probably be told to go in to be checked.
- If it is your first baby and you are having contractions but your waters have not broken, you may be told to wait. You will probably be told to come in when your contractions are regular, strong, are about five minutes apart and are lasting about 60 seconds.
- If you don't live near to your hospital, you may need to go in before you get to this stage.
- Second and later babies often arrive more quickly, so you may need to contact the hospital, midwifery unit or your midwife sooner.

Don't forget to phone the hospital or unit before leaving home, and remember your notes.

Home birth

You and your midwife should have agreed what you will do when labour starts.





ARRIVING AT THE HOSPITAL OR MIDWIFERY UNIT

Hospitals and midwifery units vary, so the following is just a guide to what is likely to happen. Your midwife will be able to give you more information about your local hospital or unit.

If you carry your own notes, take them to the hospital admissions desk. You will be taken to the labour ward or your room, where you can change into a hospital gown or a nightdress of your own. Choose one that is loose and preferably made of cotton, because you will feel hot during labour and will not want something tight.

Examination by the midwife

The midwife will ask you about what has been happening so far and will examine you. If you are having a home birth, then this examination will take place at home. The midwife will:

- take your pulse, temperature and blood pressure and check your urine
- feel your abdomen to check the baby's position and record or listen to your baby's heart, and



- probably do an internal examination to find out how much your cervix has opened. Tell her if a contraction is coming so that she can wait until it has passed. She will then be able to tell you how far your labour has progressed. If you would prefer not to have an internal examination you don't have to have one.

These checks will be repeated at intervals throughout your labour. If you and your partner have made a birth plan, show your midwife so that she knows what kind of labour you want and can help you to achieve it.

Water births

Some hospitals have birthing pools (or you can hire one if there is not one available), so that you can be in water during labour. Many women find that this helps them to relax. It is possible to deliver the baby in the pool. Speak to your midwife about the advantages and disadvantages of a water birth. If you want one, you will need to make arrangements in advance.



Delivery rooms

Delivery rooms have become more homelike in recent years. Most have easy chairs, beanbags and mats so that you can move about in labour and change position. Some have baths, showers or birthing pools. You should feel comfortable in the room where you are giving birth.



Bath or shower

Some hospitals may offer you a bath or shower. A warm bath can be soothing in the early stages of labour. Some women like to spend much of their labour in the bath as a way of easing the pain.



To help yourself get over the urge to push, try blowing out slowly and gently or, if the urge is too strong, in little puffs. Some people find this easier lying on their side, or on their knees and elbows, to reduce the pressure of the baby's head on the cervix.



Fetal heart monitoring

Your baby's heart will be monitored throughout labour. Your midwife will watch for any marked change in your baby's heart rate, which could be a sign that the baby is distressed and that something needs to be done to speed up the delivery. There are different ways of monitoring the baby's heartbeat. If you don't feel comfortable with one of these, tell your midwife.

- Your midwife may listen to your baby's heart intermittently, but for at least one minute every 15 minutes when you are in established labour, using a hand-held ultrasound monitor (often called a Sonicaid). This method allows you to be free to move around.

WHAT HAPPENS IN LABOUR

There are three stages to labour. In the first stage the cervix gradually opens up (dilates). In the second stage the baby is pushed down the vagina and is born. In the third stage the placenta comes away from the wall of the uterus and is also pushed out of the vagina.

The first stage of labour – dilation

The dilation of the cervix

The cervix needs to open to about 10cm for a baby to pass through. This is called 'fully dilated'. Contractions at the start of labour help to soften the cervix so that it gradually opens. Sometimes the process of softening can take many hours before what midwives refer to as 'established labour'. This is when your cervix has dilated to at least 4cm.

If you go into hospital or your midwifery unit before labour is established, you may be asked if you would prefer to go home again for a while, rather than spending extra hours in hospital.

If you go home, you should make sure that you eat and drink, as you will need energy. At night, try to get comfortable and relaxed.

If you can, try to sleep. A warm bath or shower may help you to relax. During the day, keep upright and gently active. This helps the baby to move down into the pelvis and helps the cervix to dilate.



Once labour is established, the midwife will check you from time to time to see how you are progressing. In a first labour, the time from the start of established labour to full dilation can be between 6 and 12 hours. It is often quicker in subsequent pregnancies.

Your midwife should be with you all the time to support you. She will tell you to try not to push until your cervix is fully open and the baby's head can be seen.



- Your baby's heartbeat and your contractions may also be followed electronically through a monitor linked to a machine called a CTG. The monitor will be strapped to your abdomen on a belt.

- Alternatively, a clip can be put on your baby's head to monitor the heart rate. The clip is put on during a vaginal examination and your waters will be broken if they have not already done so. Ask your midwife or doctor to explain why they feel that the clip is necessary for your baby.

Speeding up labour

Your labour may be slower than expected if your contractions are not frequent or strong enough or because your baby is in an awkward position.

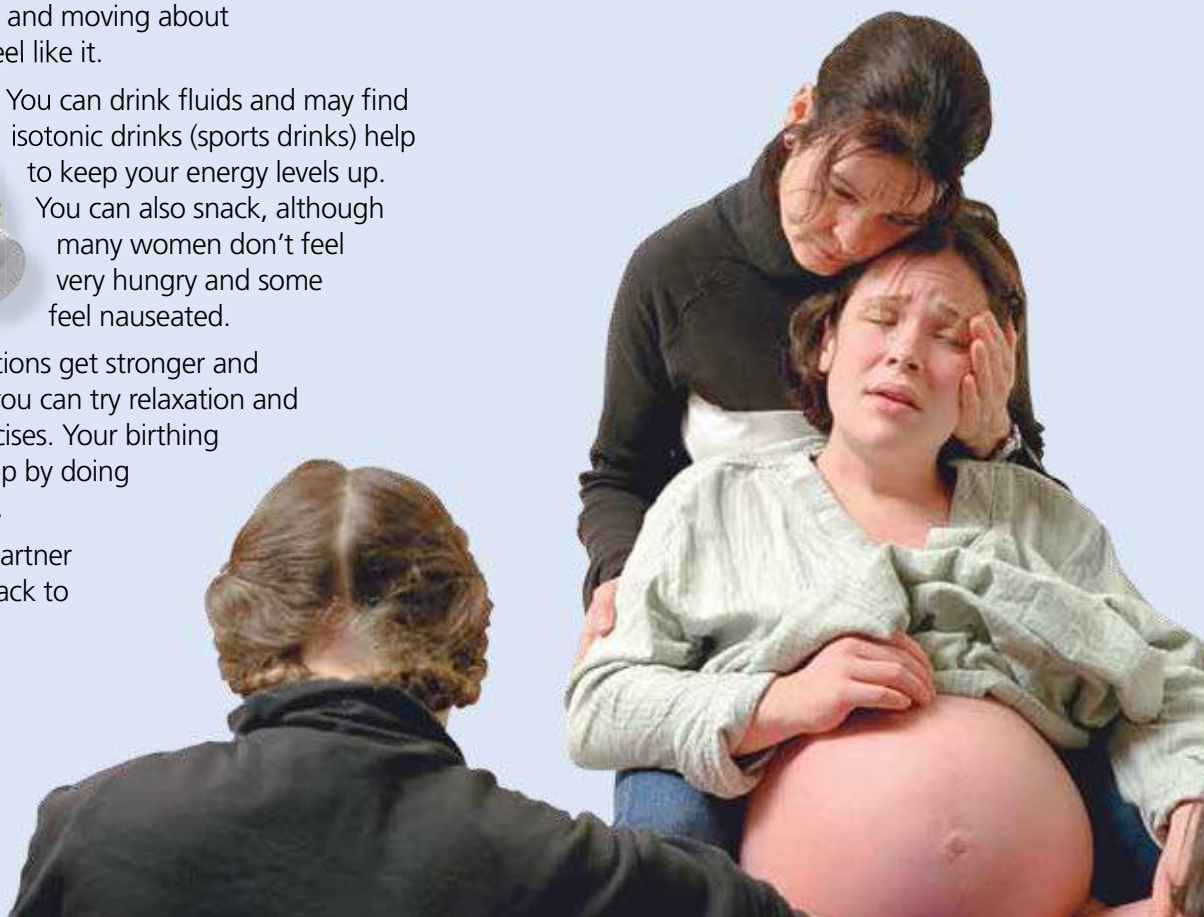
If this is the case, your doctor or midwife will explain why they think labour should be sped up and may recommend the following techniques to get things moving:

- Your waters will be broken (if this has not already happened) during a vaginal examination. This is often enough to get things moving.
- If this doesn't speed up labour, you may be given a drip containing a hormone, which is fed into a vein into your arm to encourage contractions. You may want some pain relief before the drip is started.
- After the drip is attached, your contractions and your baby's heartbeat will be continuously monitored.

support and encouragement

Coping at the beginning

- You can be up and moving about if you feel like it.
- You can drink fluids and may find isotonic drinks (sports drinks) help to keep your energy levels up. You can also snack, although many women don't feel very hungry and some feel nauseated.
- As the contractions get stronger and more painful, you can try relaxation and breathing exercises. Your birthing partner can help by doing them with you.
- Your birthing partner can rub your back to relieve the pain if that helps.



The second stage of labour – the baby's birth

This stage begins when the cervix is fully dilated, and lasts until the birth of your baby. Your midwife will help you to find a comfortable position and will guide you when you feel the urge to push.



Find a position

Find a position that you prefer and which will make labour easier for you.

- You might want to remain in bed with your back propped up with pillows, or you may wish to stand, sit, kneel or squat. Squatting may be difficult if you are not used to it.
- If you are very tired, you might be more comfortable lying on your side rather than propped up with pillows. This is also a better position for your baby.
- You may find kneeling on all fours might be helpful if you suffer from backache in labour.

It can help if you have tried out some of these positions beforehand.



Pushing

When your cervix is fully dilated, you can start to push when you feel you need to during contractions:

- Take two deep breaths as the contractions start, and push down.
- Take another breath when you need to.
- Give several pushes until the contraction ends.
- After each contraction, rest and get up strength for the next one.

This stage is hard work, but your midwife will help and encourage you all the time. Your birth partner can also give you lots of support. This stage may take an hour or more, so it helps to know how you are doing.

The birth

During the second stage, the baby's head moves down until it can be seen.

When the head is visible, the midwife will ask you to stop pushing, and to pant or puff a couple of quick short breaths, blowing out through your mouth. This is so that your baby's head can be born slowly and gently, giving the skin and muscles of the perineum (the area between your vagina and back passage) time to stretch without tearing.



The skin of the perineum usually stretches well, but it may tear. Sometimes to avoid a tear or to speed up the delivery, the midwife or doctor will inject local anaesthetic and cut an episiotomy. Afterwards, the cut or tear is stitched up again and heals.

Once your baby's head is born, most of the hard work is over. With one more gentle push the body is born quite quickly and easily.

You can have your baby lifted straight onto you before the cord is cut by your midwife or birthing partner.

Your baby may be born covered with some of the white, greasy vernix, which acts as a protection in the uterus.

Skin-to-skin contact

Skin-to-skin contact really helps bonding, so it is a good idea to have your baby lifted onto you before the cord is cut so that you can feel and be close to each other straight away.

The cord is clamped and cut, the baby is dried to prevent them from becoming cold, and you will be able to hold and cuddle your baby. Your baby may be quite messy, with some of your blood and perhaps some of the vernix on their skin. If you prefer, you can ask the midwife to wipe your baby and wrap him or her in a blanket before your cuddle.

Sometimes mucus has to be cleared out of a baby's nose and mouth. Some babies need additional help to establish breathing and may be taken to the resuscitator in the room to be given oxygen. Your baby will not be kept away from you any longer than necessary.



The third stage of labour – the placenta

After your baby is born, the uterus can contract to push out the placenta. Your midwife will offer you an injection in your thigh just as the baby is born, which will speed up the delivery of the placenta.

The injection contains a drug called Syntocinon, which makes the uterus contract and helps to

prevent the heavy bleeding which some women experience.

Let your baby breastfeed as soon after birth as possible. It helps with breastfeeding later on and it also helps your uterus to contract. Babies start sucking immediately, although maybe just for a short time. They may just like to feel the nipple in the mouth.

skin to skin





After the birth

Skin-to-skin contact with your baby is important and helps with bonding. Your baby will like being close to you just after birth. The time alone with your partner and your baby is very special.

Your baby will be examined by a midwife or paediatrician and then weighed (and possibly measured) and given a band with your name on it.

Vitamin K

You will be offered an injection of vitamin K for your baby, which is the most effective way of helping to prevent a rare bleeding disorder (haemorrhagic disease of the newborn). Your midwife should have discussed this with you beforehand. If you prefer that your baby doesn't have an injection, oral doses of vitamin K are available. Further doses will be necessary.

Stitches

Small tears and grazes are often left to heal without stitches because they frequently heal better this way. If you need stitches or other treatments, it should be possible to continue cuddling your baby. Your midwife will help with this as much as they can.

If you have had a large tear or an episiotomy, you will probably need stitches. If you have already had an epidural, it can be topped up. If you have not, you should be offered a local anaesthetic injection.

The midwife or maternity support worker will help you to wash and freshen up, before leaving the labour ward to go home or to the postnatal area.

SPECIAL CASES

Labour that starts too early (premature labour)

About 1 baby in every 13 will be born before the 37th week of pregnancy. In most cases labour starts by itself, either with contractions or with the sudden breaking of the waters or a 'show' (see page 87). About one early baby in six is induced (see next page) and about one early baby in five is delivered by caesarean section (see page 98).

If your baby is likely to be born early, you will be admitted to a hospital with specialist facilities for premature babies. Not all hospitals have these facilities, so it may be necessary to transfer you and your baby to another unit, either before delivery or immediately afterwards.



If contractions start prematurely, the doctors may be able to use drugs to stop your contractions temporarily. You will probably be given injections of steroids that will help to mature your baby's lungs so that they are better able to breathe after the birth. This treatment takes about 24 hours to work.

Many multiple birth babies are born prematurely. The normal delivery date for twins is 37 weeks and for triplets 33 weeks.

If you have any reason to think that your labour may be starting early, get in touch with your hospital or midwife straight away.

Overdue pregnancies

Pregnancy normally lasts about 40 weeks, which is approximately 280 days from the first day of your last period. Most women will go into labour within a week either side of this date.

If your labour does not start by 41 weeks, your midwife will offer you a 'membrane sweep'. This involves having a vaginal examination, which stimulates the neck of your uterus (known as the cervix) to produce hormones which may trigger natural labour.

If your labour still doesn't start, your midwife or doctor will suggest a date to have your labour induced (started off). If you don't want labour to be induced and your pregnancy continues to 42 weeks or beyond, you and your baby will be monitored. Your midwife or doctor will check that both you and your baby are healthy by giving you ultrasound scans and checking your baby's movement and heartbeat. If your baby is showing signs of distress, your doctor and midwife will again suggest that labour is induced.



Induction

Labour can be induced if your baby is overdue or there is any sort of risk to you or your baby's health – for example, if you have high blood pressure or if your baby is failing to grow and thrive. Induction is always planned in advance, so you will be able to talk over the benefits and disadvantages with your doctor and midwife and find out why they recommend your labour is induced.

Contractions are usually started by inserting a pessary or gel into the vagina, and sometimes both are used. Induction of labour may take a while, particularly if the neck of the uterus (the cervix) needs to be softened with pessaries or gels. Sometimes a hormone drip is needed to speed up the labour. Once labour starts it should proceed normally, but it can sometimes take 24–48 hours to get you into labour.

Assisted birth (forceps or ventouse delivery)

About one in eight women have an assisted birth, where forceps or a ventouse are used to help the baby out of the vagina. This can be because:

- your baby is distressed
- your baby is in an awkward position
- you are too exhausted.

Both ventouse and forceps are safe and are used only when necessary for you and your baby. A paediatrician may be present to check your baby's health. A local anaesthetic will usually be given to numb the birth canal if you have not already had an epidural or spinal anaesthetic. If your obstetrician has any concerns, you may be moved to a theatre so that a caesarean section can be carried out if needed.

As the baby is being born, a cut (episiotomy) may be needed to enlarge the vaginal opening. Any tear or cut will be repaired with stitches.

Depending on the circumstances, your baby can be delivered onto your abdomen and your birthing partner may still be able to cut the cord, if they want to.

Ventouse

A ventouse (vacuum extractor) is an instrument that has a soft or hard plastic or metal cup which is attached to your baby's head by a tube that is fitted to a suction device. The cup fits firmly onto your baby's head and, with a contraction and your pushing, the obstetrician or midwife gently pulls to help deliver your baby.

The suction cup (ventouse) can leave a small mark on your baby's head called a chignon and it may also cause a bruise on your baby's head called a cephalhaematoma. A ventouse is not used if your baby is less than 34 weeks old, because the head is too soft.

A ventouse is less likely to cause vaginal tearing than forceps.

Forceps

Forceps are smooth metal instruments that look like large spoons or tongs. They are curved to fit around the baby's head. The forceps are carefully positioned around your baby's head and joined together at the handles. With a contraction and your pushing, an obstetrician gently pulls to help deliver your baby.

There are many different types of forceps. Some forceps are specifically designed to turn the baby to the right position to be born, for example if your baby is 'back to your back'.

Forceps can leave small marks on your baby's face. These will disappear quite quickly.

Afterwards

You will sometimes be fitted with a catheter (a small tube that fits into your bladder) for up to 24 hours. You are more likely to need this if you have had an epidural, as you may not have full feeling back.





Caesarean section

There are situations where the safest option for you or your baby is to have a caesarean section. As a caesarean section involves major surgery, it will only be performed where there is a real clinical need for this type of delivery.

Your baby is delivered by cutting through your abdomen and then into your uterus. The cut is made across your abdomen, just below your bikini line. The scar is usually hidden in your pubic hair.



If you are expecting twins, triplets or more, it is more likely that you will be advised to have a caesarean section. This will depend on how your pregnancy progresses, the position of your babies and whether the babies share a placenta.

Whenever a caesarean is suggested, your doctor will explain why it is advised and any possible side effects. Do not hesitate to ask questions.

Urgent (emergency) caesareans

Urgent (emergency) caesarean sections are necessary when complications develop and delivery needs to be quick. This may be before or during labour. If your midwife and doctor are concerned about your or your baby's safety, they will suggest that you have a caesarean straight away. Sometimes your doctor or midwife may suggest an emergency caesarean if your cervix does not dilate fully during labour.

The operation

In the UK, most caesarean sections are performed under epidural or spinal anaesthesia, which minimises risk and means that you are awake for the delivery of your baby (see page 89). A general anaesthetic is sometimes used – particularly if the baby needs to be delivered very quickly.

If you have an epidural or spinal anaesthesia, you will not feel pain – just some tugging and pulling as your baby is delivered. A screen will be put up so that you cannot see what is being done. The doctors will talk to you and let you know what is happening.



Planned (elective) caesareans

A caesarean is 'elective' if it is planned in advance. This usually happens because your doctor or midwife thinks that labour will be dangerous for you or your baby.



It takes about 5–10 minutes to deliver the baby and the whole operation takes about 40–50 minutes. One advantage of an epidural or spinal anaesthetic is that you are awake at the moment of delivery and can see and hold your baby immediately. Your birth partner can be with you.

After a caesarean section

After a caesarean section, you will be uncomfortable and will be offered painkillers. You will usually be fitted with a catheter (a small tube that fits into your bladder) for up to 24 hours and you may be prescribed daily injections to prevent blood clots (thrombosis).



Depending on the help you have at home, you should be ready to leave hospital within two to four days.

You will be encouraged to become mobile as soon as possible, and your midwife or hospital physiotherapist will give you advice about postnatal exercises that will help you in your recovery. As soon as you can move without pain, you can drive – as long as you are able to make an emergency stop. This may be six weeks or sooner.

Once a caesarean always a caesarean?

If you have your first baby by caesarean section, this does not necessarily mean that any future baby will have to be delivered in this way. Vaginal birth after a previous caesarean can and does happen. This will depend on your own particular circumstances (see page 155). Discuss your hopes and plans for any other deliveries with your doctor or midwife.

Help and support

Contact the Caesarean Support Network for information and support (see page 182).

first moments together



Breech birth

If your baby is breech, it means that it is positioned with its bottom downwards. This makes delivery more complicated. Your obstetrician and midwife will talk to you about the best and safest way for your breech baby to be born. You will be advised to have your baby in hospital.



External cephalic version

You will usually be offered the option of an external cephalic version (ECV). This is when pressure is put on your abdomen to try to turn the baby to a head down position.

Caesarean section

If an ECV doesn't work, you will probably be offered a caesarean section. This is the safest delivery method for breech babies but there is a slightly higher risk for you. See the section on caesarean sections for more information (see pages 98–99).

If you choose a caesarean delivery and then go into labour before the operation, your obstetrician will assess whether to proceed with an emergency caesarean delivery. If the baby is close to being born, it may be safer for you to have a vaginal breech birth.



TWINS, TRIPLETS OR MORE

If you are expecting twins, labour may start early because of the increased size of the uterus. It is unusual for multiple pregnancies to go beyond 38 weeks. More health professionals will usually be present at the birth. For example, there may be a midwife, an obstetrician and two paediatricians (one for each baby).

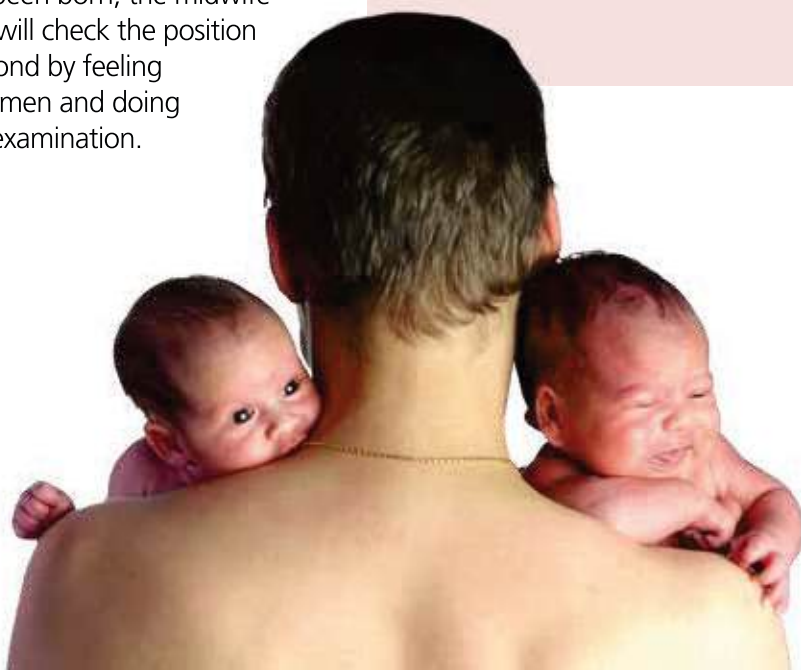
The process of labour is the same but the babies will be closely monitored. To do this, an electronic monitor and a scalp clip might be fitted on the first baby once the waters have broken (see page 87). You will be given a drip in case it is needed later, and an epidural is usually recommended. Once the first baby has been born, the midwife or doctor will check the position of the second by feeling your abdomen and doing a vaginal examination.

If the second baby is in a good position to be born, the waters surrounding the baby will be broken, and the second baby should be born very soon after the first because the cervix is already fully dilated. If contractions stop after the first birth, hormones will be added to the drip to restart them.

Triplets or more are almost always delivered by elective caesarean section.

Help and support

Contact the Multiple Births Foundation (MBF) or Twins and Multiple Births Association (Tamba) for advice and support (see pages 183 and 188).



WHAT YOUR BIRTH PARTNER CAN DO

Whoever your birth partner is – your partner, your baby's father, a close friend or a relative – there are quite a few practical things that he or she can do to help you. The most important thing will probably be just being with you. Beforehand you should talk about what you want, and what you don't want, so that they can support your decisions. There is no way of knowing what your labour is going to be like or how each of you will cope, but there are many ways in which a partner can help.



They can:

- Keep you company and help to pass the time in the early stages.
- Hold your hand, wipe your face, give you sips of water, massage your back and shoulders, help you move about or change position, or anything else that helps.
- Comfort you as your labour progresses and your contractions get stronger.
- Remind you how to use relaxation and breathing techniques, perhaps breathing with you if it helps.
- Support your decisions, for example about pain relief.
- Help you to make it clear to the midwife or doctor what you need – and the other way round. This can help you to feel much more in control of the situation.
- Tell you what is happening as your baby is born if you cannot see what is going on for yourself.



For many couples, being together during labour and welcoming their baby together is an experience that they cannot begin to put into words.

And many fathers who have seen their baby born and who have played a part themselves say they feel much closer to the child from the very start.



FEEDING YOUR BABY



Breastfeeding	103
Formula feeding	115

It's never too early to start thinking about how you are going to feed your baby. Breastfeeding gives your baby the best possible start in life as it has lots of benefits for both you and your baby that last a lifetime. Discuss it with your partner as their help is important. You both might like to watch the *Bump to Breastfeeding* DVD to see what feeding your baby might be like. If you have not received a copy of the DVD, ask your midwife for one.

- Your breastmilk is the only food designed for your baby. It contains everything your baby needs for around the first six months of life. After that, giving your baby breastmilk alongside solid food will help them continue to grow and develop. The World Health Organization recommends breastfeeding for two years or longer.
- Breastfeeding protects your baby from infections and diseases. It also offers health benefits for mums. Every day makes a difference to your baby, and the longer you breastfeed, the longer the protection lasts. And it reduces your chance of getting some illnesses later in life. Formula milk cannot give your baby the same ingredients or provide the same protection.
- Breastfeeding helps build a strong bond between mother and baby, both physically and emotionally.
- Breastfeeding reduces the risk of cot death.

What does breastfeeding help protect against?

Your baby:

Ear infections

Asthma

Eczema

Chest infections

Obesity

Gastro-intestinal infections

Childhood diabetes

Urine infections

You:

Breast cancer

Weak bones later in life

Ovarian cancer

Women who breastfeed get their figures back faster



Help and support

Midwives, health visitors and trained volunteers – or peer supporters – can all offer advice and practical help with breastfeeding. Peer supporters are mothers who have breastfed their own babies and have had special training to help them support other mothers. Talk to your midwife or health visitor about the help that is available in your area.



BREASTFEEDING

Just like any new skill, breastfeeding takes time and practice to work. In the first few days, you and your baby will be getting to know each other. Close contact and holding your baby against your skin can really help with this.

The more time you spend with your baby, the quicker you will learn to understand each other's signs and signals. The next few pages will help you to understand how breastfeeding works. And remember, it's OK to ask for help.

Immediately after your baby is born

Every pregnant woman has milk ready for her baby at birth. This milk is called colostrum and it is sometimes quite yellow in colour. It is very concentrated, so your baby only needs a small amount at each feed, which might be quite frequent. It is full of antibodies to boost your baby's ability to fight off infection.

Holding your baby against your skin straight after birth will calm them, steady their breathing and keep them warm. It will also encourage them to breastfeed. Babies are often very alert in the first hour after birth and keen to feed. Your midwife can help you with this.

The first few days

Each time your baby feeds, they are letting your body know how much milk it needs to produce. The amount of milk you make will increase or decrease in line with your baby's

needs. Around days two to four, you may notice that your breasts become fuller and warmer.

This is often referred to as your milk 'coming in'. To keep yourself as comfortable as possible, feed your baby as often as they want. Your milk will vary according to your baby's needs. It will look quite thin compared with colostrum, but gets creamier as the feed goes on. Let your baby decide when they have had enough.

Sometimes, breastmilk may leak from your breast – try gentle but firm hand pressure on your nipple whenever this happens.

This usually helps very quickly. If you decide to buy breast pads, it is necessary to change them at each feed. Plastic-backed ones can make you even soggy.

'Liquid gold': the perfect food for your newborn

Colostrum is sometimes called 'liquid gold'. This extra-special breastmilk is full of germ-fighting antibodies that will help protect your baby against infections that you have had in the past. The first few feeds 'coat' your baby's gut to protect them from germs and reduce the chances of them developing allergies as they get older.

Later on, your breastmilk will still contain antibodies, and as you come across new infections you will have new antibodies in your milk. This means that if you get colds or flu while you are breastfeeding, your baby will automatically get some immunity from those illnesses.



In the beginning, it can seem that you are doing nothing but feeding, but gradually your baby will get into a pattern of feeding and the amount of milk you produce will settle. Your baby will be happier if you keep them near you and feed them whenever they are hungry. This will quickly help your body to produce the amount of milk your baby needs. At night, your baby will be safest sleeping in a cot in the same room as you. This will make feeding easier and will reduce the risk of cot death. Try to take each day as it comes. If you are very uncomfortable or sore, ask for help.



Partners and breastfeeding

As a partner, you can bond with your baby in lots of different ways, like bathing, changing nappies and carrying your baby in a sling close to you. You can also help by bringing your baby to their mother when it's time for a feed. Some parents worry that breastfeeding will make it harder for their partner to bond with the baby. But this doesn't have to be the case.

You have an important role to play in supporting your partner, for example by preparing meals or providing extra help so she can get some rest. You can do small, practical things like making sure she has a cool drink to hand while she is feeding, and later you can even give some feeds yourself, using expressed milk.



First steps: starting to breastfeed

You can breastfeed in a number of different positions. Finding one that is comfortable for both of you will help your baby feed as well as possible.

If you are lying back in a well supported position with your baby lying on your tummy, they will often move themselves onto your breast and begin to feed. Remember at all times to keep your baby safe.

You can try feeding lying on your side or in a chair, supported in an upright position. This will make it easier to hold your baby so their neck, shoulders and back are supported and they can reach your breast easily. Their head and body should be in a straight line.



Hold your baby's whole body close with the nose level with your nipple.



Let your baby's head tip back a little so that their top lip can brush against your nipple. This should help your baby to make a wide open mouth.



When your baby's mouth opens wide, the chin is able to touch the breast first, with the head tipped back so that the tongue can reach as much breast as possible.



With the chin firmly touching, and with the nose clear, the mouth is wide open, and there will be much more of the darker skin visible above your baby's top lip than below their bottom lip – and their cheeks will look full and rounded as your baby feeds.

Your baby's sucking causes milk stored in your breasts to be squeezed down ducts inside your breasts towards your nipples. This is called the 'let-down' reflex. Some women get a tingling feeling which can be quite strong, while others feel nothing at all. You will see your baby respond and their quick sucks change to deep rhythmic swallows as the milk begins to flow. Babies often pause after the initial quick sucks while they wait for more milk to be 'delivered'. If your baby falls asleep quickly before the deep swallowing stage, check that they are properly latched on. It might be easier to get someone else to check for you. Sometimes you will notice your milk flowing in response to your baby crying or when you have a warm bath.



After your baby has finished feeding, you can hold them upright on your shoulder to wind them – that is, until they burp. Breastfed babies don't usually get as much wind as formula-fed babies.

How do I know that my baby is feeding well?

- Your baby has a large mouthful of breast.
- Your baby's chin is firmly touching your breast.
- It doesn't hurt you to feed (although the first few sucks may feel strong).
- If you can see the dark skin around your nipple, you should see more dark skin above your baby's top lip than below their bottom lip.
- Your baby's cheeks stay rounded during sucking.
- Your baby rhythmically takes long sucks and swallows (it's normal for your baby to pause from time to time).
- Your baby finishes the feed and comes off the breast on their own.

If you have any concerns about any of these points, talk to your peer supporter, midwife, GP or health visitor, or contact the National Breastfeeding Helpline on 0300 100 0212.

Note that if your baby seems unusually sleepy and/or is slow to start feeding, **they may be ill**, so contact your GP as soon as possible.

Helpful tips

Breastfeeding should feel comfortable. Your baby should be relaxed. You should hear a soft swallowing. If it doesn't feel right, start again. Slide one of your fingers into your baby's mouth, gently break the suction and try again.

**a strong
bond**



How do I know my baby is getting enough milk?

- Your baby should be healthy and gaining weight.
- In the first 48 hours, your baby is likely to have only two or three wet nappies. Wet nappies should then start to become more frequent, with at least six every 24 hours from day five onwards.
- Most babies lose weight initially. They should be weighed by a health professional some time around day three to five. From then on, they should start to gain weight. Most babies regain their birth weight in the first two weeks.
- At the beginning, your baby will pass a black tar-like stool (poo) called meconium. By day three, this should be changing to a lighter, runnier, greenish stool that is easier to clean up. From day four and for the first few weeks, your baby should pass at least two yellow stools every day. These stools should be at least the size of a £2 coin. Remember, it's normal for breastfed babies to pass loose stools.
- Your breasts and nipples should not be sore. If they are, do ask for help.
- Your baby will be content and satisfied after most feeds and will come off the breast on their own.

If you are concerned about any of these points, speak to your midwife or health visitor.



Tips for breastfeeding

- Make sure your baby is well attached to your breast (see pictures on page 104). This will help your body make the right amount of milk and stop your breasts getting sore. The more you breastfeed your baby, the more milk you will produce. When your baby comes off the first breast, offer the second. It doesn't matter if they are not interested or don't feed for long, or even if they feed for longer on the second breast. This is fine – just start with this breast next time. Sometimes your baby might seem hungrier than usual

and feed for longer or more often. Your body responds automatically and makes more milk to provide the extra needed. This is why you can feed more than one baby at the same time (see next page).

- There is no need to offer formula milk in addition to breastmilk. If your baby feels hungrier, feed more often, rather than offer formula milk.
- After a while, you will get to know the signs that mean your baby is ready to feed. Most babies will signal that they are hungry by opening and closing their mouths, making sucking noises, opening their eyes or turning their heads to bring their mouths towards you.

By the time a newborn baby starts crying, they will normally have been hungry for a while.

- Try not to give your baby any other food or drink before the age of about six months. This will reduce your milk supply and could increase the chance of your baby getting ill.
- Try not to give your baby a dummy until breastfeeding is going well, as this can also reduce your milk supply.
- When you are out and about, wear something that will make it easier for you to breastfeed.

Colour guide for a baby's stools for the first few days

Day 1

Day 2-3

Day 4



don't forget to ask for help if you need it!

Dummies

Try not to give your baby a dummy until breastfeeding is established, usually when your baby is a month old. Using dummies has been shown to reduce the amount of milk that is produced. If your baby becomes accustomed to using a dummy while sleeping, it should not be stopped suddenly in the first six months. But you should stop using a dummy when your baby is between six and 12 months old.



Breastfeeding more than one baby

Twins, triplets or more can be breastfed. Because multiple babies are more likely to be born prematurely and to have a low birth weight, breastmilk is especially important for their well-being. To start with, you may find it easier to feed each of your babies separately, until you feel confident about handling them at the same time and feeding is well established. This may take some time, so it can be really helpful to accept any offers of help around the house from family and friends.

Over time, you will learn what works best for you and your babies.

Triplets can be breastfed either two together and then one after, or all three rotated at each feed. Alternatively, you can use a combination of breast and formula, depending on the babies and your milk supply.

How long should I breastfeed?

Exclusive breastfeeding (with no other food or drink) is recommended for around the first six months of a baby's life. After this, you can carry on giving your baby breastmilk alongside other foods for as long as you and your baby want. This can be into the second year or beyond.

Every day you breastfeed makes a difference to you and your baby. There is no need to decide at the beginning how long you will breastfeed. Many mothers continue to breastfeed if or when they return to work or college. The practicalities will depend on how old your baby

is and how many feeds they need while you are apart, but it's often easier to manage than people think. Your peer supporter, midwife, health visitor, local support group or the National Breastfeeding Helpline (0300 100 0212) can explain the options and talk them through with you.

If you stop breastfeeding, it can be difficult to start again. Giving formula milk to a breastfed baby can reduce your supply of breastmilk.

More information

The Equality Bill

The Equality Bill offers mothers stronger protection when breastfeeding. The Equality Bill will make it clear that it is unlawful to force breastfeeding mothers and their babies out of places like coffee shops, public galleries and restaurants.

For further information go to www.equalities.gov.uk

positive feeding



Expressing milk

Expressing milk means removing milk from your breast. You may want to express milk if your breasts are feeling uncomfortably full, or if your baby is not sucking well but you still want to give them breastmilk.

If you have to be away from your baby – for example, because your baby is ill or premature, or because you are going back to work – you may wish to express milk so that somebody else can feed your baby.

You can express milk by hand or with a breast pump. Different pumps suit different women, so ask for information to compare them. A pump needs to be clean and sterilised each time it is used.

Expressing by hand

It is more effective to express milk by hand than to use a pump in the first few days. If you want to collect the milk, you will need a sterilised container. The following suggestions should help:

- 1 Before you start, wash your hands thoroughly then gently massage your breast.
- 2 Cup your breast and feel back from the end of the nipple to where the texture of your breast feels different.



STEP 2

- 3 Using your thumb and the rest of your fingers in a C shape, squeeze gently about 3 to 6cm behind the nipple – this should not hurt.



STEP 3

- 4 Release the pressure then repeat, building up a rhythm. Avoid sliding your fingers over the skin. At first, only drops will appear, but just keep going as it will help build up your supply. With practice, and a little time, milk will flow freely.



STEP 4

- 5 When no more drops are coming, move your fingers round to try a different section of your breast and repeat.
- 6 When the flow slows down, swap to the other breast. Keep changing breasts until the milk is dripping very slowly or stops altogether.
- 7 If the milk doesn't flow, try moving your fingers slightly towards the nipple or further away, and try giving your breast a gentle massage.

Expressing milk if your baby is premature or ill

It is important to start expressing your milk as soon as possible after your baby is born. To ensure that you produce plenty of milk, you will need to express at least six to eight times in 24 hours, including during the night, just as your baby might be doing if they were able to feed directly. Ask the hospital staff about having skin-to-skin contact with your baby as soon as possible after the birth. This will help with bonding and keeping up your milk supply.



Hospitals often have machines for expressing milk, and will show you how to use one. Alternatively, you can hire an electric breast pump. Contact breastfeeding organisations or pump companies directly to find out about pump hire in your area (see page 114 for contact details).

If you are freezing breastmilk because your baby is premature or ill, ask the staff caring for your baby for support and information. Also see opposite for guidance on storing breastmilk.

Your midwife, health visitor or peer supporter can give you practical help and answer any questions.

Cup feeding

Sometimes, your baby might need some extra milk, or find it hard to feed from your breast. In this case, your midwife might suggest that you give your baby some expressed milk in a cup. Ask her to show you how. In this way, your baby is able to taste and begin drinking your milk. You should not pour milk directly into your baby's mouth.

Storing breastmilk

You can store breastmilk for:

- up to five days in the fridge at 4°C or lower. This means putting the milk in the coolest part of the fridge, usually at the back (do not keep it in the door)
- up to two weeks in the freezer compartment of a fridge, or
- up to six months in a domestic freezer, at minus 18°C or lower.

Breastmilk must always be stored in a sterilised container. If you use a pump, make sure you wash it thoroughly after use and sterilise it before use.

Milk should be defrosted in the fridge. Once it's defrosted, you will need to use it straight away.



Milk that has been frozen is still good for your baby and better than formula milk. Milk should not be refrozen once thawed. Don't use a microwave oven to warm or defrost breastmilk.

Some common breastfeeding problems and how to solve them

It can be hard to ask for help, but tackling any problems as soon as they start will give you more time to enjoy these early days. In lots of cases, the solution is as simple as changing your baby's position slightly or feeding them a bit more often.

Unsettled feeding

If your baby is unsettled at the breast and doesn't seem satisfied by feeds, it may be that they are sucking on the nipple alone, and so are not getting enough milk. Ask for help to get your baby into a better feeding position.

Sore or cracked nipples

If your nipples hurt, take your baby off the breast and start again. If the pain continues or your nipples start to crack or bleed, ask for help so you get your baby latched on comfortably (see page 114 for information on how to get help). It can sometimes take a little while to sort out how to prevent the soreness, but it is important to get support as soon as possible.

The following suggestions may also help:

- Try squeezing out a drop or two of your milk at the end of a feed and gently rubbing it into your skin. Let your nipples dry before covering them.
- If you are using breast pads, they need to be changed at each feed (if possible, use pads without a plastic backing).
- Avoid soap as it dries your skin out.
- Wear a cotton bra, so air can circulate.
- Some mothers treat any cracks or bleeding with a thin smear of white soft paraffin or purified lanolin. Put the ointment on the crack (rather than the whole nipple) to help it heal and prevent a scab forming.

Tender breasts, blocked ducts and mastitis

Milk can build up in the ducts for a variety of reasons. The most common are wearing a too-tight bra, missing a feed, or a blow to the breast. It's important that you deal with a blocked duct as soon as possible so that it doesn't lead to mastitis (inflammation of the breast).

If you have mastitis, your breasts will feel hot and tender. You may see a red patch of skin which is painful to touch. You can feel quite ill, as if you have flu, and you may have a temperature. This can happen very suddenly. It is very important to carry on breastfeeding as this will help you get better more quickly.

If you think you might have mastitis (or a blocked duct), try the following:

- Take extra care to make sure your baby is attached well to your breast.
- Feed your baby more often.
- Let your baby feed on the tender breast first.



- If your breasts still feel full after a feed, or your baby cannot feed, express your milk (see page 108 for more information on how to do this).
- Warmth on your breast before a feed can help milk flow and make you feel more comfortable.
- While your baby is feeding, gently stroke the lumpy area with your fingertips towards your nipple. This should help the milk to flow.
- Get lots of rest. Go to bed if you can.
- Take a painkiller such as paracetamol or ibuprofen.
- Ask for help with how you get your baby latched on properly (see page 114 for information on where to get help).

Mastitis may also be a sign of infection. If there is no improvement within 12 to 24 hours, or you start to feel worse, contact your GP or healthcare professional. If necessary, they can prescribe antibiotics that are safe to take while breastfeeding.

Thrush

If you suddenly get sore, bright pink nipples after you have been feeding

without problems for a while, you might have an infection known as thrush. Ask for help to check that your baby is latched on properly, and make an appointment with your GP.

You and your baby will both need treatment. You can easily give thrush to each other, so if your baby has it in their mouth you will still need some cream for your nipples to stop it spreading to you. You may want to ask your pharmacist for advice. Some antifungal creams can be bought over the counter from a pharmacy.

Tongue-tie

Some babies are born with a tight piece of skin between the underside of their tongue and the floor of their mouth. This is known as tongue-tie, and it can affect feeding by making it hard for your baby to attach to your breast. Tongue-tie can be treated easily, so if you have any concerns talk to your midwife or health visitor or contact the National Breastfeeding Helpline on 0300 100 0212.

Staying healthy

You don't need to eat anything special while you are breastfeeding, just make sure you have a varied and balanced diet.

Your milk is good for your baby whatever you eat, but there are foods to avoid (see next page). Being a new mother is hard work though, so it's important to look after yourself and try to eat as varied and balanced a diet as you normally would. Aim to eat healthily as a family. A healthy range of food includes:

- at least five portions of a variety of fruit and vegetables a day (including fresh, frozen, tinned, dried and juiced)
- starchy foods such as wholemeal bread, pasta, rice and potatoes
- plenty of fibre, found in wholegrain bread and breakfast cereals, pasta, rice, pulses (such as beans and lentils) and fruit and vegetables. After childbirth, some women experience bowel problems and constipation – fibre helps with both of these
- protein, such as lean meat and poultry, fish, eggs and pulses
- at least two portions of fish each week, including one portion of oily fish, and
- dairy foods, such as milk, cheese and yoghurt, which contain calcium and are a useful source of protein.

It's also important to drink plenty of fluid. Aim for at least 1.2 litres (six to eight glasses) each day. It's a good idea to have a drink beside you when you settle down to breastfeed. Water, milk and unsweetened fruit juices are all good choices.

To find out more about healthy eating, go to www.eatwell.gov.uk



**healthy
eating**

Healthy snack ideas

The following snacks are quick and simple to make and will give you the energy and strength you need:

- Fresh fruit.



- Sandwiches or pitta bread filled with salad vegetables, grated cheese, salmon or sardine or cold meat.
- Yoghurts and fromage frais.
- Hummus and bread or vegetable sticks.
- Ready-to-eat dried apricots, figs or prunes.
- Vegetable and bean soups.
- Fortified unsweetened breakfast cereals, muesli or other wholegrain cereals with milk.
- Milky drinks or unsweetened fruit juice.
- Baked beans on toast or baked potato.



Vitamins

While you are breastfeeding (just as when you were pregnant) you should take supplements containing 10 micrograms (mcg) of vitamin D each day. You should be able to get all the other vitamins and minerals you need by eating a varied and balanced diet. Your skin makes vitamin D naturally when it's exposed to the sun between April and September.

Ask your GP or health visitor where to get vitamin D supplements. You may be able to get free vitamin supplements without a prescription if you are eligible for Healthy Start (see page 28).

Foods to avoid

Eating fish is good for your health. But don't have more than two portions of oily fish a week. This includes fresh tuna (not canned tuna, which doesn't count as oily fish), salmon, mackerel, sardines and trout.

The general advice for all adults is to avoid eating more than one portion of shark, swordfish or

marlin a week, because of the levels of mercury in these fish. Avoid these fish altogether during pregnancy or if you are trying to get pregnant.

Small amounts of whatever you are eating and drinking can pass to your baby through your breastmilk, so it's a good idea to think about how much alcohol and caffeine you are having. These may affect your baby in the same way they affect you. If you think a food or foods that you are eating are affecting your baby, talk to your GP or health visitor, or contact the National Breastfeeding Helpline on 0300 100 0212.

Drinks containing caffeine can also affect your baby and may keep them awake, so drink them only occasionally rather than every day while your baby is young.

See page 112 for more information on alcohol and breastfeeding.

Caffeine

Caffeine occurs naturally in lots of foods and drinks, including coffee, tea and chocolate. It's also added to some soft drinks and energy drinks and to some cold and flu remedies. In the early days, it is important that you don't have too much caffeine. Try decaffeinated tea and coffee, fruit juice or water and limit the number of energy drinks, which might be high in caffeine.



Helpful tips

- Eat when you feel hungry, and choose healthy snacks.
- You will probably feel quite thirsty. Have a drink beside you before you sit down to breastfeed.

- Try to eat a wide variety of foods (see page 25).
- Try not to restrict your diet unless you think a food is upsetting your baby. Always talk to your health visitor or doctor before cutting out foods.

- Keep your alcohol intake low. Alcohol in breastmilk can affect your baby's feeding or sleeping. Avoid drinking alcohol shortly before feeding your baby.
- Avoid drinking too much strong tea or coffee.

Peanuts

Peanuts are one of the most common causes of food allergy. Peanut allergy affects about 1% of people and can cause severe reactions. Your baby may be at higher risk of developing a peanut allergy if you, the baby's father, brothers or sisters have a food allergy or other allergic condition such as hayfever, asthma and/or eczema.

- If you would like to eat peanuts or foods containing peanuts (such as peanut butter) while breastfeeding, you can choose to do so as part of a healthy balanced diet, unless you are allergic to them or your health professional advises you not to.
- You may have heard that some women have, in the past, chosen not to eat peanuts while they were breastfeeding. This is because the government previously advised women that they may wish to avoid eating peanuts while they were breastfeeding if there was a history of allergy in their child's immediate family (such as asthma, eczema, hayfever, food allergy or other types of allergy), in case small amounts of peanut in their breastmilk increased the chance of the baby developing a peanut allergy. But this advice has now been changed because the latest research has shown that there is no clear evidence to say that eating or not eating peanuts while breastfeeding has any effect on your baby's chances of developing a peanut allergy.
- If you have a child under six months and are not breastfeeding (for example because you are feeding your baby on formula), then there is no reason why you should avoid consuming peanuts or foods containing peanuts.

Alcohol

Generally, adult women should not regularly drink more than two to three units of alcohol per day. During pregnancy, women are advised to avoid drinking. If they do drink, they are advised to drink no more than one to two units once or twice a week, and are advised not to get drunk.

By breastfeeding, you are giving your baby the best possible start in life. It's very unlikely that having an occasional drink will harm you or your baby. However, we do know that alcohol passes through to the baby in very small amounts in your breastmilk. Because of this, if you are breastfeeding it is sensible to limit your drinking and to keep within the limits recommended for pregnant women.

One unit of alcohol is approximately equal to a single (25ml) measure of spirits, half a pint of beer, or half a 175ml glass of wine, although it depends on the strength of the drink.

The website www.nhs.uk/units contains more information on units, including the units found in typical drinks.

Helpful tips

Breastfeeding and alcohol

If it's a special occasion and you know you are going to be drinking, consider expressing milk in advance. To reduce the exposure of your baby to alcohol:

- avoid breastfeeding for at least two to three hours after drinking, or
- have your drink after the last feed of the day – if you can predict when that will be!

If you drink alcohol and breastfeed, it can affect your baby in a number of ways:

- your milk may smell different and put your baby off feeding
- the alcohol may make your baby too sleepy to feed, or
- your baby may have difficulties with digestion and problems with their sleeping patterns.

Smoking

Smoking is bad for you, bad for your partner and especially bad for your baby. One of the best things you can do for your own and your baby's health is to stop smoking. Each year, more than 17,000 children under the age of five are admitted to hospital because of the effects of secondhand smoke.

Avoid smoking in the home or car, and ask your partner, friends and family to do the same when they are around your baby.

If you do smoke and you are finding it difficult to quit, breastfeeding will still protect your baby from infections and give them nutrients they cannot get through formula milk. Smoking after feeds, rather than before, will help reduce your baby's exposure to nicotine.

You are up to four times more likely to stop smoking successfully with NHS support. Call the NHS Smoking Helpline on 0800 022 4 332, or the NHS Pregnancy Smoking Helpline on 0800 169 9 169 for information about the wide range of free specialist support available and for details of your local NHS Stop Smoking Service.

You can also speak to your GP or pharmacist about the nicotine replacement therapy available to help you manage your cravings and become smokefree.

Medicines and breastfeeding

Many illnesses, including depression (see page 76), can be treated while you are breastfeeding without harming your baby. Small amounts of whatever medicines you take will pass through your breastmilk to your baby, so always tell your doctor, dentist or pharmacist that you are breastfeeding.

Medicines that can be taken while breastfeeding include:

- most antibiotics
- common painkillers such as paracetamol and ibuprofen (but not aspirin)
- hayfever medicines such as Clarityn and Zirtek

- cough medicines (provided they don't make you drowsy)
- asthma inhalers, and
- normal doses of vitamins.

You can use some methods of contraception but not all, so check with your GP or pharmacist. Some cold remedies are not suitable.

It's fine to have dental treatments, local anaesthetics, injections (including mumps, measles and rubella (MMR), tetanus and flu injections) and most types of operations. You can also dye, perm or straighten your hair, use fake tan and wear false nails.

Illegal drugs are dangerous for your baby, so talk to your midwife,

health visitor, GP or pharmacist if this is a concern.

More information

For more information go to www.breastfeedingnetwork.org.uk/drugline.html, or call the Drugs in Breastmilk Helpline on 0844 412 4665.

Your GP or pharmacist may like to look at the information from the National Formulary for Children (www.bnfc.org) to see what medicines can be given to babies and children, as these are likely to be safe for mothers to take when breastfeeding.

Medicines for minor ailments when breastfeeding

- Make sure the medicine is safe to take when breastfeeding.
- Watch your baby for side effects such as poor feeding, drowsiness and irritability. Stop taking the medicine if your baby gets side effects.
- For further information, speak to your pharmacist or NHS Direct on 0845 4647.



Minor ailment	First choice	Second choice	Do not use
Constipation	Eat more fibre Bulk laxatives that contain ispaghula Lactulose	Bisacodyl Senna	
Cough	Honey and lemon in hot water Simple linctus		Medicines that contain codeine or guaifenesin
Diarrhoea	Oral rehydration sachets	Occasional doses of loperamide	
Haemorrhoids (piles)	Soothing creams, ointments or suppositories	Ice pack	
Hayfever, house dust mite and animal hair allergy	Antihistamine eye drops or nasal sprays Steroid nasal sprays	Antihistamines – cetirizine or loratadine	Other antihistamines unless advised by your doctor
Head lice	Wet combing Dimeticone lotion	If ineffective, then head lice lotions that contain permethrin	
Indigestion	Antacids (indigestion mixtures)	On your doctor's information: medicines that reduce acid production, e.g. omeprazole	
Nasal congestion (stuffy or runny nose)	Steam inhalation	Oxymetazoline or xylometazoline nasal sprays. Occasional doses of pseudoephedrine	Medicines that contain phenylephrine
Pain (e.g. headache, mastitis, toothache)	Paracetamol	Ibuprofen	Medicines that contain aspirin Medicines that contain codeine (e.g. co-codamol, co-dydramol), unless advised by your doctor
Threadworms	Mebendazole		
Vaginal thrush	Clotrimazole pessaries or cream	Fluconazole	



Help and support

Breastfeeding help and support

Don't be afraid to ask for the support and information you need to make breastfeeding work for you and your baby. No problem is too small – if something is worrying you, the chances are that other mothers will have felt the same.

You can get help from a peer supporter, your midwife or health visitor. You might also want to join a local breastfeeding group. It's a great way of making new friends as well as sharing the ups and downs of looking after a new baby. Most groups usually include a mix of healthcare professionals and local trained volunteer mothers (peer supporters). These mothers have breastfed their own babies and have had some training in basic breastfeeding techniques. Some peer supporters will have had more in-depth training to help them support new mothers.

There may be specialist drop-ins in your area where you can go if you have a specific concern or difficulty.

To find out what is available in your area, talk to your midwife or health visitor, or contact the **National Breastfeeding Helpline** on 0300 100 0212 (lines are open from 9.30am to 9.30pm) or go to the website at www.nationalbreastfeedinghelpline.org.uk

You can also get information online from the **Association of Breastfeeding Mothers** (www.abm.me.uk) and the **Breastfeeding Network** (www.breastfeedingnetwork.org.uk). The Breastfeeding Network runs a Supporterline on 0300 100 0210, and also offers a helpline for speakers of Bengali/Sylheti on 0300 456 2421. Lines are open from 9.30am to 9.30pm.

NHS guidance on breastfeeding is available at www.breastfeeding.nhs.uk

The following voluntary organisations can also provide information and advice:

La Leche League
0845 120 2918
www.laleche.org.uk

NCT Breastfeeding Line
0300 330 0771
www.nct.org.uk

The **Unicef Baby Friendly** site at www.babyfriendly.org.uk provides information and links to useful resources about the benefits of breastfeeding.

The **Breastfeeding Network's Drugs in Breastmilk Helpline** can provide information about breastfeeding and medicines. Call 0844 412 4665.

All these voluntary organisations provide training for peer supporters.

The *Bump to Breastfeeding (Best Beginnings)* DVD is a useful source of information and will give you an insight into other mothers' experiences of breastfeeding. You should have been given a copy of the DVD during your pregnancy. If not, ask your health visitor or visit www.bestbeginnings.info



support for you

Types of milk to avoid

Cows' milk should not be given as a main drink to a child under the age of one year. Small amounts of cows' milk can be used for cooking after six months of age. Condensed milk, evaporated milk, dried milk, sheep's milk, goats' milk, or any other type of 'milk' drink (such as rice, oat or almond drinks, often known as 'milks') should never be given to a baby under the age of one year. You should not use soya formula unless it has been prescribed by your GP.

You can find more information on rice drinks at www.food.gov.uk/science/surveillance/fsisbranch2009/survey0209

Follow-on formula is not suitable for babies under six months.

FORMULA FEEDING

The following new advice is based on guidance from the Department of Health and the Food Standards Agency. It may differ from what you have done before if you have older children, but to minimise any risk it is recommended that you follow this new advice.

Helpful tips

There are a number of different brands of infant formula milk available in the shops. All should meet the legal standards for formula milk, and it's up to you to decide which one to use. In the past it was thought better to stick to one brand, but there is no evidence to suggest that changing brands does any good or any harm.



Choosing a formula

Infant formula milk usually comes in powder form and is based on processed, skimmed cows' milk, and is treated so babies can digest it. Vegetable oils, vitamins, minerals and fatty acids are added to make sure the milk contains the vitamins and minerals that young babies need. This information will be on the contents list on the pack. Infant formula powders are not sterile, so it is important to follow the **cleaning and sterilising** instructions on page 116.

Formula is either 'whey dominant' or 'casein dominant', depending on the balance of proteins it contains. It may also be referred to as stage one or stage two milk.

Vitamin drops

If your baby is formula fed, you should give them vitamin drops from the age of six months or if they are drinking less than 500ml of formula a day. You can buy suitable drops at any pharmacy. Ask your midwife or health visitor where you can get vitamin drops.

Whey-dominant milk is thought to be easier to digest than casein-dominant milk, so should always be the first formula you give your baby.

There is little nutritional difference in the two forms of milk, so if whey-dominant formula milk suits your baby, they can stay on it for the first year or even longer.

'Ready-to-feed' infant formula milk in cartons is also available. This is generally more expensive than powdered milk. Once opened, the carton should be stored in the fridge with the cut corner turned down. Do not store it for longer than 24 hours.

You can continue giving your baby infant formula when they are older than six months.

If you have any worries about the infant formula milk you are giving your baby, ask your midwife, health visitor or GP for advice.



Using formula milk safely

Powdered infant formula milk must be prepared as carefully as possible. It is not a sterile product, and even though tins and packets of milk powder are sealed, they can contain bacteria such as *Cronobacter sakazakii* (formerly known as *Enterobacter sakazakii*) and, more rarely, salmonella.

If the feed is not prepared safely, these bacteria can cause infections. Infections are very rare, but can be life-threatening. Formula must therefore be made up with water hot enough to kill the bacteria – at least 70°C. In practice, this means boiling the kettle and leaving it to cool for no longer than 30 minutes. Very young babies are at most risk, and it is better to use sterile, liquid ready-to-feed products for premature or low birth weight babies. If you are using formula, mix the formula and water and cool quickly to feeding temperature in cold water.

It's also essential to make up a fresh bottle for each feed. Throw away unused formula within two hours. Bacteria multiply rapidly at room temperature and can even survive and multiply slowly in some fridges, so storing formula milk for any length of time increases the risk.



Sterilising

All the equipment used for feeding your baby must be sterilised. By sterilising your feeding equipment, washing your hands and keeping the preparation area clean, you will reduce the chance of your baby getting sickness and diarrhoea.

The following cleaning and sterilising instructions apply whether you are using expressed breastmilk or infant formula milk.

- 1 Clean and rinse.** Clean the bottle and teat in hot soapy water as soon as possible after a feed, using a clean bottle brush. Rinse all equipment in cold, clean running water before sterilising.
- 2 Cold water sterilising.** Follow the manufacturer's instructions. Change the sterilising solution every 24 hours, and leave feeding equipment in the solution for at least 30 minutes. Make sure there is no air trapped in the bottles or teats when putting them in the sterilising solution. Keep all the equipment under the solution with a floating cover.
- 3 Steam sterilising (electric or microwave).** Follow the manufacturer's instructions. Make sure the openings of the bottles and teats are facing down in the steriliser. Any equipment not used straight away should be re-sterilised before use.

Preparing a feed

STEP 1: Before making up a feed, clean and disinfect the surface you are going to use. Wash your hands carefully. If you are using a cold water steriliser, shake off any excess solution from the bottle and the teat or rinse the bottle with cooled boiled water from the kettle (not the tap). Stand the bottle on a clean surface. Keep the teat and cap on the upturned lid of the steriliser. Don't put them on the work surface.



STEP 2: Use fresh tap water to fill the kettle. After it has boiled, let the water cool for no more than 30 minutes. Don't use artificially softened water or water that has already been boiled. If you have to use bottled water, you will still need to boil it. The water must still be hot, otherwise any bacteria in the milk powder might not be destroyed.

For information about using bottled water, go to www.eatwell.gov.uk

Always put the partially cooled boiled water in the bottle first.

Be careful – at 70°C, water is still hot enough to scald. Always check that the water level is correct. Failure to follow the manufacturer's instructions may make your baby ill.

**careful
preparation**



STEP 3

STEP 3: Loosely fill the scoop with milk powder and level it off using the flat edge of a clean, dry knife or the leveller provided. Do not pat it down.



STEP 4

STEP 4: Add the milk powder to the water. Repeat, until you have added the number of scoops specified in the manufacturer's instructions.

It is important to use only the scoop that is enclosed with that milk powder. Using too much powder can give your baby constipation and lead to dehydration; too little could mean that your baby is not getting the nutrients they need. Don't add sugar or cereals to the feed in the bottle.



STEP 5

STEP 5: Holding the edge of the teat, put it on the bottle. Screw the retaining ring onto the bottle. Cover the teat with a cap. Shake the bottle until the powder dissolves.

Make sure you make up a fresh bottle each time you feed your baby and throw away unused feed after two hours. Using stored formula milk can increase the chance of your baby becoming ill.

Feeding your baby

Always cool your baby's milk down before feeding. At 70°C, it is still hot enough to scald. To cool it, hold the bottle, with the cap covering the teat, under cold running water. Test the temperature of the feed by dropping a little onto the inside of your wrist. It should just feel warm to the touch, not hot.

If the milk is too cool, and your baby doesn't like it that way, you can warm it up a little by putting the bottle upright in some hot water, keeping the teat out of the water. Never warm milk in a microwave oven. It will continue to heat up for a time after you take it out of the microwave, even though the outside of the bottle may feel cold.

The milk inside may be very hot and could scald your baby's mouth.

Get everything you need ready before you start feeding. Find a comfortable position to hold your baby while you are feeding. You may need to give your baby time. Some babies take some milk, pause for a nap, and then wake up for more. So you might have to be patient. Remember, feeding is an opportunity to feel close to your baby and get to know them. Even when your baby is a little older, they should never be left alone to feed with a propped-up bottle, as they may choke.

You should check regularly that teats are not torn or damaged.

When feeding, make sure you keep the teat full of milk, otherwise your baby will take in air and get wind. If the teat becomes flattened while you are feeding, pull gently on the corner of your baby's mouth to release the vacuum. If the teat gets blocked, replace it with another sterile teat.

Help and support

If you want help or advice on formula feeding, talk to your midwife or health visitor. See the list of useful organisations at the back of this book.

Bottles and teats

You might find it useful to have about six bottles and teats, so you can always have at least one or two bottles clean, sterilised and ready for use. Ask your midwife or health visitor for more information.

You should always buy new teats. They come in different shapes and with different hole sizes, and you may have to try several before you find the one that suits your baby. If the hole is too small, your baby will not get enough milk. If it's too big, the milk will come too fast.

It's best if you can buy new bottles too. Check regularly to make sure the bottles are in good condition. If they are badly scratched, you will not be able to sterilise them properly. If in doubt, ask your midwife or health visitor for more information.

Bottled water

Bottled water is not a healthier choice than tap water and usually is not sterile. In fact, some natural mineral waters are not suitable for babies because of the amount of minerals they contain. If you need to use bottled water, remember that any bottled water that is labelled 'natural mineral water' might contain too much sodium for babies.

If you are giving bottled water to babies under six months, you should boil and cool it just like tap water. If you need to use bottled water to make up infant formula (for babies of any age), you should boil it and allow it to cool for no more than half an hour.



At the end of the feed, sit and hold your baby upright and gently rub or pat their back for a while to bring up any wind. There is no need to overdo it – wind is not as big a problem as many people think. Talk to your baby as you rub or pat. This will help them feel closer to you and get them used to listening to your voice. Don't forget to throw away any milk that is not used within two hours.

Most babies gradually settle into a pattern. Babies vary in how often they want to feed and how much milk they want to take. Feed your baby when they are hungry, just as you would if you were breastfeeding, and don't try to force your baby to finish a bottle. They may have had enough for the time being or just want a rest.

Feeding away from home

The safest way of feeding your baby away from home is to carry a measured amount of milk powder in a small clean and dry container, a flask of boiled hot water and an empty sterilised feeding bottle. Make up a fresh feed whenever you need it. The water must still be hot when you use it, otherwise any bacteria in the milk powder might not be destroyed. Remember to cool the bottle under cold running water before you use it.

Alternatively, you could use ready-to-drink infant formula milk when you are away from home.

If it's not possible to make up a fresh feed, or if you need to transport a feed – for example to a nursery or childminder – you should prepare the feed at home and cool it in the back of the fridge for at least one hour. Take it out of the fridge just before you leave, and carry it in a cool bag with an ice pack and use it within four hours.

out and about



If you reach your destination within four hours, take it out of the cool bag and store it at the back of a fridge for a maximum of 24 hours. Re-warm for no more than 15 minutes.

Helpful tips

It is always safer to make up a fresh feed whenever possible. When this is not possible, feeds should never be stored for longer than 24 hours.

Coping with allergies

If you think your baby might be allergic to formula milk, talk to your GP. They can prescribe formula feeds called extensively hydrolysed protein feeds.

Some formulas are labelled as hypoallergenic, but they are not suitable for babies with a diagnosed cows' milk allergy. Talk to your GP before using this milk. Always get their advice before using soya-based

infant formulas, too. Babies who are allergic to cows' milk may also be allergic to soya.

Babies sometimes grow out of allergies, and you may find that you can introduce cows' milk into your baby's diet as they get older. Always ask your GP or health visitor for advice before making any changes to your baby's diet.



Some common problems with formula feeding



Crying and colic

For information about crying and colic, see pages 138–139.

Sickness and vomiting

Some babies bring up more milk than others during or just after a feed. This is called 'possetting', 'regurgitation' or 'gastric reflux'. It is not unusual for babies to bring up quite a lot, but it can be upsetting when it happens and you may be worried that something is wrong.

As long as your baby is gaining weight, there is usually nothing to worry about. But if your baby is violently sick or appears to be in pain, or you are worried for any other reason, talk to your health visitor or GP.

Cover your baby's front when feeding and have a cloth or paper towels handy to mop up any mess. Check too that the hole in your baby's teat is not too big, as giving milk too quickly can cause sickness. Sitting your baby upright in a baby chair after a feed can also help. The problem usually stops after six months when your baby is starting on solid foods and drinking less milk.

If your baby brings up a lot of milk, remember that they are likely to be hungry again quite quickly. Don't force your baby to take on more milk than they want during a feed. Remember, every baby is different. Some prefer to feed little and often.

Constipation

Always stick to the recommended amount of infant formula milk powder.

Using too much can make your baby constipated or thirsty. Breastfed babies don't usually get constipated. If your baby is under eight weeks old and has not passed a stool for a few days, talk to your health visitor or GP.

Water

In very hot weather, babies fed on infant formula milk can get thirsty. If this happens, you can give them cool boiled tap water if they seem unsettled between feeds. Talk to your health visitor or GP if you have any concerns.

Breastfed babies do not need any water. Instead, you may notice that they have shorter, more frequent feeds if the weather is hotter.

THE FIRST DAYS WITH YOUR BABY

10



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The first few days with your baby can be a very emotional time for you and your partner. There is a lot to learn and do. There is the excitement of getting to know your baby, but you will also be tired and your body will be recovering from labour and the birth.

Keep your baby close to you as much as you can. Your partner should also spend time holding and being close to your baby. They may feel a little left out, especially if they have to leave you and the baby in hospital and return to an empty home. They may need support and encouragement to get involved.

The more you can both hold and cuddle your baby, the more confident you will all feel.

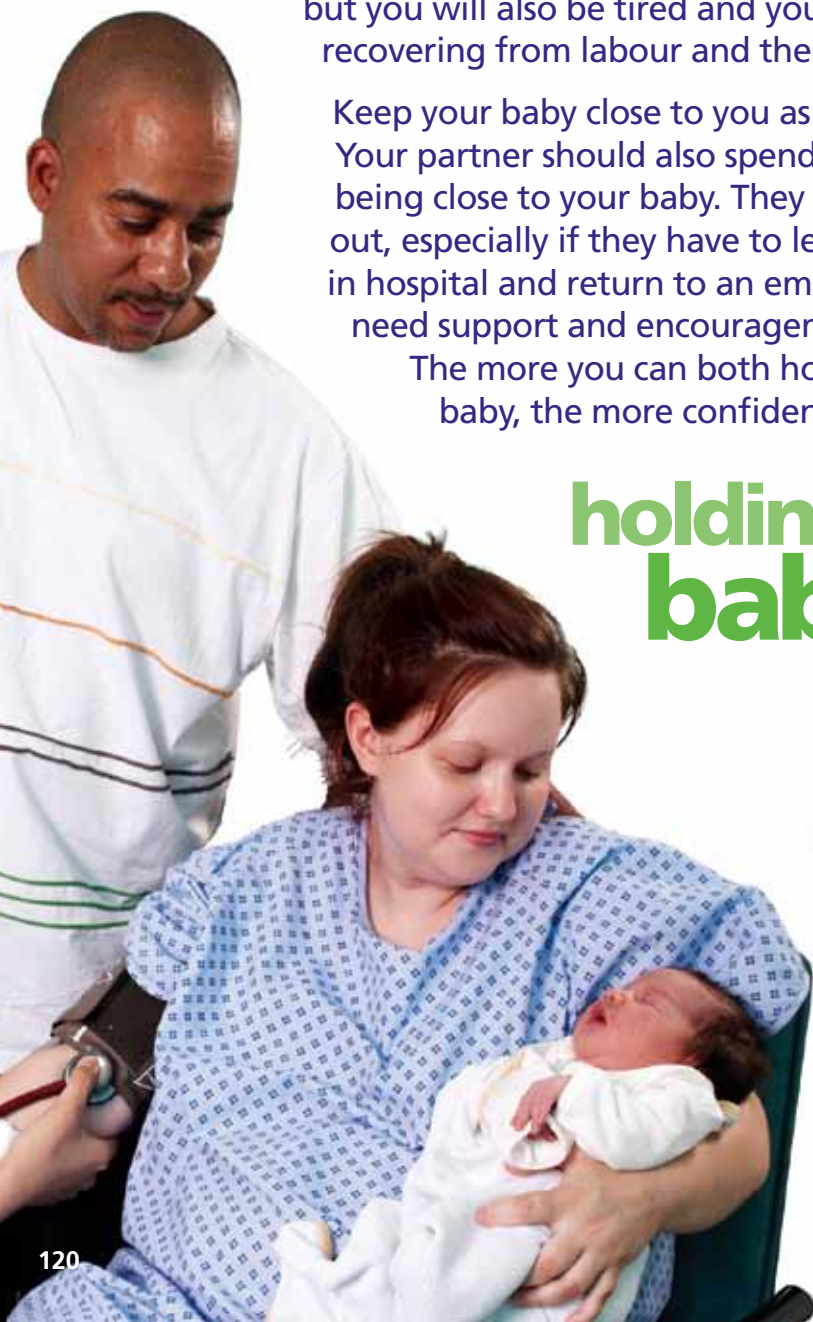


holding your baby close

HOW YOU FEEL

You may feel tired for the first few days, so make sure you get plenty of rest. Even just walking and moving about can seem like hard work.

For a lot of mothers, the excitement and the pleasure of the new baby far outweigh any problems. But you can begin to feel low or rather depressed, especially if you are very tired or feel you cannot look after your baby in the way you would like.



Giving birth is an emotional and tiring experience and your hormones change dramatically in the first few days. Some women get the 'baby blues' and feel rather weepy around three to five days after giving birth (see page 136). This can be worse if your labour was difficult, you are very tired or you have other worries. Some women worry because they don't love their baby immediately. It is not always love at first sight. You may just need to give yourself time – you can still care for your baby and provide all the warmth and security they need.

POSTNATAL CARE

If you have your baby in hospital, you may be able to return home with your baby straight from the labour ward or you may be moved to a transfer lounge or a postnatal ward where you will be with other mothers and babies.

You should discuss your postnatal care with your midwife during pregnancy so you know what to expect.

You are likely to need quite a lot of help and advice with your first baby. Whether you are in hospital or at home, the midwives are there to guide and support you as well as to check that you are recovering from the birth. Don't hesitate to ask for help if you need it. A midwife will be available in your community to help you look after yourself and your baby.



STITCHES

If you have had stitches, bathe the area often in clean warm water to help it to heal. Have a bath or shower with plain warm water. Afterwards, dry yourself carefully. In the first few days, remember to sit down gently and lie on your side rather than on your back. Pelvic floor exercises can also help you to heal (see page 35).

If the stitches are sore and uncomfortable, tell your midwife as they may be able to recommend treatment. Painkillers will also help. If you are breastfeeding, check with your midwife, GP or pharmacist before you buy over the counter products like ibuprofen or paracetamol.

Usually stitches just dissolve by the time the cut or tear has healed, but sometimes they have to be taken out.

Going to the toilet

The thought of passing urine can be a bit frightening at first if you are sore or cannot feel what you are doing. Drinking lots of water dilutes your urine, but if it is difficult to pass urine, tell your midwife.

You probably will not need to open your bowels for a few days after the birth, but it's important not to let yourself become constipated. Eat fresh fruit, vegetables, salad and wholemeal bread, and drink plenty of water. Whatever it may feel like, it's very unlikely that you will break the stitches or open up the cut or tear again.

BLEEDING

After the birth you will bleed from your vagina. This will be quite heavy at first, which is why you will need super-absorbent sanitary towels. Do not use tampons until after your postnatal check, as they can cause infections. While breastfeeding you may notice that the discharge is redder or heavier.

You may also feel cramps like period pain, known as 'after pains'. These are both because feeding causes the uterus to contract.

Gradually, the discharge will become a brownish colour and may continue for some weeks, getting less and less until it stops. If you find you are losing blood in large clots, you should save your sanitary towels to show the midwife as you may need some treatment.

SEX AND CONTRACEPTION

Soon after your baby is born, a midwife or doctor will talk to you about contraception. If this doesn't happen, ask. You can become pregnant straight away, even if you are breastfeeding or have not had a period.

Make sure you are using a reliable form of contraception before you and your partner have sex again, unless you want to get pregnant (see page 135 for your different contraceptive options). If you are breastfeeding, you may not have another period until you stop feeding, or even for some weeks or months after that. If you are not breastfeeding, your first period might start as early as a month after the birth, or it might be much later.



recovery and **healing**

YOUR BODY

Your body will have gone through some major changes over the past few days.

Your breasts

Many women experience changes in the size of their breasts during pregnancy and breastfeeding. See Chapter 9 for more information about this.

If you don't intend to breastfeed from the start, you need not do anything. But on the third or fourth day, your breasts may be tender as the milk is still being produced. Wearing a firm, supportive bra may help. Your breasts will reduce in size in a week or so.

Speak to your midwife if you are very uncomfortable.

Your abdomen

Your abdomen will probably be quite baggy after delivery. Despite having delivered your baby plus the placenta and a lot of fluid, you will still be quite a lot bigger than you were before pregnancy. This is partly because your muscles have stretched. If you eat a balanced diet and exercise, your shape should soon return to normal.

Rhesus negative mothers

If your blood group is rhesus negative and your baby's father's is rhesus positive, blood samples will be taken after the delivery to see whether your baby is rhesus positive. You may need an injection to protect your next baby from anaemia. This should be given within 72 hours of delivery.

Breastfeeding helps because it makes the uterus contract. Sometimes, because this is happening, you may feel a quite painful twinge in your abdomen or period-type pain while you are breastfeeding.

Your bladder

It's quite common after having a baby to accidentally leak urine if you laugh, cough or move suddenly. Pelvic floor exercises (see page 35) will help with this. If the problem persists after three months, see your doctor, who may refer you to a physiotherapist.

Your bowels

Piles (see page 63) are very common after delivery but they usually disappear within a few days. Eat plenty of fresh fruit, vegetables, salad, brown bread and wholegrain cereals, and drink plenty of water. This should make it easier and less painful when you pass a stool. Try not to push or strain as this will make the piles worse. Let the midwife know if you feel very uncomfortable. They will be able to give you an ointment to soothe the piles.

Helpful tips

Postnatal exercises

Postnatal exercises (see page 133) will help to tone up the muscles of your pelvic floor and abdomen. They will also get you moving and feeling generally fitter. You may be able to attend a postnatal exercise class at your hospital. Ask your midwife or physiotherapist to help you organise this.

Personal child health record (PCHR)

You will be given a PCHR for your baby within a few days of their birth. This book records important information about your child. Take it with you whenever you see anyone about your child's health or development. This is **your** record, so do add information yourself. This could be a note of when your child does something for the first time or advice given to you by a healthcare professional.





YOUR BABY'S HEALTH

When your baby is born, they will have a quick physical examination to check that there are no major problems that need urgent treatment. Within 72 hours of birth, another more detailed examination will be carried out. You can find more information at www.screening.nhs.uk

Your baby will also have some other routine health checks and care.

Cord care (belly button)

Shortly after birth, the midwife will clamp the umbilical cord close to your baby's navel with a plastic clip. They then cut the cord, leaving a small bit of cord with the clamp attached. The cord will take about a week to dry out and drop off. Keep the navel clean and dry until this happens. If you notice any bleeding or discharge from the navel, tell your midwife, health visitor or doctor.

Vitamin K

We all need vitamin K to make our blood clot properly so that we will not bleed too easily. Some newborn babies have too little vitamin K.

Although this is rare, it can cause them to bleed dangerously into the brain. To prevent this, your baby should be offered vitamin K. You will be offered an injection of vitamin K for your baby, as this is the most effective way of helping to prevent a rare bleeding disorder (haemorrhagic disease of the newborn). If you prefer that your baby doesn't have an injection, oral doses of vitamin K are available. Further doses will be necessary.

Newborn hearing screening programme

A small number of babies are born with hearing loss. Your baby will be given a quick and simple test to check their hearing. Finding out about hearing loss early means that babies and parents can get the support they need. This can help the development of the child's language and social skills. See www.hearing.screening.nhs.uk for further information.

Newborn blood spot screening (heel prick test)

When your baby is between five and eight days old, your midwife will ask to take a sample of blood from their heel. This is used to test for rare but potentially serious illnesses. All babies are tested for phenylketonuria (PKU – a metabolic disorder), cystic fibrosis, sickle cell disorders and congenital hypothyroidism (CHT – low thyroid hormone). Some babies are also tested for MCADD, an inherited problem with the metabolism.

YOUR BABY'S APPEARANCE



You will probably spend the first few days looking at your baby. You will notice every detail – the colour and texture of their hair, the shape of their hands and feet, and the different expressions on their face. If you notice anything that worries you, however small, ask your midwife. Your baby will be examined by a midwife, paediatrician or neonatal nurse practitioner to make sure everything is all right.

The fontanelle

On the top of your baby's head, near the front, is a diamond-shaped patch where the skull bones have not yet fused together. This is called the fontanelle. It will probably be a year or more before the bones close over. You may notice the fontanelle moving as your baby breathes. Don't worry about touching it or washing the area. There is a tough layer of membrane under the skin.

More information

For more information on blood spot screening: <http://newbornbloodspot.screening.nhs.uk>

For more information on sickle cell screening: www.sct.screening.nhs.uk

Bumps and bruises

It is quite common for a newborn baby to have some swelling and bruises on its head, and perhaps to have bloodshot eyes. This is just the result of the squeezing and pushing that is part of being born and will soon disappear.

Birthmarks and spots

Once you begin to look closely at your baby, you will probably find lots of little marks and spots, mainly on their head and face. Some babies have larger marks. Most of them will go away eventually. Ask the doctor who examines your baby if they will disappear completely.

Most common are the little pink or red marks some people call 'stork marks'. These V-shaped marks on the forehead and upper eyelids gradually fade, though it may be some months before they disappear altogether. Marks on the nape of the neck can stay for much longer, but they will be covered by hair.

Strawberry marks are also quite common. They are dark red and slightly raised. They sometimes appear a few days after birth and gradually get bigger. They may take a while to go away.

Spots and rashes are very common in newborn babies and may come and go. You should tell your doctor or midwife immediately if you also notice a change in your baby's behaviour, for example if your baby is not feeding properly or is very sleepy or very irritable.

Your baby's skin

At birth, the top layer of your baby's skin is very thin and easy to damage. Over the first month (longer in premature babies) your baby's skin matures and develops its own natural protective barrier.

Vernix (the white sticky substance that covers your baby's skin in the uterus) should always be left to absorb naturally. This is nature's own moisturiser and gives added protection against infection in the first few days.

Premature babies' skin is even more delicate. Staff in a specialised neonatal area will advise you on skin care.

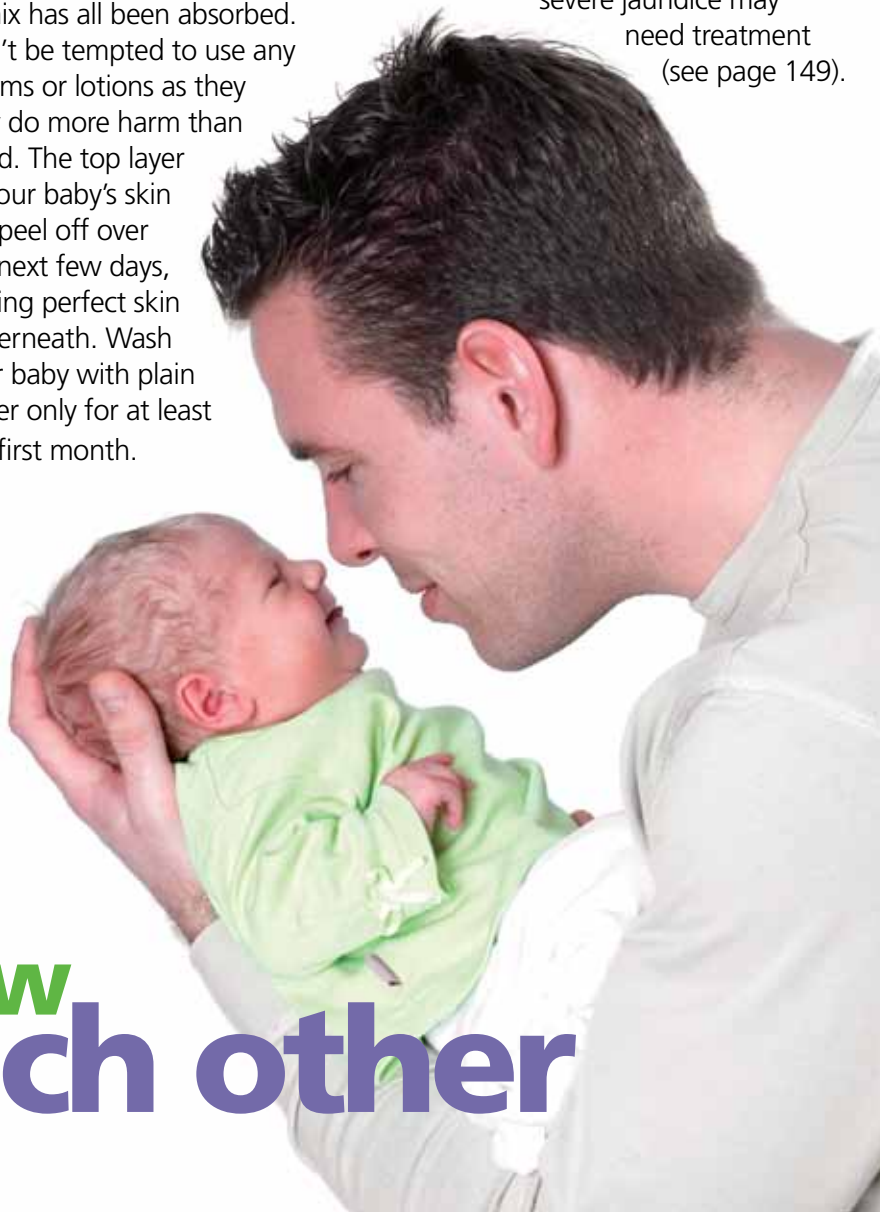
If your baby is overdue, their skin may well be dry and cracked. This is to be expected, as the protective vernix has all been absorbed. Don't be tempted to use any creams or lotions as they may do more harm than good. The top layer of your baby's skin will peel off over the next few days, leaving perfect skin underneath. Wash your baby with plain water only for at least the first month.

Breasts and genitals

A newborn baby's breasts can be a little swollen and ooze some milk, whether the baby is a boy or a girl. Girls also sometimes bleed a bit or have a white, cloudy discharge from their vagina. These are a result of hormones passing from the mother to the baby before birth and are no cause for concern. The genitals of male and female newborn babies often appear rather swollen, but they will look in proportion to their bodies in a few weeks.

Jaundice

When they are about three days old, many babies develop mild jaundice. This will make their skin and the whites of their eyes look a bit yellow. This usually fades within 10 days or so. But more severe jaundice may need treatment (see page 149).



getting
to know
each other

Rubella

If you were not immune to rubella (German measles) when tested early in your pregnancy, you will usually be offered the MMR (measles, mumps and rubella) immunisation. You should get this before you leave hospital, or shortly afterwards from your GP. If it is not offered, speak to your doctor or midwife, as it's a good opportunity to get it done. You should not get pregnant again for one month after the injection. For more information about rubella, visit www.immunisation.nhs.uk

Tests for hepatitis B and C

All babies born to mothers who are infected with hepatitis B should receive a course of immunisation to prevent them getting hepatitis B. Your baby will be offered immunisation soon after birth and at one, two and 12 months old. Your baby should be tested at 12 months to check that immunisation has worked. For more information about hepatitis B immunisation, refer to page 37.

If you are infected with hepatitis C when your baby is born, there is a small risk that you could pass on the infection. Your baby will be tested at an appropriate time.



WHAT YOUR NEWBORN BABY CAN DO

There is one important skill that your baby will not have to learn. They are born knowing how to suck. During the first few days they learn to co-ordinate their sucking and their breathing.

Newborn babies also automatically turn towards a nipple or teat if it is brushed against their cheek, and they will open their mouths if their upper lip is stroked. They can also grasp things (like your finger) with either their hands or feet, and they will make stepping movements if they are held upright on a flat surface. Apart from sucking, these automatic responses will go, and your baby will begin to make controlled movements instead.

Newborn babies can use all of their senses. They will look at people and things, especially if they are near, and particularly at people's faces. They will enjoy gentle touch and the sound of a soothing voice, and they will react to bright light and noise. Very soon they will also know their mother's special smell.



WHAT YOU NEED FOR YOUR BABY



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It can be easy to get confused about what you really need for your baby. You can always ask your midwife or health visitor for advice on what to buy, and you may be given a list of essentials at your antenatal classes or by your maternity service. There are some essentials that every new mother needs, as well as extras that you might want to think about. You may be able to borrow some items, and then pass them on later to another mother or keep them for a second child.

NAPPIES

Disposable nappies

Disposable nappies are convenient to use and are available from supermarkets and other retail outlets.

Cloth nappies

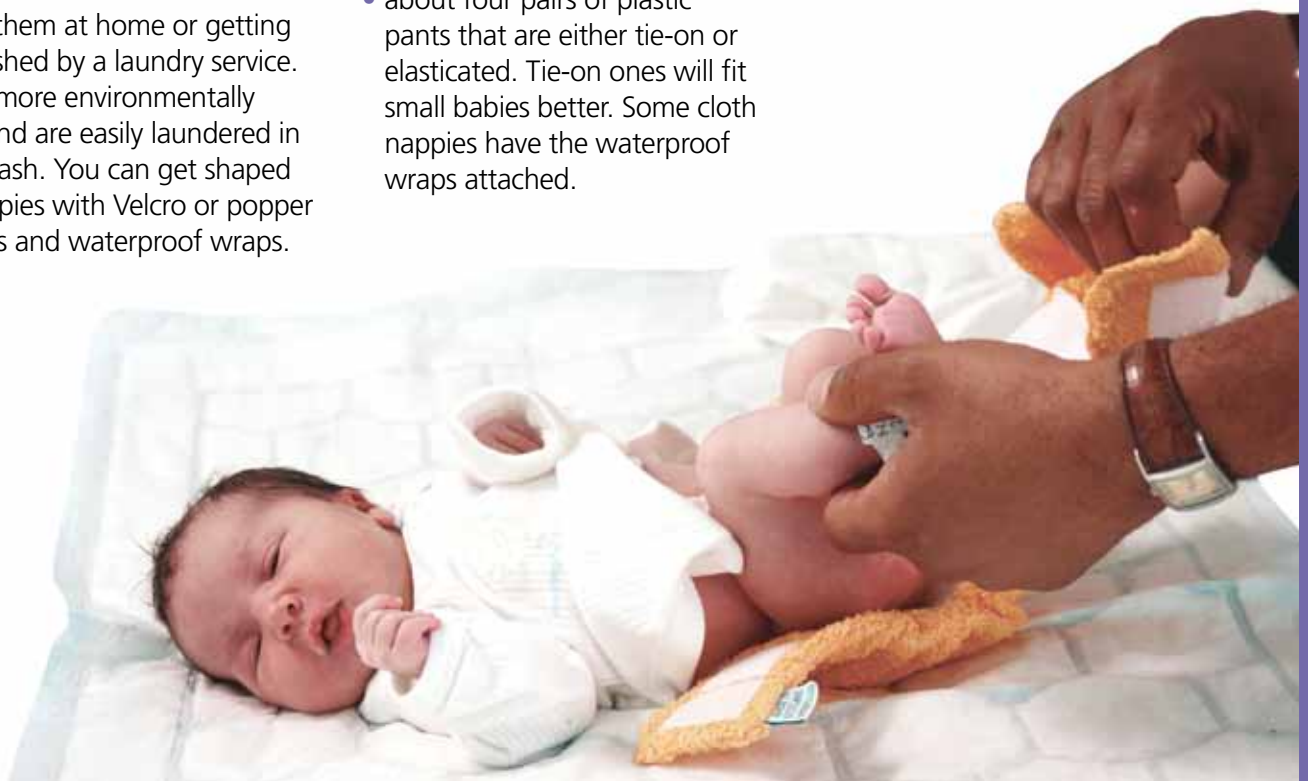
Washable cloth nappies are cheaper than disposable nappies, even when you take into account the cost of washing them at home or getting them washed by a laundry service. They are more environmentally friendly and are easily laundered in a 60°C wash. You can get shaped cloth nappies with Velcro or popper fastenings and waterproof wraps.

For cloth nappies, you will need:

- nappy pins for nappies without Velcro or fasteners
- nappy liners – either disposable or cloth, which you can wash and use again
- a bucket with a lid and nappy sterilising powder or liquid for sterilising nappies, and
- about four pairs of plastic pants that are either tie-on or elasticated. Tie-on ones will fit small babies better. Some cloth nappies have the waterproof wraps attached.

More information

For information about choosing and using cloth nappies, visit www.wen.org.uk, or visit www.goreal.org.uk to find local suppliers.



Nappy services

Nappy laundry services deliver freshly laundered nappies to your home and take away the soiled ones to wash each week. They supply everything you need – wraps, liners and storage bins.

Nappy changing



To change nappies, you will need:

- cotton wool. Always choose white. Rolls are usually cheaper than balls
- a changing mat
- baby lotion or wipes
- baby barrier cream to help prevent nappy rash, and
- a bag to carry all the nappy-changing equipment when you go out. A carrier bag will do but you can get special bags that include a changing mat.

Safety

The safest place to change a nappy is on a mat on the floor. If you use a higher surface, keep your hand on your baby at all times to stop them rolling off.

See page 144 for how to change your baby's nappy.



BATHING

It is a personal choice how frequently you bathe your baby; a wash will often be enough to keep your baby clean and ensure they are comfortable. A warm bath may help your baby to sleep.

You will need:

- a baby bath or any large, clean bowl, such as a sink, as long as it's not metal.

Remember to wrap a towel round the taps for safety

- two towels, the softer the better. Keep them only for your baby's use. There is no need for special baby towels, unless you want them
- unperfumed soap – although washing your baby with just water is fine.

See page 144 for how to bathe your baby.

whose turn?



SLEEPING

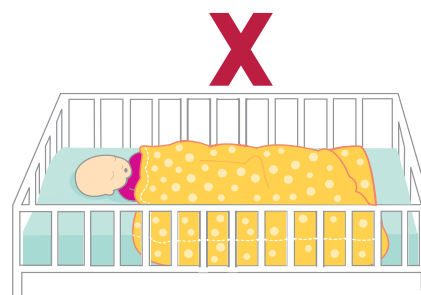
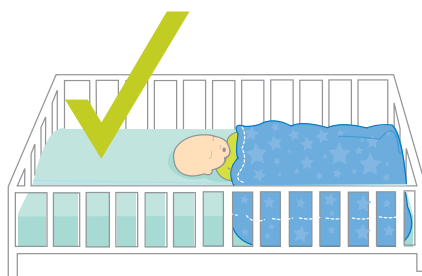
For the first few months, you will need a crib, a carry cot or a Moses basket (a light, portable bassinet). Your baby needs somewhere to sleep that is safe and warm and not too far away from you. If you are borrowing a crib or cot, or if you have one that has been used by another of your children, you will need a new mattress. See the section on reducing cot death on the right.



You will also need:

- a firm mattress that fits the cot snugly without leaving spaces round the edges so that your baby cannot trap their head and suffocate
- sheets to cover the mattress. You need at least four because they need to be changed often. Fitted sheets make life easy but they are quite expensive. You could use pieces of old sheet
- light blankets for warmth.

Pillows and duvets are not safe for babies less than a year old because of the risk of suffocation. Duvets can also make the baby too hot. Baby nests and quilted sleeping bags are not suitable for your baby to sleep in when you are not there because of the danger of suffocation.



The baby on the left is sleeping in the **'feet to foot' position** (also see page 140). This means that the baby's feet are right at the end of the cot to prevent the baby wriggling under the covers and overheating.

Cot safety

Your baby will spend many hours alone in a cot, so make sure it's safe.

- The mattress must fit snugly with no space for your baby's head to get stuck.
- The bars must be smooth and securely fixed, and the distance between each bar should be not less than 1 inch (25mm) and not more than 2 ½ inches (60mm) so that your baby's head cannot become trapped.
- The cot should be sturdy.
- The moving parts should work smoothly so that fingers or clothing cannot get trapped.
- Cot bumpers are not recommended as babies can overheat or become entangled in the fastenings.
- Never leave anything with ties – for example, bibs or clothes – in the cot in case they get caught around your baby's neck.
- If you are buying a new cot, look for the British Standard mark BS 1753.

Reducing the risk of cot death

The Foundation for the Study of Infant Deaths (FSiD) has developed important key messages for parents to help to reduce the risk of cot death.

- Place your baby on their back to sleep, in a cot in a room with you.
- Do not smoke in pregnancy or let anyone smoke in the same room as your baby.
- Do not share a bed with your baby if you have been drinking alcohol, if you take drugs or if you are a smoker.
- Never sleep with your baby on a sofa or armchair.
- Do not let your baby get too hot – keep your baby's head uncovered – and place your baby in the 'feet to foot' position.





OUT AND ABOUT

Spend some time looking at what is available for getting around with your baby. Think about what will suit you best. You could always ask other mothers what they have found useful.

Baby carriers (also called slings) carry your baby in front of you. Most babies like being carried like this because they are close to you and warm. The back part of the carrier must be high enough to support your baby's head. Check that the buckles and straps that attach the carrier to you are secure. Older babies who can hold up their heads and whose backs are stronger (at about four months) can be carried in backpacks.

Pushchairs are only suitable for young babies if they have fully reclining seats that let your baby lie flat. Wait until your baby can sit up before using any other type of pushchair. You should also consider the weight of the pushchair if you use public transport as you might have to lift it onto trains or buses.

Prams give your baby a lot of space to sit and lie comfortably, although they take up a lot of space and are hard to use on public transport.

If you have a car, look for a pram that can be dismantled easily. Buy a pram harness at the same time, as you will soon need it.

Carrycot on wheels. Your baby can sleep in the carrycot for the first few months and the cot can be attached to the frame to go out. It can also be taken in a car with appropriate restraints.

Three-in-one. This is a carrycot and transporter (set of wheels) that can be converted into a pushchair when your baby outgrows the carrycot.

Shopping trays that fit under the pushchair or pram can be very useful when you are out.



Checks

Before buying a pushchair or pram, check that:

- the brakes are in good working order
- the handles are at the right height for pushing, and
- the frame is strong enough.

IN THE CAR

If you have a car, you must have a car seat. This is also called a safety restraint. Your baby must always go in their seat, including when you bring them home from the hospital. It's very dangerous – and illegal – to carry your baby in your arms.

The best way for your baby to travel is in a rear-facing infant car seat, on either the front or back seat. This is held in place by the adult safety belt.



If you have a car with air bags in the front, your baby should not travel in the front seat, even if they are facing backwards, because of the danger of suffocation if the bag inflates.

To keep your baby as safe as possible:

- Make sure the car seat is fitted correctly.
- Do not place a rear-facing infant car seat in the front passenger seat if your car is fitted with an air bag.



- Don't buy a second-hand car seat as it may have been damaged in an accident.
- Look for United Nations ECE Regulation number R44.03, or a later version of this standard, when you buy a car seat. This is the standard for new seats. However, if you have car seats that conform to a British Standard or to an earlier version of R44, you can continue to use them.

FEEDING

If you are going to breastfeed, you will probably want:

- nursing bras that open at the front and have adjustable straps. Cotton is best because it allows air to circulate. If you try on bras at about 36–38 weeks, they should fit when you need them

- breast pads. You put these into your bra to prevent milk from leaking onto your clothes.

If you are going to formula feed, you will need:

- six bottles with teats and caps
- sterilising equipment
- a bottle brush
- infant formula milk. Avoid buying this too far in advance, as instant formula milk has a 'use by date' printed on the package.

See Chapter 9 for how to feed your baby.

CLOTHES

Babies grow very quickly. All you need for the first few weeks are enough clothes to make sure that your baby will be warm and clean. You will probably need:

- six stretch suits for both day and night or four stretch suits and two nighties for the night. Use socks or booties with the nightie if it's cold
- two cardigans. They should be wool or cotton rather than nylon, and light rather than heavy. Several light layers of clothing are best for keeping your baby warm
- four vests

- a shawl or blanket to wrap your baby in
- a wool or cotton hat, mittens and socks or booties for going out if the weather is cold. It's better to choose close-knitted patterns for safety
- a sun hat for going out if the weather is hot or the sun is bright.



Washing baby clothes

If you use a washing machine, don't use washing powders with enzymes (bio powders) or fabric conditioner, as they may irritate your baby's skin. Always rinse clothes very thoroughly.

for tiny
toes



THE EARLY WEEKS: YOU

12



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Your first few weeks at home can be an exciting but anxious time for parents as you get used to caring for your new baby.

If you have been in hospital or a midwifery unit, you may feel apprehensive about being on your own without staff on call to help you. The more you handle your baby, the more your confidence will increase. And your community midwife, health visitor and GP are there to support you if you have any worries or problems. Ask your midwife or health visitor for a copy of the book *Birth to Five*, which has advice on looking after your child up to the age of five.

PARTNERS

As the mother's partner, you can get involved in caring for your baby from day one. In the first weeks, you can:

- help your baby's mother to breastfeed by:
 - spending time with her while the baby is feeding
 - bringing your baby to their mother when they need feeding in the night
 - helping to wind your baby

- getting specialist help and information on breastfeeding if the mother has any concerns
- provide emotional support and encouragement
- make nutritious meals and snacks for your baby's mother
- change your baby's nappies
- bathe and dress your baby
- cuddle and play with your baby
- clean the house, go shopping and do other household chores.



You may feel quite nervous about handling the baby at first but you will get more confident. Don't be embarrassed to ask for help or encouragement.

HELP AND SUPPORT

You will probably need a lot of practical help, as well as emotional support. You are bound to feel up and down and to get tired easily in the first few weeks. Many women want to have their partner around so that you get to know the baby together and have help with the work. Being together at this time helps you to start to adjust to the changes in your life. If you are on your own, or your partner cannot be with you, ask your mother or a close friend to be there.

Even with help, you will probably feel tired. Here are some things you could try:

- Cut down on cleaning – a bit of dust will not hurt.
- Keep meals simple but healthy. You need to eat well but this need not involve a great deal of preparation and cooking.
- Try to space visitors out and say no to visitors if you feel too tired or need some time with your baby.



Too many visitors in a short time can be very tiring. If visitors do come, don't feel you have to tidy up or lay on a meal. Let them do things for you, like the washing up, making a meal or bringing some groceries.

- If you need extra help, ask. Friends or neighbours will probably be very willing to help you by doing things like shopping.

LOOKING AFTER YOURSELF

Although you may feel like your every waking hour is spent caring for your baby, it's important to look after yourself as well.

Rest

While you are feeding your baby at night and your body is recovering from childbirth, it is essential to catch up on rest.

It's tempting to use your baby's sleep times to catch up on chores, but try to have a sleep or a proper rest at least once during the day.

Exercise

Continue with any postnatal exercises you have been shown by your midwife. You can also do this deep stomach exercise when you feel well enough.

- 1 Lie on your side with your knees slightly bent.
- 2 Let your tummy relax and breathe in gently.
- 3 As you breathe out, gently draw in the lower part of your stomach like a corset, narrowing your waistline.
- 4 Squeeze your pelvic floor.
- 5 Hold for a count of 10 then gently release.
- 6 Repeat 10 times.

You should not move your back at any time. After six weeks, progress to the box position (see page 34).

Besides these exercises, try to fit in a walk with your baby every day. This can help you lose weight and feel better.





Eating properly

It's very important to eat properly (see Chapter 3). If you want to lose weight, don't rush it. A varied diet without too many fatty foods will help you lose weight gradually. Try to make time to sit down, relax and enjoy your food so that you digest it properly. It doesn't have to be complicated. Try food like baked potatoes with baked beans and cheese, salads, pasta, French bread pizza, scrambled eggs or sardines on toast, followed by fruit mixed with yoghurt or fromage frais.

A healthy diet is especially important if you are breastfeeding. Breastfeeding can help mothers to lose weight. Some of the fat you put on in pregnancy will be used to help produce milk, but the rest of the nutrients will come from your diet. This means that you may be hungrier than usual. If you do need a snack, try having beans on toast, sandwiches, bowls of cereal or fruit (see page 29).

Sure Start Children's Centres give advice about healthy eating plans for mothers, as well as support for breastfeeding. You can find out more about the services offered in Children's Centres in your area by visiting www.surestart.gov.uk

YOUR RELATIONSHIPS

After you have had a baby, the relationships around you can change. Many women find that they turn to their own mother for help and support. But your mother may not be sure about how much to get involved. You may find that she is trying to take over or that she is so anxious not to interfere that she doesn't help at all. Try to let her and others know what help and support you want from them.

Your relationship with your partner will also change. It is very easy in those exhausting early weeks just to leave things to sort themselves out. You may wake up six months later to find that you have not spent an hour alone together and have lost the knack of easily talking your problems through. You both need time alone, without the baby, to recharge your own batteries. You also need time together, without the baby, to keep in touch with each other.



Your relationship with your baby may not be easy either, particularly if you are not getting much sleep. Don't feel guilty if you sometimes feel resentful at the demands your baby makes, or if your feelings are not what you expected them to be. Talk to your midwife or health visitor if you are upset or worried. But remember, many mothers find their babies difficult at first and come to love them gradually over some weeks.

If you are on your own and don't have family to support you, ask a friend to help you in the early weeks.

Sex and contraception

There are no rules about when to start having sex again. Don't rush into it – if it hurts, it will not be pleasurable. You may want to use a lubricating jelly the first time because hormone changes may make your vagina feel drier than usual.





It might be some time before you want to have sex. Until then, you both may feel happier finding other ways of being loving and close. If you or your partner have any worries, discuss them with your GP or health visitor.

It is possible to get pregnant even if you have not started your periods again or if you are breastfeeding. It is therefore important to use

contraceptives as soon as you start having sex again.

Your midwife or doctor should

talk to you about contraception before you leave hospital and again when you go for your six-week postnatal check. Alternatively, you could talk to your midwife or health visitor when they visit you at home or go to your GP or community contraceptive clinic (sometimes called family planning or CASH clinic).

The FPA (Family Planning Association – see page 184) publishes free leaflets about all methods of contraception.

Contraceptives

Short-acting contraceptive methods

Short-acting contraceptive methods rely on you taking them every day or when you have sex.

- **The condom.** This may be the easiest choice for the early weeks after childbirth. Condoms offer the best protection against sexually transmitted infections (STIs) so if you think you or your partner may have been exposed to an STI you should use a condom in addition to your other choice of contraception.
- **The combined pill.** If you are not breastfeeding, you can start taking this pill 21 days after you give birth. If you start it later than the 21st day, it will not be reliable for the first seven days. So for this time you will have to use another contraceptive (like a condom) as well. Don't take this pill if you are breastfeeding as it reduces milk flow.
- **The progestogen-only pill.** If you are breastfeeding, you can take a progestogen-only pill, which will not affect your milk supply. This can also be started 21 days after you give birth. It has to be taken at the same time every day. If you start it later than the 21st day, it will not be reliable for two days. So for this time you will

have to use some other form of contraceptive (like a condom) as well. There is no evidence to suggest that this pill affects your baby in any way. Even so, some women prefer not to take it while they are breastfeeding and use another form of contraception instead.

- **The cap or diaphragm.** These can be used six weeks after you give birth. If you had a cap before, it probably will not be the right size any longer. You can have a new one fitted at your postnatal check-up.

Long-acting contraceptive methods

Long-acting contraceptive methods last between three months and ten years. They may be suitable if you think you will forget to take or use a short-acting contraceptive.

- **The IUD (intra-uterine device) or IUS (intra-uterine system).** These can be fitted from the fourth week after you give birth. They can be fitted at your postnatal check-up when your uterus is back to its normal size.
- **The contraceptive injection.** It is recommended that you wait until six weeks after you give birth before you are given this. It can be given earlier in some circumstances. The contraceptive injection will not affect your milk supply if you are breastfeeding.
- **The contraceptive implant (Implanon).** This contains a long-lasting progestogen and is effective for three years. It can be fitted 21 days after you give birth or earlier in some circumstances. If it's fitted after 21 days, you will have to use another contraceptive for seven days. The contraceptive implant will not affect your milk supply if you are breastfeeding.

THE 'BABY BLUES' AND POSTNATAL DEPRESSION

As many as 8 out of 10 mothers get the 'baby blues', often about three to five days after the birth. You might feel upset, mildly depressed, or just keep bursting into tears for no apparent reason. It usually only lasts for a few days.

Around 1 in 10 mothers become depressed. This is usually mild but sometimes can be quite severe. You must get help if you are taken over by a feeling of sadness and hopelessness, you feel irritable and anxious, or you have difficulty sleeping and coping with even the smallest task. See page 82 for more information.

Help and support

If you think you are depressed, contact your GP or health visitor and explain how you are feeling. Your partner or a friend could contact them for you if you want. You can also contact the Association for Post-Natal Illness (see page 186) for more information.

If you have twins or triplets, you are more likely to experience postnatal and longer-term depression. This is mainly because of the additional stress of caring for more than one baby. Just getting out of the house can be difficult when you have more than one baby, and this can make you feel isolated. Tamba (see page 188) can help you make contact with other mothers of multiples via local twins clubs and through their helpline – Tamba Twinline on 0880 138 0509 – where you can talk to other mothers of multiples. You may also find it helpful to contact the Multiple Births Foundation (see page 183).



YOUR POSTNATAL CHECK

You should have your postnatal check about six weeks after your baby's birth to make sure that you feel well and are recovering from the birth. You may be offered an appointment to go back to the hospital or midwifery unit where you gave birth, but otherwise you should see your GP. It's time to introduce your baby to your GP as the new member of your family!

It's a good opportunity to ask any questions and sort out any problems that are troubling you. You may like to make a list of questions to take along with you so that you don't forget what you want to ask.

What usually happens

- You will be weighed and can get weight loss advice if you need it.
- Your urine will be tested to make sure your kidneys are working properly and that there is no infection.
- Your blood pressure will be checked.
- You may be offered an examination to see if:
 - your stitches (if you had any) have healed
 - your uterus is back to its normal size, and
 - all the muscles used during labour and delivery are returning to normal.

Tell the doctor if the examination is uncomfortable.

- Your breasts are unlikely to be examined unless you have a particular concern.
- A cervical smear test may be discussed if you have not had one in the past three years (see page 48). This is usually delayed until three months after delivery.
- If you are not immune to rubella (German measles) and were not given an immunisation before you left hospital, you will be offered one now. You should not become pregnant for one month after this immunisation.
- You will be asked if you still have any vaginal discharge and whether you have had a period yet.
- Tell your doctor if:
 - you are having trouble holding in urine or wind, or you are soiling yourself
 - intercourse is painful
 - you are feeling very tired, low or depressed, or
 - you are worried about anything.

You can also ask your doctor about contraception. You may wish to choose a different method to the one you had previously used (especially if your pregnancy was not planned). The doctor or nurse can help you decide which method is right for you now. See the box on page 135 for some of the different options.

Your baby's check

Your GP's surgery or health clinic will probably arrange for your baby's six-week check to be done at your postnatal check. If you go to the hospital, the baby's check will usually need to be arranged separately.

13

THE EARLY WEEKS: YOUR BABY



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In the first few weeks, you will be learning how to look after your baby. You will start to understand them and will learn what is normal and what may be a sign that something is wrong. But the most important thing to do in the first few weeks is to enjoy your baby. Spending time with them is the best way to help them feel safe and loved.

ENJOYING YOUR BABY

Keeping your baby warm, fed and safe may seem to take up all of your time in the first weeks. But they are only a tiny part of what it means to be a parent. Every second that your baby is awake, they are learning from you. Learning about what it feels like to be touched gently, the sound of your voice and your very special smell.

They are learning about what the world is like and, above all, what it feels like to love and be loved. It is important to talk to your baby.

listening to your voice

Talking to your baby

It is very important to talk to your baby. If you or your family speak another language, use it to speak to your baby. It can help your baby to learn other languages, and enjoy another culture. You can talk to them about anything and everything. Talking to young children, even very young babies helps them become good communicators later in life. It will also help your baby build their early bond with you.





REGISTERING THE BIRTH

Your baby's birth must be registered within six weeks from when they were born. This will take place at the register office in the district where they were born. The contact details will be in the telephone book under the name of your local authority or you can find it online at www.direct.gov.uk



If you are married, you or the father can register the birth. If you are not married, you may register together with your baby's father and his name will appear on the birth certificate. In most circumstances, children benefit from being acknowledged by both parents and by knowing the identity of both their mother and father. To register jointly, you must either go together to register the birth or one of you can go with an appropriate document. Including the father's name in the birth register will usually give him parental responsibility. Your local register office will explain this process.

At the moment, if you are not married, you can decide whether you want the father's name to appear on the birth certificate. If you do not want his name to appear, you can register the birth by yourself. However, the government plans to change the law so that joint registration, by both mother and father, becomes the normal arrangement for unmarried parents. Your local register office will be able to provide detailed information about these changes when they come into effect.

If you live in a different district from the one where your baby was born, you can go to your nearest register office. The registrar will take details from you and then send them to the district where your baby was born. You will then be sent the birth certificate. You cannot claim benefits, such as Child Benefit, until you have a birth certificate.

All babies born in England and Wales are now given a unique NHS number at birth. Midwives request and receive a newborn baby's NHS number. They send this NHS number to the Registrar of Births, Deaths and Marriages via your local child health department.

CRYING

All babies cry. It's their way of saying that something is not right. Sometimes you will be able to find the reason for your baby's distress and deal with it. At other times all you can do is try to comfort or distract your baby. If it's not obvious why your baby is crying, think of possible reasons.

Are they:

- hungry?
- hot, cold or uncomfortable?
- feeling tired and unable to sleep?
- lonely and wanting company?
- bored and wanting to play?

Do they have:

- a wet or dirty nappy?
- wind?
- colic?

It could be none of these things. Perhaps your baby simply feels overwhelmed and a bit frightened by all the new sights, sounds and sensations.





When crying gets too much

Some babies do cry more than others and it's not really clear why. Don't blame yourself, your partner or your baby if they cry a lot. It can be very exhausting so try to get rest when you can. Share soothing your baby with your partner. You could ask a friend or relative to take over for an hour from time to time, just to give you a break. If there is no one to turn to and you feel your patience is running out, leave your baby in the cot and go into another room for a few minutes. Put on some music to drown the noise, take some deep breaths, make yourself a cup of tea or find some other way to unwind. You will cope better if you do. If you are very angry or upset, telephone someone who will make you feel better.

Never shake your baby. Shaking makes a baby's head move violently. It can cause bleeding and damage the brain.

Colic

If your baby has repeated episodes of excessive and inconsolable crying but they otherwise appear to be thriving and healthy, they may have colic.

Although it may appear that your baby is in distress, colic is not harmful. Your baby will continue to feed and gain weight normally. There is no evidence that colic has any long-term effects.

Colic can be very upsetting for parents. You may feel like you are letting your baby down or that you are doing something wrong. Although colic can be distressing at the time, it is a common phase that should last only a few weeks at the most. It may help to remind yourself that you are not causing the crying and it is not under your control. If you are concerned, talk to your health visitor or GP.

Comforting your baby

Holding your baby close and talking in a soothing voice or singing softly will reassure them.

Movement often helps to calm down crying. Gently sway or rock your baby or take them for a walk or for a ride in a car.

Sucking can also be comforting. You can put your baby to your breast or give them a dummy, as long as breastfeeding is well established

(see page 106). Make

sure the dummy is sterilised and don't dip it in honey or sugar to make your baby suck. They will suck anyway. Using

sugar will only encourage a craving for sweet things, which are bad for their teeth.



Getting help

If you feel you are having difficulties coping with your baby's crying, talk to your midwife or health visitor. Or contact Cry-sis on 08451 228669 – they will put you in touch with other parents who have been in the same situation. If you have twins or more, the crying can seem relentless – Twinline, Tamba's helpline (see page 188), can offer support.

If your baby's crying sounds different or unusual, it may be the first sign of illness, particularly if they are not feeding well or will not be comforted. If you think your baby is ill, contact your doctor immediately. If you cannot contact your doctor and it's an emergency, take your baby to the nearest hospital accident and emergency department.





SLEEP

The amount that babies sleep, even when they are very small, varies a lot. During the early weeks some babies sleep for most of the time between feeds. Others will be wide awake. As they grow older, they begin to develop a pattern of waking and sleeping. Some babies need more sleep than others and at different times. Try not to compare what your baby does with other people's babies. All babies are different, and their routines will change as they grow.

You will gradually begin to recognise when your baby is ready for sleep and is likely to settle. Some babies settle better after a warm bath. Most sleep after a good feed. A baby who wants to sleep is not likely to be disturbed by ordinary household noises, so there is no need to keep your whole home quiet while your baby sleeps. It will help you if your baby gets used to sleeping through a certain amount of noise. See the column on the right for advice on sleeping positions.

Twins, triplets or more can have specific sleeping issues and it may be difficult for you to get them into a routine. The Multiple Births Foundation and Tamba (see pages 183 and 188) have information that you may find useful. They can sleep in the same cot – there is information from Tamba on how you can do this safely.

Reducing the risk of cot death

Sadly, we don't know why some babies die suddenly and for no apparent reason from what is called 'cot death' or 'Sudden Infant Death Syndrome' (SIDS). But we do know that placing a baby to sleep on their back reduces the risk, and that exposing a baby to cigarette smoke or overheating a baby increases the risk.

All the advice that we now have for reducing the risk of cot death and other dangers, such as suffocation, is listed on this page and opposite. Remember that cot death is rare, so don't let worrying about it stop you enjoying your baby's first few months. But do follow the advice given here to reduce the risks as much as possible.

To reduce the risk of cot death:

- Place your baby on their back to sleep, in a cot in a room with you.
- Do not smoke in pregnancy or let anyone smoke in the same room as your baby.
- Do not share a bed with your baby if you have been drinking alcohol, if you take drugs or if you are a smoker.
- Never sleep with your baby on a sofa or armchair.
- Do not let your baby get too hot – keep your baby's head uncovered.
- Place your baby in the 'feet to foot' position.

The safest place for your baby to sleep is on their back in a cot in a room with you for the first six months.

Place your baby on their back to sleep

Place your baby on their back to sleep from the very beginning for both day and night sleeps. This will reduce the risk of cot death. Side sleeping is not as safe as sleeping on the back. Healthy babies placed on their backs are not more likely to choke. When your baby is old enough to roll over, they should not be prevented from doing so.

Babies may get flattening of the part of the head they lie on (plagiocephaly). This will become rounder again as they grow, particularly if they are encouraged to lie on their tummies to play when they are awake and being supervised. Experiencing a range of different positions and a variety of movement while awake is also good for a baby's development.

The risks of bed sharing

The safest place for your baby to sleep is in a cot in a room with you for the first six months. Do not share a bed with your baby if you or your partner:

- are smokers (no matter where or when you smoke and even if you never smoke in bed)
- have recently drunk alcohol
- have taken medication or drugs that make you sleep more heavily
- feel very tired.

The risks of bed sharing are also increased if your baby:

- was premature (born before 37 weeks), or
- was of low birth weight (less than 2.5kg or 5.5lb).

There is also a risk that you might roll over in your sleep and suffocate your baby, or that your baby could get caught between the wall and the bed, or could roll out of an adult bed and be injured.

Never sleep with a baby on a sofa or armchair

It's lovely to have your baby with you for a cuddle or a feed but it's safest to put your baby back in their cot before you go to sleep.

Cut out smoking during pregnancy – partners too!

Smoking in pregnancy greatly increases the risk of cot death. It is best not to smoke at all.

If you are pregnant and want to give up, call the NHS Pregnancy Smoking Helpline on 0800 169 9 169.

Don't smoke near your baby.



Don't let anyone smoke in the same room as your baby

Babies exposed to cigarette smoke after birth are also at an increased risk of cot death. Nobody should smoke in the house, including visitors. Anyone who needs to smoke should go outside. Do not take your baby into smoky places. If you are a smoker, sharing a bed with your baby increases the risk of cot death.

Don't let your baby get too hot (or too cold)

Overheating can increase the risk of cot death. Babies can overheat because of too much bedding or clothing, or because the room is too hot. Remember, a folded blanket counts as two blankets. When you check your baby, make sure they are not too hot. If your baby is sweating or their tummy feels hot to the touch, take off some of the bedding. Don't worry if your baby's hands or feet feel cool – this is normal.

- It is easier to adjust the temperature with changes of lightweight blankets.

Remember, a folded blanket counts as two blankets.

- Babies do not need hot rooms; all-night heating is rarely necessary. Keep the room at a temperature that is comfortable for you at night. About 18°C (65°F) is comfortable.
- If it is very warm, your baby may not need any bedclothes other than a sheet.
- Even in winter, most babies who are unwell or feverish do not need extra clothes.
- Babies should never sleep with a hot-water bottle or electric blanket, next to a radiator, heater or fire, or in direct sunshine.
- Babies lose excess heat from their heads, so make sure their heads cannot be covered by bedclothes during sleep periods.

Don't let your baby overheat.

Remove hats and extra clothing as soon as you come indoors or enter a warm car, bus or train, even if it means waking your baby.



Don't let your baby's head become covered

Babies whose heads are covered with bedding are at an increased risk of cot death. To prevent your baby wriggling down under the

covers, place your baby feet to foot in the crib, cot or pram.

Make the covers up so that they reach no higher than the shoulders. Covers should be securely tucked in so they cannot slip over your baby's head. Use one or more layers of lightweight blankets.

Sleep your baby on a mattress that is firm, flat, well fitting and clean. The outside of the mattress should be waterproof. Cover the mattress with a single sheet.

Remember, do not use duvets, quilts, baby nests, wedges, bedding rolls or pillows.

Put your baby feet to foot in the crib.

Feeding

Breastfeeding your baby reduces the risk of cot death. See Chapter 9 for everything you need to know about breastfeeding.



It is possible that using a dummy at the start of any sleep period reduces the risk of cot death. Do not begin to give a dummy until breastfeeding is well established, usually when your baby is around one month old. Stop giving the dummy when your baby is between six and 12 months old.

If your baby is unwell, seek MEDICAL advice promptly

Babies often have minor illnesses that you do not need to worry about.

Make sure your baby drinks plenty of fluids and is not too hot. If your baby sleeps a lot, wake them regularly for a drink.

It can be difficult to judge whether an illness is more serious and requires prompt medical attention. See the section on illnesses on page 145 for guidance on when you should get help.

Monitors

Normal healthy babies do not need a breathing monitor. Some parents find that using a breathing monitor reassures them. However, there is no evidence that monitors prevent cot death. If you have any worries about your baby, ask your doctor about the best steps to take.

Immunisation reduces the risk of cot death. For more information about immunisation, visit www.immunisation.nhs.uk

More information

For more information on reducing the risk of cot death, or to buy a simple room thermometer for your baby, contact the Foundation for the Study of Infant Deaths (FSID):

Telephone: 020 7802 3200
Email: office@fsid.org.uk
Website: www.fsid.org.uk

CHANGING YOUR BABY

Babies need their nappies changed fairly often, otherwise they become sore. Unless your baby is sleeping peacefully, always change a wet or dirty nappy and change your baby before or after each feed.

Organise the place where you change your baby so that everything you need is handy (see page 128). The best place to change a nappy is on a changing mat or towel on the floor, particularly if you have more than one baby. That way, if you take your eye off your baby for a moment to look after another child, your baby cannot fall and hurt themselves.

Try to sit down, so you don't hurt your back. If you are using a changing table, keep an eye on your baby at all times.

See the next page for the different kinds of nappies that are available.

How to change a nappy

You need to clean your baby's bottom carefully each time you change a nappy to help prevent soreness and nappy rash.

STEP 1

- Take off the nappy. If it's dirty, wipe away the mess from your baby's bottom with tissues or cotton wool.
- Wash your baby's bottom and genitals with cotton wool and warm water and dry thoroughly. For girls, wipe the bottom from front to back, away from the vagina, so that germs will not infect the vagina or bladder. For boys, gently clean the foreskin of the penis (it can be pulled back very gently).



Clean under the penis and the scrotum. Water is fine for cleaning your baby's bottom but you may want to use wipes or lotion for convenience when you are away from home.

- You may want to use a cream, such as zinc and castor oil cream, which forms a waterproof coating to help protect the skin. Or you can just leave the skin clean and dry, especially with disposable nappies, since cream may prevent them absorbing urine so well. Don't use baby powder as it can cause choking.



- If you are using a cloth nappy, place it in a waterproof cover (if needed) and put a nappy liner inside. Lay your baby carefully on the nappy, bring the centre of the nappy between your baby's legs and then fasten the poppers or Velcro. Check that it fits snugly around the waist and legs.

STEP 2

- If you are using a disposable nappy, put the side with the sticky tapes under your baby's bottom.

STEP 3

- Fasten the tapes at the front. Be very careful not to get cream on the tabs or they will not stick.
- Wash your hands.

Nappy hygiene**Disposable nappies**

If the nappy is dirty, flush the contents down the toilet. Roll up the nappy and re-tape it securely. Put it into a plastic bag. Don't put anything but nappies in this bag. Fasten the bag and put it outside in your bin each day.

Cloth nappies

- If the nappy is dirty, flush the contents down the toilet. Biodegradable, flushable nappy liners are available to make it easy.
- Have a lidded bucket ready to store the dirty nappies. You can soak them in a nappy cleanser (follow the instructions on the packet) or just store them here until you have a load ready for washing.
- Wash nappies every two to three days. Follow the care instructions on your nappies, but a 60°C wash is usually OK. If you did not soak the nappies before, add an antibacterial nappy cleanser to your normal washing detergent (follow the instructions on the packet). Don't use enzyme (bio) washing powders or fabric conditioner as these may irritate your baby's skin – and the conditioner may make the

nappy less absorbent. Make sure you use the correct amount of detergent and rinse thoroughly.

Nappy rash

Most babies get a sore bottom or have nappy rash at some time, but some have extra-sensitive skins. Nappy rashes are caused by contact between sensitive skin and soiled nappies. If you notice redness or spots, clean your baby very carefully and change their nappies more frequently. Better still, give your baby time without a nappy and let the air get to their skin. Keep a spare nappy handy to mop up any accidents. You will soon see the rash start to get better.

If your baby does have a rash, ask your midwife or health visitor about it. They may advise you to use a protective cream. If the rash seems to be painful and will not go away, see your health visitor or GP.

Babies' poo (stools)

Immediately after birth and for the first few days, your baby is likely to pass a sticky, greenish-black substance. This is called meconium and it is the waste that has collected in your baby's bowels while they were in your uterus.

As your baby begins to digest milk, the stools will change. They will become more yellow or orange and can be quite bright in colour. Breastfed babies have quite runny



stools. Formula-fed babies' stools are firmer and smell more.

Babies vary a lot in how often they pass stools. Some have a bowel movement at or around each feed; some can go for several days without having a movement. Either can be normal, but most breastfed babies produce at least one stool a day for the first six weeks.

When to get help

Most small babies strain and go red in the face, or even cry, when passing a stool. This is normal and doesn't mean they are constipated as long as the stools are soft. If you are worried that your baby may be constipated, mention this to your midwife or health visitor.

What you find in your baby's nappies will probably vary from day to day, and usually there is no need to worry. For example, it is normal for some babies to have very runny stools. But ask your doctor, midwife or health visitor if you notice any big changes, such as stools:

- becoming very frequent and watery
- being very smelly
- changing colour to become green, white or creamy.

See 'Babies with jaundice after two weeks' on page 149.

Putting on a disposable nappy**STEP 1****STEP 2****STEP 3**

WASHING AND BATHING

Washing

You don't need to bath your baby every day, but you should wash their face, neck, hands and bottom carefully each day. You can do this on your lap or on a changing mat. Choose a time when your baby is awake and contented, and make sure the room is warm. You will need a bowl of warm water, some cotton wool, a towel and a fresh nappy. If you want to use soap, make sure that it is mild and unperfumed.



- 1 Take off your baby's clothes except for the vest and nappy. Wrap your baby in a towel.
- 2 Gently wipe round each eye, from the nose side outwards. Use a fresh piece of cotton wool for each eye, so you don't transfer any stickiness or infection.
- 3 Using fresh, moist cotton wool, wipe out each ear – but don't clean inside their ears. Never use cotton buds inside the ear canal.
- 4 Wash the rest of your baby's face and neck with moist cotton wool and dry gently. Wash and dry your baby's hands in the same way.
- 5 Take off the nappy and wash your baby's bottom (genitals), with fresh cotton wool and warm water. Dry your baby very carefully, including in skin folds, and put on a clean nappy.

See page 124 on keeping your baby's umbilical cord clean and dry.

Bathing

Bath your baby two or three times a week, or more often if they enjoy it. Don't bath them straight after a feed or when they are hungry or sleepy. Make sure the room is warm and that you have everything you need ready in advance.

- 1 Check that the water is not too hot. Test it with your wrist or elbow. It should be just comfortably warm.
- 2 Undress your baby except for their nappy, and wrap them snugly in a towel. Wash your baby's face with cotton wool and water as described above. There is no need to use any soap.
- 3 Wash your baby's hair with baby soap or liquid, supporting their head over the baby bath or basin. Rinse carefully. You don't need to use soap every time.
- 4 If you want to use soap occasionally, use a mild, unperfumed soap. Unwrap your baby and soap them all over, but keep them on your lap so you have a firm grip. Take the nappy off at the last minute.
- 5 Put your baby gently into the water. Using one hand for support, gently swish the water to wash your baby without splashing their face. You should never leave your baby alone in the water even for a few seconds. For boys, gently clean the top of the foreskin of the penis. The foreskin can be pulled back very gently to clean.



- 6 Lift your baby out and pat them dry with the towel. Dry carefully in all the creases. If your baby's skin is dry, gently massage in some baby oil or cream (not aqueous cream). Your baby may enjoy this.

If your baby seems frightened of the bath and cries, it may help to try bathing together. You may like to do this anyway. Make sure the water is only warm, not hot, and don't add anything to the water. You should also think about how you are going to get out of the bath with your baby. You might need someone around who you can pass them to.



ILLNESS

It's sometimes difficult to tell at first when a baby is ill, but you may have a funny feeling that things are not quite right. If you are at all worried, ask for help. You are not fussing. It's far better to be on the safe side, particularly with a very small baby. Trust your own judgement. You know your baby best.

Very urgent problems

Sometimes there are obvious signs that your baby is not well. Contact your doctor at once if your baby:

- turns blue or very pale
- has quick, difficult or grunting breathing, or unusual periods of breathing, for example breathing with pauses of over 20 seconds between breaths
- is very hard to wake, unusually drowsy or doesn't seem to know you
- develops a rash of red spots that do not fade and lose colour (blanch) when they are pressed (see the 'glass test'). This may be the rash of meningococcal disease and meningitis, which causes infection in the blood. There may not be any other symptoms.

Your baby may need treatment very quickly. If you cannot get hold of your GP at once, dial 999 for an ambulance or take your baby to the nearest accident and emergency (A&E) department with a paediatrician on site.

Problems that could be serious

- If your baby has a hoarse cough with noisy breathing, is wheezing, or cannot breathe through the nose.
- If your baby is unusually hot, cold or floppy.



- If your baby cries in an unusual way or for an unusually long time or seems to be in pain.
- If you notice any bleeding from the stump of the umbilical cord or from the nose, or any bruising.
- If your baby keeps refusing feeds.
- If your baby keeps vomiting a substantial part of feeds or has frequent watery diarrhoea. Vomiting and diarrhoea together may mean your baby is losing too much fluid, and this may need prompt treatment.
- If your baby develops jaundice (looks yellow) when they are over a week old, or has jaundice that continues for over two weeks after birth (see page 149).

If you have seen your GP and your baby is not getting better or seems to be getting worse, tell your GP again the same day. If you become very worried and cannot get hold of your GP, dial 999 for an ambulance or take your baby to the nearest A&E department with a paediatrician on site.

If you are worried about your baby

- Phone your midwife or health visitor for advice. Keep their phone numbers where they can be reached easily.
- Phone your GP. Your GP may be able to advise you over the phone or may suggest that you bring your baby along to the surgery. Most GPs will try to fit a young baby in without an appointment, although it may mean a wait in the surgery.
- If you are really worried about your baby, you should always phone your GP for help immediately, whatever the time of day or night. There will always be a doctor on duty, even if it is not your own GP. If you cannot contact a GP, take your baby to an appropriate paediatric emergency department. Not all A&E departments have resident paediatricians. You need to take them to one that does.

The 'glass test'



The 'glass test' can help you to tell if a rash is a symptom of meningitis. Press the side or bottom of a glass firmly against the rash. You will be able to see if the rash fades and loses colour under the pressure (see photo). If it doesn't change colour, contact your GP immediately.



Group B streptococcal infection

Group B streptococcal infection is a life-threatening infection in babies. Most babies who are infected show symptoms within 12 hours of birth, but there are some who get it later. The symptoms include:

- being floppy and unresponsive
- not feeding well
- grunting
- high or low temperature
- fast or slow heart rate
- fast or slow breathing rate
- irritability.

Your baby may need treatment very quickly. If you cannot get hold of your GP at once, dial 999 for an ambulance or take your baby to the nearest accident and emergency department with a paediatrician on site. For more information, see www.gbss.org.uk

GETTING SUPPORT

Everyone needs advice or reassurance at some time when they are caring for a young baby, even if it's just to make sure that they are doing the right thing. Some problems just need talking over with someone. It's always better to ask for help than to worry on your own. Do talk to your midwife or health visitor. As you grow more confident, you will begin to trust your own judgement more. You will be able to decide which advice makes most sense for you and your baby and which suggestions you can safely ignore.

You will also want to talk to friends, relations or other mothers in a similar situation. You will meet other mothers when you start taking your baby to the child health clinic or Sure Start Children's Centre. Your health visitor will explain where these are and when you should go.



Your nearest Children's Centre can be found by visiting www.surestart.gov.uk



Your health visitor can tell you about any mother and baby groups in the area. Or your local branch of the NCT (see page 183) or MAMA (Meet A Mum Association) (see page 184) may be able to put you in touch with other mothers nearby.



BABIES WHO NEED ADDITIONAL CARE

14



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Contact with your baby	148	Newborn babies with jaundice	149
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About one in eight of all babies will need extra care in hospital, sometimes on the ordinary postnatal ward and sometimes in a specialist neonatal area. Having a baby in neonatal care is naturally worrying for parents and every effort should be made to ensure that you receive the information, communication and support you need. Not all hospitals provide neonatal services, so it may be necessary to transfer your baby to another hospital for specialist care.



WHY BABIES NEED ADDITIONAL CARE

Babies can be admitted to neonatal services for any of the following reasons:

- They are born early. One in 10 of all babies are born prematurely. Babies born earlier than 34 weeks may need extra help with breathing, feeding and keeping warm.
- They are very small and have a low birth weight.
- They have an infection.
- Their mother is diabetic.
- The delivery was very difficult and they need to be kept under close observation for a time.
- They have very marked jaundice (see page 149).
- They are awaiting or recovering from complex surgery.

close observation



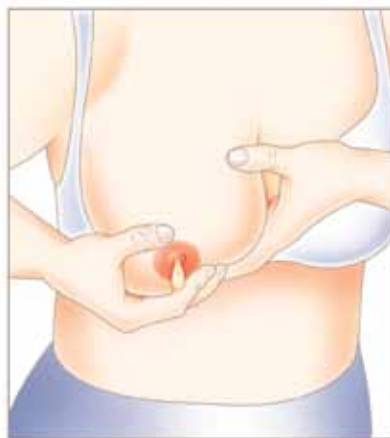
CONTACT WITH YOUR BABY



Your baby will benefit from physical contact with you, even though the environment of the unit may seem strange and confusing. When you first go into the unit, your baby may be in an incubator and on a breathing machine. There may also be tubes and wires attached to their face and body. Ask the nurse to explain what everything is for and to show you how you can be involved with your baby's care. Once your baby is stable, you will be able to hold them. The nurses will show you how to do this.

FEEDING

To begin with, your baby may be too small or sick to feed themselves. You may be asked to express some of your breastmilk, which can be given to your baby through a tube. A fine tube is passed through their nose or mouth into their stomach. This will not hurt them. Breastmilk has particular benefits, and especially for sick or premature babies, as it is specially enriched with fats and minerals.



If your baby is unable to have your breastmilk to begin with, it can be frozen and given to them when they are ready. When you go home, you can express milk for the nurses to give while you are away. There is no need to worry about the quantity or quality of your milk. Some mothers find that providing breastmilk makes them feel that they are doing something positive for their baby.

See Chapter 9 for information on expressing and storing milk.

INCUBATORS

Babies who are very small are nursed in incubators rather than cots to keep them warm. However, you can still have a lot of contact with your baby. Some incubators have open tops. If not, you can put your hands through the holes in the side of the incubator and touch your baby. When your baby is stable, the nurses will be able to help you take your baby out of the incubator and show you how to have skin to skin contact. You should carefully wash and thoroughly dry your hands before touching your baby. You can talk to your baby as well – this can help both of you.





NEWBORN BABIES WITH JAUNDICE

Jaundice in newborn babies is common because their livers are immature. Severely jaundiced babies may be treated with phototherapy. Babies are undressed and put under a very bright light, usually with a soft mask over their eyes. The special light helps to break down the chemical that causes jaundice. It may be possible for your baby to have phototherapy by your bed so that you don't have to be separated. This treatment may continue for several days, with breaks for feeds, before the jaundice clears up. If the jaundice gets worse, an exchange transfusion of blood may be needed. This is not common. Some babies have jaundice because of liver disease and need a different treatment. Your baby will be given a blood test before phototherapy is started to check for this.

Babies with jaundice after two weeks

Many babies are jaundiced for up to two weeks following birth. This can be as long as three weeks in premature babies. This is common in breastfed babies and usually it is normal and does no harm. It is not a reason to stop breastfeeding. But it's important to see your doctor if your baby is still jaundiced after two weeks. You should see them within a day or two. This is particularly important if your baby's poo (stools) is chalky white. A blood test will show whether your baby has 'breastmilk' jaundice, which will go away by itself, or jaundice that may need urgent treatment.

BABIES WITH DISABILITIES

If your baby is disabled, you will be coping with a lot of different feelings. You will also need to cope with the feelings of others – your partner, relations and friends – as they come to terms with the fact that your baby has a disability. More than anything else at this time, you will need to talk to people about how you feel as well as about your baby's health and future.



Your own GP, a neonatologist or paediatrician at your hospital, or your health visitor can all help you. You can also contact the hospital Patient Advice and Liaison Service (PALS) or your social services department for information about local organisations that may be able to help. In the useful organisations section (page 182) you will find a list of organisations that can offer help and advice. Many are self-help groups run by parents. Talking to other parents with similar experiences can often be the best help.

Getting information

Hospital staff should explain what kind of treatment your baby is being given and why. If they don't, make sure you ask. It is important that you understand what is happening so that you can work together to make sure that your baby gets the best possible care. Some treatments will need your consent and the doctors will discuss this with you. It is natural to feel anxious if your baby requires additional care. Talk over any fears or worries with the hospital staff. Hospitals often have their own counselling or support services, and a number of charities run support and advice services.

The consultant neonatologist or paediatrician should arrange to see you, but you can also ask for an appointment at any time if you wish. The hospital social worker may be able to help with practical problems such as travel costs or help with looking after other children.

Help and support

Bliss, the neonatal charity, supplies all neonatal services with a free *Parent Information Guide*, which you should be given on admission.

For more information contact Bliss Family Support Helpline on freephone 0500 618 140 or visit the website www.bliss.org.uk

THE LOSS OF YOUR BABY



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Some women may have to cope with miscarriage, ectopic pregnancy, termination, stillbirth or neonatal death (death shortly after birth). This chapter explains why some of these things may happen.

Help and support

If your pregnancy goes wrong, you will need both information and support.

Talk to the people close to you about how you feel, and to your midwife, doctor or health visitor about what has happened and why. Sometimes it is easier to talk to someone who is not a family member or friend, for example your doctor, midwife or health visitor.

There are also a number of voluntary organisations that offer support and information. These are often run by bereaved parents. It can be very helpful to talk to another parent who has been through a similar experience.

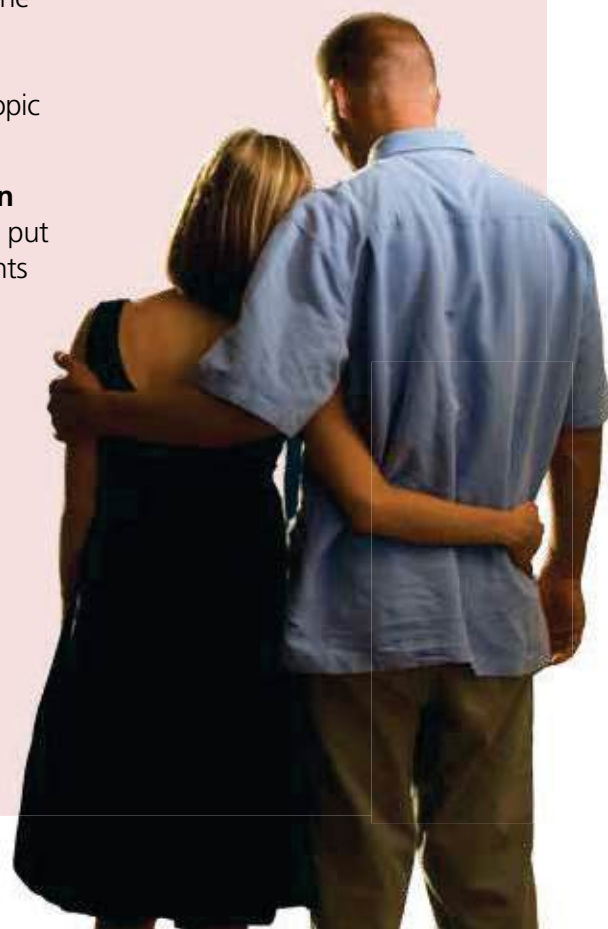
The following organisations may help:

The **Ectopic Pregnancy Trust** (www.ectopic.org.uk) offers support and information for parents who have had an ectopic pregnancy. They have a helpline on 020 7733 2653 and can put you in touch with other people who have had an ectopic pregnancy.

The **Miscarriage Association** can give you information and put you in touch with other parents who have experienced a miscarriage. See page 186 for details.

Sands can put you in touch with other parents who have had a late miscarriage, stillbirth or neonatal death. They also have an internet forum at www.sandsforum.org and a parents' telephone helpline on 020 7436 5881. See page 186 for details.

Antenatal Results and Choices (ARC) is a voluntary organisation that supports parents who are making decisions about terminating or continuing their pregnancies. See page 186 for details.



ECTOPIC PREGNANCY

After fertilisation, the egg should move down into the uterus to develop. Sometimes it gets stuck in the fallopian tube and begins to grow there. This is called an ectopic or tubal pregnancy. Rarely, the egg can become stuck elsewhere, such as the ovary or the cervix. The fertilised egg cannot develop properly and your health may be at serious risk if the pregnancy continues. The egg has to be removed. This can be done through an operation or with medicines.

Ectopic pregnancy can be caused by damage in the fallopian tube, possibly as a result of an infection. Previous abdominal surgery and previous ectopic pregnancy can also increase the risk. The warning signs start soon after a missed period.



These are:

- severe pain on one side, low down in the abdomen
- vaginal bleeding or a brown watery discharge
- pain in your shoulders
- feeling dizzy or faint
- pain when you have a bowel movement.

If you have any of these symptoms and you might be pregnant – even if you have not had a positive pregnancy test – you should see your doctor immediately.

Some women have no obvious signs or symptoms at all and an ectopic pregnancy may sometimes be mistaken for irritable bowel syndrome, food poisoning or even appendicitis.

Afterwards

You may feel a strong sense of loss and it is important to give yourself time to grieve. An ectopic pregnancy involves abdominal surgery or treatment with powerful medicines. It may affect your chances of becoming pregnant again.

It may be helpful to talk to your doctor to discuss the possible causes and whether your chances of conceiving a baby have been affected.

MISCARRIAGE

If a pregnancy ends before the 24th week, it is known as a miscarriage. Miscarriages are quite common in the first three months of pregnancy. At least one in six confirmed pregnancies end this way. Many early miscarriages (before 14 weeks) happen because there is something wrong with the development of the baby. There can be other causes, such as hormone or blood-clotting problems. A later miscarriage may be due to an infection, problems in the placenta, or the cervix being weak and opening too early in the pregnancy.

A miscarriage in the first few weeks may start like a period, with spotting or bleeding and mild cramps or backache. The pain and bleeding may get worse and there can be heavy bleeding, blood clots and quite severe cramping pains. With a later miscarriage, you may go through an early labour. If you bleed or begin to have pains at any stage of pregnancy, you should contact your GP or midwife. You could also contact your local early pregnancy unit (though they may want a referral from your



GP before they see you). If you are more than six or seven weeks pregnant, you may be referred for an ultrasound scan to see if your baby has a heartbeat and is developing normally. Sometimes the bleeding stops by itself and your pregnancy will carry on quite normally.

Some women find out that their baby has died only when they have a routine scan. If they have had no pain or bleeding, this can come as a terrible shock, especially if the scan shows that the baby died days or weeks before. This is sometimes called a missed or silent miscarriage.

Treatment for miscarriage

Sometimes it is preferable to wait and let the miscarriage happen naturally, but there are three ways of actively managing a miscarriage:

- **Medicine.** You may be offered tablets or pessaries to start the process of miscarriage.
- **Operation.** If you have been pregnant for less than 14 weeks, your doctor may advise an operation called an ERPC (evacuation of retained products of conception). This will empty your uterus. It is done under anaesthetic.

The Quiet Room

The cervix is gently widened and the contents of your uterus are removed by suction.

- **Induced labour.** If your baby dies after about 14 weeks, you may go into labour. If this doesn't happen, you will be offered tablets that start labour. Although some women would prefer not to go through labour, this is safer for you than an operation to remove the baby. You will be cared for and supported throughout the labour and the birth of your baby.

Afterwards

One early miscarriage is unlikely to affect your chances of having a baby in the future. If you have three or more early miscarriages in a row, you should be referred to a specialist for further investigations. However, sometimes no clear cause can be found.

Both women and men find it difficult to come to terms with a miscarriage at any stage. You will almost certainly feel a sense of loss. You will need time to grieve over the lost baby just as you would over the death of anyone close to you, especially if the miscarriage has happened later in your pregnancy.

You may feel shocked, distressed, angry, or just numb. You may feel guilty, wondering whether your miscarriage was caused by anything you did or did not do. It is important to know that, whatever the cause, miscarriage is never anyone's fault. If a miscarriage is going to happen, there is very little that anyone can do to stop it.

Some people find having something to remember their baby by helps. In an early loss, this may be a copy of a scan picture. If you have a late miscarriage, you may be able to see and hold your baby if you wish. You might also be able to take photographs, footprints and handprints as a keepsake. Some hospitals offer parents a certificate to commemorate their baby. This is done because there is no formal registration of a baby who dies before 24 weeks of pregnancy.

Talk about your feelings with your partner and those close to you. You might also want to contact the Miscarriage Association or Sands (see page 150).



ABNORMAL TEST RESULTS

When tests show that the baby has a significant abnormality, some couples wish to continue the pregnancy and be prepared for the needs of their newborn baby. Others decide to terminate the pregnancy. If tests show that your baby has a serious abnormality, find out as much as you can from your doctor about the particular condition and how it might affect your baby, so that you can make a decision that is right for you and your family.

You will probably be very shocked when you are first told the diagnosis and may find it hard to take in. You may need to go back and talk to the doctor with your partner or someone close to you. Spend time talking things through. You may also find it helpful to contact Antenatal Results and Choices (see page 150).

What happens

A termination in the first three months can be done under a general anaesthetic. A later termination usually involves going through labour.

You may wish to think beforehand about whether you want to see and perhaps even hold your baby, and whether you want to give your baby a name. If you do not want to see your baby, you could ask hospital staff to take a photograph for you in case you want to see it in the future. The photograph can be kept in your notes.

Afterwards

You may find it hard to cope after a termination. It can help to talk, but sometimes family and friends find it difficult to understand what you are going through. If you would like to make contact with people who have undergone a similar experience, you can contact Antenatal Results and Choices (see page 150).

STILLBIRTH AND NEONATAL DEATH

In the UK about 4,000 babies are stillborn every year. This means that the pregnancy has lasted for 24 weeks or more and the baby is dead when it is born. About the same number of babies die soon after birth. Often the causes of these deaths are not known.

Sometimes a baby dies in the uterus (an intra-uterine death or IUD) but labour does not start spontaneously. If this happens, you will be given medicines to induce the labour. This is the safest way of delivering the baby. It also means that you and your partner can see and hold the baby at birth if you want to.

It is shocking to lose a baby like this. You and your partner are likely to experience a range of emotions that come and go unpredictably. These can include disbelief, anger, guilt and grief. Some women think they can hear their baby crying, and it is not uncommon for mothers to think that they can still feel their baby kicking inside. The grief is usually most intense in the early months after the loss.

*forever
in our
thoughts
memory
book*

Some parents find it helpful to create memories of their baby, for example they may see and hold their baby and give their baby a name. You may want to have a photograph of your baby and to keep some mementos, such as a lock of hair, hand and footprints or the baby's shawl. All this can help you and your family to remember your baby as a real person and may, in time, help you to live with your loss. You may also find it helpful to talk to your GP, community midwife or health visitor or to other parents who have lost a baby. Sands can put you in touch with other parents who can offer support and information (see page 150).

Post-mortems

One of the first questions you are likely to ask is why your baby died. Sometimes a post-mortem examination can help to provide some answers, although often no clear cause is found. A post-mortem may, however, provide other information that could be helpful for future pregnancies and may rule out certain causes. If it is thought that a post-mortem could be helpful, a senior doctor or midwife will discuss this with you and explain the possible benefits. If you decide to have a full or partial post-mortem, you will be asked to sign a consent form. When the post-mortem report is available, you will be offered an appointment

with a consultant who can explain the results to you and also what these might mean for a future pregnancy.

Multiple births

The loss of one baby from a multiple pregnancy is very difficult for any parent. Grieving for the baby who has died while caring for and celebrating the life of the surviving baby brings very mixed and complex emotions. Often the surviving baby is premature and in a neonatal unit, causing additional concern. For further information and support, contact the Multiple Births Foundation or Tamba (see pages 183 and 188 for contact details).

Saying goodbye to your baby

A funeral or some other way of saying goodbye can be a very important part of coping with your loss, however early it happens.

If your baby dies before 24 weeks, the hospital may offer to arrange for a cremation, possibly together with other babies who have died in pregnancy. If you prefer to take your baby home or to make your own arrangements, you can do that. You may need some form of certification from the hospital and they should provide helpful information and contacts. The Miscarriage Association and Sands can provide further support and information.

If your baby dies after 24 weeks, you will need to register your baby's birth (even if they were stillborn) with the Registrar of Births, Deaths and Marriages. The hospital will offer to arrange a funeral, burial or cremation free of charge, or you may choose to organise this yourself. The hospital chaplain will be able to help you.

Alternatively, you may prefer to contact someone from your own religious community, the Miscarriage Association or Sands about the kind of funeral you want. You do not have to attend the funeral if you don't want to.

Many hospitals arrange a regular service of remembrance for all babies who die in pregnancy, at birth or in infancy. Again, you can choose to attend if you wish.

Many parents are surprised at how much and how long they grieve after losing a baby. Friends and acquaintances often don't know what to say or how to offer support, and they may expect you to get back to 'normal' long before that is possible. You may find it helpful to contact Sands or the Miscarriage Association (see page 150) so that you can talk to people who have been through similar experiences and who can offer you support and information.

THINKING ABOUT THE NEXT BABY?



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Holding your new baby in your arms, it may be impossible to imagine that you will ever have the energy to go through it all again! But sooner or later, you may decide that you want another child.

If you had a low birth weight baby, a baby with a disability or special needs, a miscarriage or a stillbirth, you may be particularly anxious to do everything you can to create the best possible circumstances for your next pregnancy. This chapter explains how you and your partner can prepare for your next pregnancy.

Finding it hard to get pregnant?

It can take several months or more to get pregnant, even if it happened really quickly the first time.



Chapter 1 (page 14) explains when is the best time of the month to have sex if you want to get pregnant. If you are still not pregnant after a few months, talk to your doctor or family planning clinic.

IT TAKES TWO

You will increase your chances of getting pregnant if you are in good health – and that applies to men too. A bad diet, smoking, drinking and unhealthy working conditions can affect the quality of sperm and stop you getting pregnant. You should both try to make your lifestyle as healthy as possible before you try to conceive.

Chapter 3 has advice about diet, smoking, alcohol and exercise, which can help you to conceive.

FOLIC ACID

Women should take 400 micrograms of folic acid from the time you start trying to conceive right up until you are 12 weeks pregnant. You can get these tablets from a supermarket or pharmacist. Eat foods that contain this important vitamin as well.



These include green, leafy vegetables, and breakfast cereals and breads with added folic acid.

You will need a bigger dose of folic acid if:

- you already have a baby with spina bifida
- you have coeliac disease
- you have diabetes
- you take anti-epileptic medicines.

Ask your GP for advice as well.

THINGS TO CONSIDER

Rubella (German measles)

Rubella in early pregnancy can damage your developing baby. If you were not immune during your last pregnancy, you should have been offered a measles, mumps and rubella (MMR) immunisation immediately after your baby was born. Before trying for another baby, it is important to check that you are immune by having a blood test. The blood test will measure if you have enough protection (antibodies) against rubella. Women with low or uncertain levels of antibodies can be immunised again.

Your weight

Maintaining a healthy weight can improve your chances of getting pregnant. You may have put on weight during your last pregnancy and want to go back to your normal size. This is particularly important if you weigh more than 100kg. The best way to lose weight is by following a balanced low-fat diet and doing exercise. It might help to join a slimming class with a friend or your partner to encourage and support you. Speak to your doctor if you need help or advice.



Medicines and drugs

Some medicines can harm a baby in pregnancy but others are safe.

If either you or your partner has a long-term illness or disability and has to take long-term medication, talk to your doctor about any possible effects on fertility or pregnancy.

Check with your doctor, midwife or pharmacist before you take any over the counter drugs.

Illegal drugs will affect your ability to conceive and can damage your baby's health. See page 183 for contact details for Narcotics Anonymous or talk to FRANK, the drugs information line, on 0800 77 66 00.

Diabetes and epilepsy

If you have diabetes or epilepsy, talk to your doctor before you try to get pregnant.

Postnatal depression and puerperal psychosis

If you have previously experienced postnatal depression or puerperal psychosis, talk to your doctor before you try to get pregnant.

Sexually transmitted infections (STIs)

STIs can affect your health and your ability to conceive. If there is any chance that either of you has an STI, it's important to get it diagnosed and treated before you get pregnant. STIs, including HIV, hepatitis B and hepatitis C, can be passed on through sex with an infected person, especially if you don't use a condom. Some STIs can be transmitted during sex without penetration. HIV, hepatitis B and hepatitis C can also be passed on by sharing equipment for injecting drugs.

If you are HIV positive, you can pass the virus on to your baby during pregnancy, at birth or when breastfeeding (see box on page 47).

WORK-RELATED RISKS

Your employer is required to take into account any work-related risks to new and expectant mothers.

Once you have told your employer that you are pregnant, they should make sure that your job does not pose a risk to you or your baby. Some risks can be avoided, for example by changing your working conditions or hours of work. If a risk cannot be avoided, your employer should offer you suitable alternative work with similar terms and conditions to your present job. If this is not possible, you should be suspended on full pay. This means that you will be given paid leave for as long as necessary. If you want advice on these issues, speak to Citizens Advice or your union if you have one.

Vaginal birth after a caesarean section

Most women who have had a caesarean section can have a vaginal delivery for their next baby. This depends on why you had a caesarean section the first time. Women thought to have a small pelvis, for example, may be advised to have a 'planned' (elective) caesarean section next time. Your GP, or midwife, will be able to advise you. Most women who are advised to try for a vaginal delivery in subsequent pregnancies do have normal deliveries.



RIGHTS AND BENEFITS



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Make sure that you know your rights and that you claim all the benefits that you are entitled to when you are pregnant. Maternity rights do change and different benefits have to be claimed using different forms and from different offices. The benefit rates in this chapter are accurate from April 2009. Get further advice if you are unsure of anything.

Help and advice

Working out what benefits and rights you are entitled to and making claims can be complicated. There are a number of government departments and voluntary organisations that can help you.

- Your local Jobcentre Plus can give you advice about benefits. Look in the business numbers section of the phone book under 'Jobcentre Plus'.
- Citizens Advice Bureaux, law centres and other advice agencies can advise you about your rights at work. To find your local advice agencies, look in your Yellow Pages phone book under 'Counselling and Advice'.
- Some local authorities have welfare officers who can give you advice. Phone your social services department and find out if your area has one.

- Some national voluntary organisations offer information and advice on benefits and rights at work, for example Acas and One Parent Families/Gingerbread (see pages 182 and 184).
- If you are a member of a trade union, your staff representative or local office should be able to advise you on your maternity rights at work.
- The Equality and Human Rights Commission can advise you if your problem is to do with sex discrimination (see page 174).
- The Health and Safety Executive has a useful booklet for women explaining the health and safety rights that apply to pregnant women and women who have recently given birth.



Useful websites

- www.direct.gov.uk
- www.dwp.gov.uk (Department for Work and Pensions)
- www.hmrc.gov.uk/taxcredits
- www.hse.gov.uk (Health and Safety Executive)
- www.equalityhumanrights.com (Equality and Human Rights Commission)
- www.adviceguide.org.uk (Citizens Advice Bureau)
- www.cmoptions.org (Child Maintenance Options)
- www.acas.org.uk (Acas)
- www.direct.gov.uk/employees
- www.healthystart.nhs.uk
- www.workingfamilies.org.uk
- www.jobcentreplus.gov.uk



BENEFITS FOR EVERYONE

Some benefits are available to all mothers, regardless of how much they earn.

Free prescriptions and NHS dental treatment

What are they?

Prescriptions and NHS dental treatment are free while you are pregnant and for 12 months after you have given birth. Your child also gets free prescriptions until they are 16.

How do I claim?

To claim for free prescriptions, ask your doctor or midwife for form FW8 and send it to your health authority. You will be sent an exemption certificate that lasts until a year after your due date.

To claim after your baby is born (if you did not claim while you were pregnant) fill in form A in leaflet P11, *NHS Prescriptions*, which you can get from your doctor or Jobcentre Plus.

To claim for dental treatment, tick a box on a form provided by the dentist or show your exemption certificate (see above).

Child Trust Fund

What is it?

A long-term savings and investment account for children.

Who gets it?

All children born on or after 1 September 2002, provided they are eligible for Child Benefit, live in the UK, and are not subject to immigration control.

How much is it?

You will get a voucher for £250 from the government to start an account for your child.

If you get the full amount of Child Tax Credit (CTC) because your household income is at or below the Child Tax Credit income limit (£16,040 in 2009/10), your child will get a further £250 paid directly into their account.

At seven, children will get another payment of £250 (with children from lower income families again receiving a further £250).

You, your family, your friends and, in time, your child can contribute up to a total of £1,200 a year to the account tax free. The money can only be withdrawn by your child, and they cannot take it out until they are 18.

How do I claim?

All you have to do is claim Child Benefit for your child. You will automatically be sent an information pack and voucher within a month.

From 6 April 2009, some account providers will not require the Child Trust Fund voucher to be handed in or posted when you are opening an account. However, you will still need to provide information such as your child's unique reference number (printed on the voucher) to open an account.

More information

For more information, call 0845 302 1470 or go to www.childtrustfund.gov.uk

Child Benefit

What is it?

Child Benefit is a tax-free benefit to help parents with the cost of caring for their children. It is payable for each child from birth until at least age 16.

Who gets it?

Every mother or the person responsible for the care of a child, but you must generally be living in the United Kingdom.

How much is it?

- £20.00 per week for your first child.
- £13.20 a week per child for any other children.

Child Benefit can be paid directly into a bank, building society or Post Office™ card account. It is usually paid every four weeks in arrears, but single parents and families on low incomes can choose to be paid weekly.

How do I claim?

You can get claim packs:

- in your Bounty Pack (which most new mothers are given in hospital)
- from your Jobcentre Plus office
- from the post office
- by phoning 0845 302 1444.

Fill in the forms and send them with your baby's birth certificate to the Child Benefit Centre. The birth certificate will be returned to you. You need to register your baby to get a birth certificate (see page 138).

You can also apply online at www.hmrc.gov.uk/childbenefit/

You should start to claim Child Benefit within three months of your baby's birth, otherwise you will lose some of the benefit.

More information

Child Benefit can help to protect your State Pension if you stay at home to look after your child. For every complete year that you get Child Benefit, but you don't pay enough National Insurance contributions to count towards the basic pension, you automatically get Home Responsibilities Protection.



TAX CREDITS

What are they?

Two tax credits were introduced in April 2003:

- Child Tax Credit gives financial support for children.
- Working Tax Credit helps people in lower-paid jobs by topping up their wages.

You may not be able to get tax credits if you have come to live here from another country. You should get advice.

Who gets Child Tax Credit?

Child Tax Credit can be claimed by lone parents or couples with one or more children. Nine out of 10 families with children get this credit.

Who gets Working Tax Credit?

Working Tax Credit can be claimed by single people or couples, with or without children.

You must work at least 16 hours each week if:

- you have dependent children and/or
- you have a disability
- or
- you must be 25 or over and work at least 30 hours a week.

You can be treated as if you are working during the first 39 weeks of your maternity leave if you were working enough hours immediately before starting your maternity leave.



Help with childcare costs

Many working parents can get help with their childcare costs through tax credits. If you work at least 16 hours a week and use registered childcare, you could get 80% of the costs back. This is up to a limit of £175 a week if you have one child or £300 a week if you have two or more. Your household income is taken into account in working out what you get. Call the Tax Credits Helpline on 0845 300 3900 to find out more.

How do I claim?

Call the Tax Credits Helpline on 0845 300 3900 for a form to claim both Child Tax and Working Tax Credits.

How much will I get?

The amount you get will depend on your circumstances, including:

- the number of children in your household
- the number of hours you and your partner work
- your household's gross income for the last tax year.

Claims for the current tax year will initially be based on your previous tax year's income. Awards will run until the end of the tax year.

If there is a change in your circumstances, for example after the birth of your baby, the amount you are entitled to may change. As long as you report the change within three months, any extra money can be backdated to the date of the change.

Maternity Allowance or the first £100 a week of Statutory Maternity Pay are not counted as income.

Families with children, with an annual income of £50,000 or less, will get at least £545 a year.

More information

If you get tax credits you may also be able to get the £500 Sure Start Maternity Grant and help with fares to hospital for treatment (including antenatal appointments).

You can get help from Healthy Start if you get Child Tax Credit but not Working Tax Credit with an annual family income of £16,040 or less (2009/10).

See page 162 for more information.

help for
families

BENEFITS IF YOUR INCOME IS LOW

Income-based Jobseeker's Allowance and Income Support

What are they?

Income-based Jobseeker's Allowance (JSA) and Income Support are payments for people who are not in work and do not have enough to live on. If your family income falls below a set level, the benefit will 'top it up'. This means that you may be able to get Income Support even if you are already getting Statutory Maternity Pay, Maternity Allowance, Employment and Support Allowance or some income from part-time work.

Who gets them?

You can claim income-based JSA if:

- you are 18 or over and you are capable of and actively seeking work. You can claim this benefit if you are living with your partner as long as you are both either unemployed or working part time.

If you are 16–17 and face severe hardship you may be able to claim. You should get further advice about this.

You can claim Income Support if:

- you are 16 or over and cannot be available for work because you are a single parent or because you are 29 weeks pregnant or more, or
- you are pregnant and not well enough to work because of your pregnancy.

You cannot claim income-based JSA or Income Support if:

- you live with your partner and they work for 24 hours or more a week

- you work for more than 16 hours a week, or
- you have savings of more than £16,000.

If you or your partner are too sick or disabled to work for another reason (not your pregnancy), you should get advice. You may be able to claim Employment and Support Allowance instead.

How much are they?

This depends on:

- your age
- the size of your family
- what other income you have.

If you are under 25 or have more than £6,000 in savings, you can get a lower rate. If you are claiming during pregnancy, you should let your Jobcentre Plus know as soon as the baby is born, as your benefit may go up.

How do I claim?

To claim income-based JSA before your baby is born, you or your partner must both go to the Jobcentre Plus in person. You may be able to claim by post if you live a long way from the Jobcentre. Once you are 29 weeks pregnant, you do not have to sign on if your partner is claiming with you. Your partner can continue to claim for you and the baby.

To claim Income Support, fill in form A1, which you can get from a post office or a Jobcentre Plus. You do not need to sign on.

The benefit is paid directly into your bank account. If you are claiming income-based JSA, you or your partner (or both, before you are 29 weeks pregnant) will have to go to your Jobcentre Plus every fortnight to 'sign on' to show that you are available for work.

More information

If you get Income Support, income-based JSA, income-related Employment and Support Allowance or Pension Credit, you can claim other benefits, such as:

- a £500 Sure Start Maternity Grant
- help with fares to hospital
- Housing Benefit
- Council Tax Benefit.

You may be able to get help with mortgage interest payments.

You can get help from Healthy Start.

See page 162 for more information.





£500 Sure Start Maternity Grant from the Social Fund

What is it?

The £500 Sure Start Maternity Grant is a lump sum payment to help buy things for a new baby.

Who gets it?

Pregnant women and new parents who get:

- Income Support
- income-based Jobseeker's Allowance
- income-related Employment and Support Allowance
- Pension Credit
- Working Tax Credit where a disability or severe disability element is included in the award, or
- Child Tax Credit payable at a rate higher than the family element.

How much is it?

£500 for each baby who is:

- expected
- born
- adopted
- the subject of a parental order (following a surrogate birth), or
- the subject of a residence order (in certain circumstances).

How do I claim?

Claim using form SF100 (Sure Start), which you can get from Jobcentre Plus. You can claim any time from 11 weeks before your due date until three months after the birth, adoption or date of parental or residence order. If you are adopting or have been granted a residence order, your baby must be aged under 12 months when you claim.

Part of the form will need to be completed by your midwife, GP or health visitor. This is to confirm when your baby is due or actually born, and that you have received advice about the health and welfare of your baby and, if you claim before your baby is born, yourself.

If you cannot get any of the benefits listed above (see 'Who gets it?') until after your baby is born, you must still claim the Sure Start Maternity Grant within the three-month time limit.

Health in Pregnancy Grant

As a mum-to-be living in the UK, you can claim a one-off payment of £190 to help you. You can use the grant to keep yourself healthy or for things for your baby. It's your choice.

Who gets it?

Almost every pregnant woman gets it. It doesn't depend on your income. The grant is available between the 25th week and your expected due date. You may not be able to claim if:

- you are subject to immigration control, or
- you are not ordinarily resident in the UK.

How much is it?

£190 and it's tax free, so it will not affect your tax credits or any other benefits.

How do I claim?

When you reach your 25th week, ask your midwife or doctor for a claim form at your next appointment. Make sure your midwife or doctor has completed and signed their part of the form. If they have not, it could delay your claim.

You have 31 days from the date your midwife or doctor signs the claim to get it back to Her Majesty's Revenue and Customs (HMRC). Once HMRC receives your form, they aim to send you a letter within three weeks to tell you if your claim has been allowed. You will be paid your grant about one week after you get the letter.

For more information visit www.direct.gov.uk/money4mum2be or call 0845 366 7885.

The Discretionary Social Fund

What is it?

The Discretionary Social Fund provides grants and interest-free loans for needs that are difficult for people to meet out of their weekly benefits or regular income.

Who gets it?

There are three types of payments available:

- Community Care Grants are for people getting Income Support, income-based Jobseeker's Allowance (JSA), income-related Employment and Support Allowance or Pension Credit.
- Budgeting Loans are interest-free, repayable loans for people getting Income Support, income-based JSA, income-related Employment and Support Allowance or Pension Credit for at least 26 weeks.
- Crisis Loans are interest-free, repayable loans for people (on benefits or not) who are unable to meet their immediate short-term needs in a crisis.

How much can you get?

This depends on your personal circumstances, your ability to pay and how much money is available. Social Fund payments are not a right and there is a limited amount of money to be distributed between all those who successfully apply.

How do I claim?

Contact Jobcentre Plus.

More information is also available in leaflets:

- *A Guide to the Social Fund* (SB16, available at www.dwp.gov.uk)
- *The Social Fund* (DWP1007).

More information

- Loans have to be repaid at a set amount per week, which will be taken directly from your income if you are claiming other benefits. The amount you have to repay per week depends on the size of the loan, the size of your income and any other debts you may have.
- You cannot get a Budgeting Loan or a Crisis Loan for more than £1,500 and the total you owe the Social Fund cannot be more than £1,500.
- The amount of any Discretionary Social Fund payment you get will be reduced on a pound-for-pound basis by any savings you or your partner has. For Community Care Grants, savings over £500 (£1,000 if you or your partner are aged 60 or over) will usually affect how much you can get. For Budgeting Loans, savings over £1,000 (£2,000 if you or your partner are aged 60 or over) will usually affect how much you can get.
- The Social Fund can only provide Community Care Grants to families receiving Income Support, income-based JSA, income-related Employment and Support Allowance or Pension Credit under certain circumstances. These could be to help pay fares to visit a mother and baby in hospital or to help a family under exceptional pressure. Grants do not have to be repaid.



Housing Benefit – help with your rent

What is it?

Housing Benefit will help pay your rent if you are on income-based Jobseeker's Allowance (JSA), Income Support or income-related Employment and Support Allowance, or if you have a low income. If you are a council tenant it will be paid direct to the council; if you are a private tenant, it will be paid either to you or directly to your landlord.

How much is it?

It depends on:

- the rent you pay
- average rents in your area
- the size of your home
- your income
- savings
- other benefits
- your age, and
- your family size.

It may not be the same amount as the rent you are actually paying. The amount of savings you have can also affect the amount of Housing Benefit you get. You cannot get Housing Benefit if you have savings of more than £16,000.

How do I claim?

If you are getting income-based JSA or Income Support, you will get a Housing Benefit claim pack with your JSA/Income Support claim form. Otherwise, get a form from your local council.

Help with mortgage interest repayments

Who gets it?

If you have got a mortgage and you are on income-based Jobseeker's Allowance (JSA), Income Support or income-related Employment and Support Allowance, you may be able to get help with your interest payments. There is usually a waiting period during which you will not get any help.

How much is it?

You can only get help with interest payments (not repayments of capital or contributions to a linked PEP, endowment or insurance policy) and the amount is usually based on a standard average interest rate (which may not be the same as the interest you are paying).

You usually have to wait for 13 weeks before you get help, but you may have had to wait longer if you claimed benefits before January 2009.

How do I claim?

Once you have claimed income-based JSA or Income Support, your Jobcentre Plus office will automatically send you form M112 about your housing costs shortly before your benefits become payable. You fill out part of the form and then send it to your mortgage lender to fill out the rest.

The money will either be paid to you as part of your income-based JSA or Income Support, or it will be paid directly to your mortgage lender.

More information

Tell your mortgage lender straight away if you get into difficulties with your mortgage. If you are unable to meet your repayments, you may be able to negotiate a temporary agreement for reduced repayments (e.g. during your maternity leave).

If you have a 'flexible mortgage', this should be relatively easy to arrange. Some mortgage lenders allow a 'repayment holiday' of a few months once during the life of the mortgage.

If you have mortgage protection insurance, contact your insurer immediately. Most insurance policies will pay out if you are receiving out-of-work benefits, but not if you are only receiving Statutory Maternity Pay or Maternity Allowance.



Council Tax Benefit

What is it?

Council Tax Benefit helps you to pay your Council Tax if your income is low.

Who gets it?

If your income is low or you are getting income-based Jobseeker's Allowance (JSA), income-related Employment and Support Allowance or Income Support, you may get Council Tax Benefit.



How much is it?

You may get all of your Council Tax paid or just part of it. It will depend on your income, savings, whether other adults live with you, and an assessment of your circumstances.

How do I claim?

If you are getting income-based JSA or Income Support, you will get a Council Tax Benefit claim form with your JSA/Income Support claim form. Otherwise, get a form from your local council.

Healthy Start

What is it?

Healthy Start is a scheme that provides vouchers that can be exchanged for milk, fresh fruit and vegetables and infant formula milk. You can also get free vitamins. You can get vouchers that are worth £3.10 per week or £6.20 per week for children under one year old.

Who gets it?

You qualify for Healthy Start if you are pregnant or have a child under four years old and you and your family get one of the following:

- Income Support
 - income-based Jobseeker's Allowance
 - income-related Employment and Support Allowance
 - Child Tax Credit and have an annual family income of below £16,040 or less (2009/10)
 - Working Tax Credit run-on (but not Working Tax Credit). Working Tax Credit run-on is the Working Tax Credit you receive in the four weeks immediately after you have stopped working for 16 hours or more per week
- OR
- you are pregnant and under 18 years of age.

How do I claim?

- Pick up the Healthy Start leaflet HS01, *A Healthy Start for Pregnant Women and Young Children*, from your local health centre, or call 0845 607 6823 to request a free copy.
- Ask your health visitor for more information.
- Visit www.healthystart.nhs.uk

You will need your midwife to fill in their part of the application form. You can apply as soon as you are 10 weeks pregnant. Getting vouchers and vitamins cannot be backdated, so apply as early as you can.

Once your baby is born, you should claim Child Tax Credit to make sure you continue to get your vouchers, if you are still entitled. See page 158 for more information.

Help with hospital fares

Who gets it?

If you or your partner gets income-based Jobseeker's Allowance (JSA), income-related Employment and Support Allowance or Income Support, you can get a refund for fares to and from the hospital (including for your visits for antenatal care). This can cover normal public transport fares, estimated petrol costs and taxi fares if there is no alternative. You may also be entitled to help if your family has a low income. You may also get help if you get tax credits or Pension Credit. Check your award letter for details.

How do I claim?

If you get income-based JSA, income-related Employment and Support Allowance or Income Support, you can claim when you visit the hospital. You will just need to show proof that you get the benefit.

You can claim within three months of your visit by filling in form HC5, which you can get from the hospital or Jobcentre Plus.

Fill in form HC1 if you don't get income-based JSA, income-related Employment and Support Allowance or Income Support but your income is low. You can get this from your doctor, hospital or Jobcentre Plus. Depending on how low your income is, you will then be given:

- certificate HC2, which means you qualify for free services, or
- certificate HC3, which means that you qualify for some help.

You show the certificate when you go to the hospital, or you can claim within three months of your visit on form HC5.



MATERNITY BENEFITS

Maternity Allowance

What is it?

Maternity Allowance (MA) is a weekly allowance paid through Jobcentre Plus.

Who gets it?

Women who cannot get Statutory Maternity Pay (see page 165) get MA. These are:

- women who have changed jobs during pregnancy
- women who have had periods of low earnings or unemployment during pregnancy
- women who are self-employed.

You can claim MA if you have been employed and/or self-employed in at least 26 of the 66 weeks before your expected week of childbirth. This 66-week period is known as the test period. You must also have gross average weekly earnings of at least £30. The average is taken over any 13 weeks in the test period. You should choose the 13 weeks in which you earned the most. In your chosen weeks, you can add together earnings from more than one job, including any self-employed work. You will be treated as earning a certain amount if you are self-employed.

How much is it?

MA is paid for 39 weeks at a standard rate of £123.06 per week, or 90% of your gross average weekly earnings if this is less than £123.06.

When is it paid?

The earliest that MA can start is 11 weeks before the week your baby is due and the latest is the day following the birth.

If you are unemployed, your MA will start 11 weeks before the week your baby is due.

If you are employed or self-employed at the start of the 11th week before the week your baby is due, you can choose when to start your MA. You can even work right up until the date the baby is due, unless:

- you are absent from work because of a pregnancy-related reason during the four weeks before the week your baby is due. In this case your MA will start automatically on the day following the first day of your absence from work, or
- your baby is born before your MA is due to start. In this case your MA will start on the day following the birth and will last for 39 weeks.

How do I claim?

You can make a claim for MA from the 14th week before the week your baby is due.

- Fill in form MA1, available from Jobcentre Plus or your antenatal clinic.
- Download an MA claim pack in PDF format from www.dwp.gov.uk/advisers/claimforms/ma1.pdf
- Contact Jobcentre Plus on 0800 055 6688.

You must also send your maternity certificate (form MAT B1). This is issued by your GP or midwife from 20 weeks before the week your baby is due.



If you are employed in the 15th week before your baby is due and do not qualify for Statutory Maternity Pay, you must also send in form SMP1 from your employer to show why you don't qualify. You will have to provide original payslips to show you meet the earnings condition.

If you are self-employed, Jobcentre Plus will confirm this direct with Her Majesty's Revenue and Customs.

When you have completed your claim form, send it to Jobcentre Plus, together with your maternity certificate (MAT B1) and your original payslips.

Claim as soon as you can, even if you are still at work, do not have the medical certificate, or cannot provide any other information needed to complete the claim form. You can always send things in later. You must claim within three months of the date your MA period is due to start. If you delay, you will lose money.

How is it paid?

MA is paid directly into your bank account, weekly or every four weeks in arrears.

Working during the Maternity Allowance pay period

You are allowed to work as an employed or self-employed person for up to 10 days during your MA pay period without losing any MA.

These 10 days are called Keeping in Touch (KIT) days. Once you have used up your 10 KIT days, if you do any further work you will lose a day's MA for any day on which you work. You must tell Jobcentre Plus about any work you do.

The amount you get paid for the days you work in your MA pay period will not affect your MA.

More information

If you are not entitled to MA, your Jobcentre Plus office will automatically check whether you might be entitled to Employment and Support Allowance (see below).

For further information about MA, see leaflet NI17A, *A Guide to Maternity Benefits*, available from www.dwp.gov.uk/advisers/ni17a

Employment and Support Allowance

What is it?

This is a weekly allowance that is normally paid to people whose ability to work is limited because of an illness or disability. It may also be paid to women who don't qualify for Statutory Maternity Pay or Maternity Allowance.

Who gets it?

Women who have paid enough National Insurance contributions during the last three tax years or women who are on a low income.

Jobcentre Plus will check this. If you are not sure whether or not you qualify, phone Jobcentre Plus for more information.

How much is it?

- £64.30 per week if you are aged 25 or over.
- £50.95 if you are aged under 25.

You may get more than this in some circumstances, for example if you have a partner who is not working and is not claiming benefits for themselves.

It is awarded from the Sunday of the sixth week before your baby is due until two weeks after your baby's birth. It may not be paid for the first three days of your claim.

How do I claim?

Make a claim for Maternity Allowance using form MA1, which you can get from Jobcentre Plus or your antenatal clinic. You also have to send your maternity certificate (form MAT B1), which is issued by your GP or midwife from 20 weeks before the week your baby is due. You don't need to send in a sick note from your doctor.

If you are not entitled to Maternity Allowance, Jobcentre Plus will check automatically to see if you qualify for Employment and Support Allowance. It can be paid directly into your bank. You must claim within three months of the start of your entitlement.

More information

To find out more about Employment and Support Allowance:

- call Jobcentre Plus on 0800 055 6688
- ask for leaflet DWP 1001, or
- visit the website at www.dwp.gov.uk/esa

Statutory Maternity Pay

What is it?

Statutory Maternity Pay (SMP) is money paid by your employer to help you take time off at and around the birth of your baby. It is paid up to a maximum of 39 weeks. Your employer can claim back some or all of it from Her Majesty's Revenue and Customs (HMRC). SMP counts as earnings and your employer will deduct tax and National Insurance.

You can get it even if you don't plan to go back to work or you leave your employment after you qualify for SMP. You will not have to pay SMP back if you don't return to work.

You may qualify for SMP from more than one employer.

Who gets it?

You get SMP if:

- you have been continuously employed for at least 26 weeks by the same employer up to the qualifying week. This is the 15th week before the week your baby is due. **This means you must have been employed by that employer before you were pregnant.** Part weeks count as full weeks and one day's employment in the qualifying week counts as a full week, and
- you earn an average of £95 a week before tax. This amount is called the Lower Earnings Limit for National Insurance contributions and is the amount you have to earn to qualify for benefits. You have to earn more than this amount before you actually start paying National Insurance.

Your earnings are averaged over an eight-week period, running up to and including the 15th week before the week your baby is due. This period may vary slightly depending

on whether you are paid weekly, monthly, or at other intervals.

To find out which is your qualifying week, look on a calendar for the Sunday before your baby is due (or the due date if that is a Sunday). Count back 15 Sundays from there. You should use the due date on the MAT B1 certificate, which your midwife or GP will give you when you are 20 weeks pregnant.

If you are not sure if you are entitled to SMP, ask your employer anyway. Your employer will work out whether or not you should get it, and if you don't qualify they will give you form SMP1 to explain why. If your employer is not sure how to work out your SMP or how to claim it back, they can ring the HMRC Employer Helpline on 08457 143 143 for advice.

How much is it?

SMP is paid for a maximum of 39 weeks.

- For the first six weeks you get 90% of your average gross weekly earnings, with no upper limit.
- For the remaining 33 weeks, you get a standard rate of £123.06, or 90% of your average gross weekly earnings if 90% is less than £123.06.

SMP is usually paid in the same way and at the same time as your normal wages, but your employer may decide to pay differently, for example in a lump sum.

When is it paid?

The earliest you can start your SMP is 11 weeks before the week your baby is due. The latest is the day following the birth.

To work out the earliest date, use the due date on your MAT B1 certificate, which your midwife or GP will give you.

Find the Sunday before your baby is due (or the due date if it is a Sunday) and count back 11 Sundays from there.

It is up to you to decide when you want to stop work, unless your job finishes before your SMP starts or you are off work for pregnancy-related reasons in the four weeks before your baby is due.

If your job finishes before the 11th week before the week your baby is due, your SMP must start 11 weeks before the week your baby is due.

If your job finishes after the 11th week but before your SMP is due to start, your SMP must start the day after you left your job. If you are still employed you can choose to work right up until the date the baby is due, unless:

- you are absent from work because of pregnancy-related reasons during the four weeks before the week that your baby is due. In that case your SMP should start automatically the day following the first day of absence from work, or
- your baby is born before the start of your SMP. In that case your SMP will start the day following the birth and will be paid for 39 weeks.



You can work for up to 10 days for the employer who pays you SMP and still keep the SMP for the weeks in which you do that work. These days are called Keeping in Touch (KIT) days.

After that, if you do any further work you cannot get SMP for any week in which you work for the employer who pays you.

If you return to work early, your SMP will stop. Your SMP cannot start again once you have stopped your maternity leave.

If after the birth you start work for a new employer who did not employ you in the 15th week before the week your baby was due, you must tell the employer paying your SMP. They will then stop paying your SMP.

How do I claim?

You must give your employer at least 28 days' notice of the date you want to start your pay. They may need this in writing. You must also send your maternity certificate (MAT B1 form), which is issued by your GP or midwife from 20 weeks before the week your baby is due.

You can give notice for leave and pay together in the 15th week before the week your baby is due. You can change your mind about the dates you have given for the start of your SMP but you must give your employer 28 days' notice of this change and confirm the new date in writing.

More information

See leaflet NI17A, *A Guide to Maternity Benefits*, which is available from www.dwp.gov.uk/advisers/ni17a

IF YOU ARE UNEMPLOYED

Contribution-based Jobseeker's Allowance

What is it?

Contribution-based Jobseeker's Allowance (JSA) is an allowance that lasts for up to 26 weeks for people who are unemployed or working less than 16 hours a week.

Who gets it?

You get it if:

- you have paid enough National Insurance contributions during the last two tax years before the current calendar year. Tax years run from April to March.
- you are available for work for as many hours as your caring responsibilities permit (this must be at least 16 hours a week), and
- you are actively seeking work.

How much is it?

- £50.95 a week if you are under 25.
- £64.30 a week if you are 25 or over.

Your partner's earnings are not taken into account, but, if you are in part-time work, **your** earnings are and will reduce how much benefit you get.

The benefit is paid directly into your bank account, normally every two weeks.

How do I claim?

Go to your local Jobcentre Plus, or claim by post if you live too far away. You will have to go to your Jobcentre Plus every fortnight to 'sign on' to show that you are available for work.

More information

If your family has no other income, you will probably be entitled to income-based JSA and other benefits for families on low incomes (see page 159).

If you resign from your job

If you resign from your job and don't go back to work after maternity leave, you may be able to claim contribution-based Jobseeker's Allowance (JSA) for up to six months. However, you will have to show that you had 'just cause' for voluntarily leaving your job. You will also have to be available for work for as many hours a week as your caring responsibilities permit. This must be at least 16 hours a week.

If you have not paid enough National Insurance contributions, you may be able to claim income-based JSA instead (see page 159), depending on your personal circumstances. Apply in person at your local Jobcentre Plus.

If you are a single parent, you may be able to claim Income Support (see page 159) once your baby is born.

Remember that you may still be able to claim tax credits if you are unemployed (Child Tax Credit for your children; Working Tax Credit if your partner works enough hours). Apply to Jobcentre Plus for Income Support or to Her Majesty's Revenue and Customs for tax credits.



MATERNITY LEAVE

All employed women are entitled to 52 weeks' maternity leave, no matter how long they have worked for their employer, or the hours they worked. This is made up of 26 weeks of Ordinary Maternity Leave (OML) and 26 weeks of Additional Maternity Leave (AML).

You are usually considered to be an employee if:

- your employer deducts tax and National Insurance from your pay
- your employer controls the work you do, when and how you do it, and
- your employer provides all the equipment for your work.

If you work for an agency or do casual work, you are probably not an employee. However, you can still get maternity pay if you meet the normal conditions (see 'Maternity Allowance' on page 163 and 'Statutory Maternity Pay' on page 165).

time
with your **baby**

Ordinary Maternity Leave

All employed women:

- can take 26 weeks' leave, and
- have the right to return to the same job.

Additional Maternity Leave

All employed women:

- can take 26 weeks' leave from the end of their Ordinary Maternity Leave, and
- have the right to return to the same job. If that is not reasonably practicable, then you have the right to a suitable job on very similar terms and conditions.

When does maternity leave start?

The earliest you can start your statutory maternity leave is 11 weeks before the expected week of childbirth. This is when

you are about 29 weeks pregnant, so count back from the due date on your MAT B1 certificate, which your midwife or GP will give you. Find the Sunday before your baby is due (or the due date if it is a Sunday) and count back 11 Sundays from there.

You can decide when you want to stop work. You can even work right up until the date your baby is born, unless:

- you have a **pregnancy-related illness/absence in the last four weeks of your pregnancy.** In this case your employer can start your maternity leave even if you are off sick for only one day. However, if you are ill for only a short time, your employer may agree to let you start your maternity leave when you had planned, or
- your baby is born before the day you were planning to start your leave. In this case leave will start

on the day after you give birth. You should tell your employer as soon as you can that you have given birth.

How to give notice

Telling your employer that you are pregnant

The latest time you can tell your employer that you are pregnant is the 15th week before your baby is due. However, it is best to tell your employer as soon as possible to make sure that you have health and safety protection during your pregnancy and the right to paid time off for antenatal care. The law protects you from being dismissed or discriminated against because you are pregnant.

If you cannot give notice by the 15th week before you are due (for example, because you have to go into hospital unexpectedly), you must give notice as soon as you reasonably can.

Giving notice for statutory maternity leave

To give notice that you will be taking maternity leave, you must tell your employer the following in or before the 15th week before your baby is due. It is probably best to put this in writing:

- that you are pregnant
- the expected week of childbirth, and
- the date on which you intend to start your maternity leave.

If you want to change the date on which you start your maternity leave, you must give your employer notice of the new date at least 28 days before either the new date or the old date – whichever is earliest. If there is a good reason why that is not possible, tell your employer as soon as you reasonably can.

You can choose when to start maternity leave, but the earliest you can start getting Statutory Maternity Pay is in the 11th week before the week your baby is due.

Once you have given notice, your employer must write to you within 28 days and state the date you are expected to return from maternity leave.

Working out the 15th week before your baby is due

Find the Sunday before your baby is due (or the due date if it is a Sunday) and count back 15 Sundays from there. That is the start of the 15th week before the expected week when your baby is due.

You should use the due date on the MAT B1 certificate that your midwife or GP will give you when you are about 20 weeks pregnant.

RIGHTS DURING MATERNITY LEAVE

Since 5 October 2008, your contractual rights (that is, any special rights that apply to your particular workplace, such as a company car) continue throughout your maternity leave (Ordinary Maternity Leave (OML) and Additional Maternity Leave (AML)) as if you were still at work. This includes your legal right to 5.6 weeks' paid annual leave (normally 28 days for full-time employees and the pro-rata equivalent for part-time workers) whether you are on maternity leave or not. This does not include your normal pay.

During the first 39 weeks of your leave you will probably be entitled

to either Statutory Maternity Pay or Maternity Allowance (see pages 165 and 163). After that your leave will be unpaid. Some employers also offer extra maternity pay: check your contract, or ask the human resources department or your union representative.

If you are made redundant while on maternity leave, your employer must offer you any suitable alternative work that is available. If there is none, they must give you any notice and redundancy pay that you are entitled to, although they could offset any maternity pay you get from the notice pay. Also, your employer must not discriminate against you by failing to consider you for opportunities such as promotion.

For more information visit www.direct.gov.uk/workandfamilies

Pay

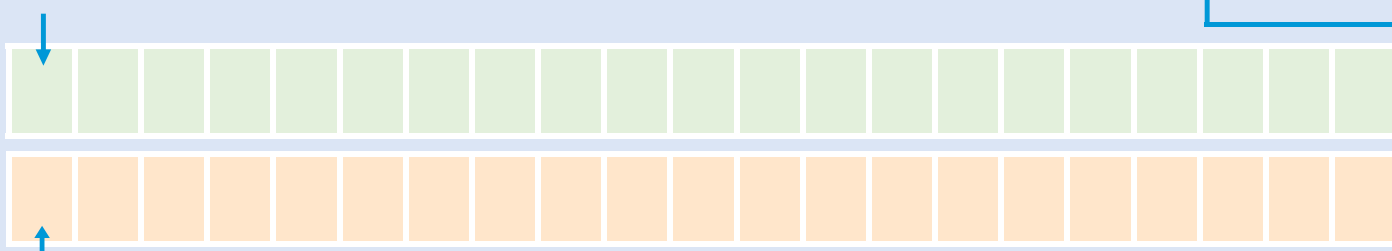
During OML and the first 13 weeks of AML, you may be entitled to Maternity Allowance or Statutory Maternity Pay (see pages 163 and 165). After that your leave will usually be unpaid. Some employers offer extra (or contractual) maternity pay, so check your contract or ask the human resources department or your union representative.

Rights and benefits in pregnancy

This guide shows you **when** you should claim for a range of benefits. The timing of your rights and benefits in pregnancy is very complicated, so use this chart as a rough guide only.

In this box, write in the date of the Sunday before the first day of your last period. (If your last period started on a Sunday, write in that date.) Then work along the top row filling in the dates of each successive Sunday.

You can claim the Health in Pregnancy Grant payment from this week.



Write in the first day of your last period here. Then work along the row filling in the remaining boxes. Each box represents a week. Write in the dates week by week until you get to the date on which your baby is due.

Discrimination

Your employer must not discriminate against you while you are on maternity leave. This means that they have to consider you for opportunities such as promotion.

If you are made redundant while on maternity leave, your employer must offer you any suitable alternative work that is available. If there is none, they must pay you any notice and redundancy pay that you are entitled to.

RETURNING TO WORK

Giving notice about returning to work

Your employer should assume that you will be taking your full entitlement of 52 weeks unless you tell them otherwise. You will be due back to work on the day after the 52-week period of maternity leave.

If you want to take all of your leave, you simply go back to work on that day.

If you decide not to take some or all of your maternity leave, whether Ordinary Maternity Leave (OML) or Additional Maternity Leave (AML), you should give eight weeks' notice to return to work early. Even if you only wish to take OML, or you just want to be off work while you still

get maternity pay, you must give eight weeks' notice of your return as you will in fact be returning early.

If you don't give this notice and just turn up at work before the end of your maternity leave, your employer can refuse to allow you to work for up to eight weeks or until the end of your leave, whichever is earlier. If you change your mind and wish to continue taking your maternity leave, you must give your employer eight weeks' notice before the earlier date of return.

The law does not allow you to work for two weeks (four weeks if you work in a factory) after childbirth. This period is known as **Compulsory Maternity Leave**. You will not be allowed to return to work during this time.

Your job when you go back

When you go back to work after AML, you have the right to return to the same job. But if your employer can show that this is not reasonably practicable, you have the right to be offered a suitable alternative job on at least the same terms and conditions. If the job no longer exists, this could be a redundancy situation and you should get advice. You should also be offered any suitable alternative vacancies if your post is made redundant while you are on maternity leave.

If you need more time off work

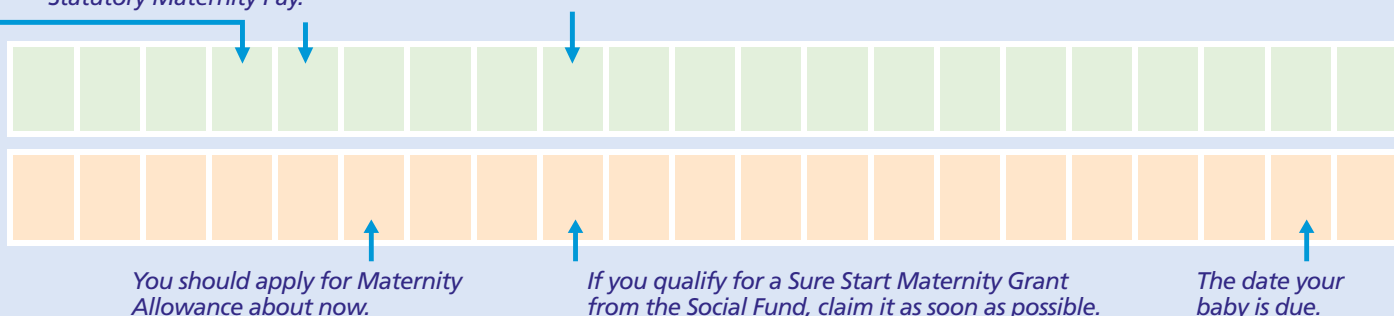
If you stay off work after your maternity leave has ended, you will lose your right to return to the same job. If you need more time off you could do one of the following:

- Ask your employer if you can take annual leave immediately after your maternity leave. Your paid holiday continues to accrue during maternity leave so you may have some holiday owing to you.
- Take some parental leave at the end of your maternity leave (see page 172). You must give 21 days' notice to take parental leave, and it is usually unpaid, unless your employer offers paid parental leave.
- If you cannot return because you are ill, you can take sick leave as long as you follow your employer's sickness procedures.

If you are not able to take annual leave and don't have enough notice to ask for parental leave, you can still ask your employer if they will agree to a further period off work (this will usually be unpaid). You should ask your employer to confirm this agreement in writing and to confirm that you will have the right to return to the same job. You should also check whether your employer is counting this as part of your parental leave entitlement.

You must have notified your employer of your pregnancy, the expected week of childbirth and the date you want to start Ordinary Maternity Leave. This is also your 'qualifying' week for Statutory Maternity Pay.

This is the earliest you can start your maternity leave and Maternity Allowance or Statutory Maternity Pay.



You should apply for Maternity Allowance about now.

If you qualify for a Sure Start Maternity Grant from the Social Fund, claim it as soon as possible.

The date your baby is due.



If you don't go back to work

You should resign in the normal way, giving at least the notice required by your contract or the notice period that is normally given in your workplace. If you don't have a contract, you should give at least a week's notice.

If you say you are going to return to work and then change your mind, you can resign from your job in the normal way. Your notice period can run at the same time as your maternity leave.

If you don't go back to work, you don't have to repay any of the Statutory Maternity Pay you received during your maternity leave.

Work during maternity leave

During maternity leave it is often helpful to keep in touch with your employer. Your employer is entitled to make reasonable contact with you during maternity leave. This might be to discuss things like arrangements for your return to work, or to update you on any significant changes in the workplace while you have been away.

You are entitled to do up to 10 days' work during your maternity leave without losing maternity pay or bringing your leave to an end.

These Keeping in Touch (KIT) days may only be worked if both you and your employer agree. Although particularly useful for things such as training or team events, they may be used for any form of work and should make it easier to return to

work after your leave. You will need to agree with your employer what work is to be done on KIT days and how much pay you will receive.

If you are pregnant again

Maternity leave does not break your continuity of employment, so if you are pregnant again, your right to maternity leave will be based on your total service with your employer. You may also qualify for Statutory Maternity Pay (SMP), as long as you meet the normal conditions. However, this will mean you will have to be receiving an average of at least £95 per week from your employer, worked out over approximately weeks 18–25 of your pregnancy when SMP entitlement is calculated.

If you have already taken Ordinary Maternity Leave (OML) and Additional Maternity Leave (AML) (a year off) you will be entitled to a second period of OML and AML. If you go straight into another period of OML without physically returning to work and decide to return to work after the second period of OML, you will not have the right to return to exactly the same job as you normally would at the end of OML. However, you will have the same right as you would have had at the end of AML. This is the right to return to the same job or, if that is not reasonably practicable, a suitable alternative job on similar terms and conditions.

If you return to work after the end of your first period of AML and before the start of your second period of OML, your rights to maternity leave are not affected. This means that you have the right to return to exactly the same job after your second period of OML. This applies even if you only returned to work for one day.

OTHER EMPLOYMENT RIGHTS

These rights apply no matter how long you have been employed or how many hours you work per week.

Paid time off for antenatal care

If you are an employee, you have the right to take reasonable time off for your antenatal appointments, including time needed to travel to your clinic or GP, without loss of pay.

You should let your employer know when you need time off. For appointments after the first one, your employer can ask to see your appointment card and a certificate stating that you are pregnant.

Antenatal care can include antenatal education and relaxation classes. You may need a letter from your GP or midwife to show your employer, saying that these classes are part of your antenatal care.

Health and safety rights

If you are pregnant, have recently given birth or are breastfeeding, your employer must make sure that the kind of work you do and your working conditions will not put your health or your baby's health at risk. To get the full benefit of this legal protection, you must notify your employer in writing that you are pregnant, have recently given birth or are breastfeeding.



- Your employer must carry out a risk assessment at your workplace and do everything reasonable to remove or reduce the risks found.
- If there are still risks, your employer must change your working conditions or hours of work to remove the risk.
- If this is not possible or would not remove the risk, your employer must offer you a suitable alternative job.
- If this is not possible, your employer must suspend you on full pay for as long as is necessary to avoid the risk. If you do night work and your doctor advises that you should stop for health and safety reasons, you have the right to transfer to day work or, if that is not possible, to be suspended on full pay. You must provide a medical certificate.



Dismissal or unfair treatment

It is sex discrimination for your employer to treat you unfairly, dismiss you or select you for redundancy for any reason connected with pregnancy, childbirth or maternity leave.

If you are dismissed while you are pregnant or during your maternity leave, your employer must give you a written statement of the reasons. You may also have a claim for compensation for sex discrimination. If you are making a claim against your employer, you must put your claim into the Employment Tribunal within three months of the problem arising – get advice as soon as possible.



OTHER TYPES OF LEAVE

Paternity leave

Paternity leave is one or two weeks' leave to care for a child or support their mother.

Who gets it?

Your baby's biological father, your husband or your partner, including a same-sex partner, will be able to take paternity leave providing they:

- expect to have responsibility for bringing up the child, and
- have worked for the same employer for at least 26 weeks by the 15th week before your baby is due.

If your partner is not the biological father and is not married to you or in a civil partnership with you, they must live with you and your baby to get paternity leave.

When does it start?

It can start:

- from the date of your baby's birth
- from a chosen number of days or weeks after the date of your baby's birth (whether this is earlier or later than expected), or
- from a chosen date.

Paternity leave must be taken within 56 days of your baby's birth or, if your baby is born early, within the period from the actual date of birth up to 56 days after the expected week of birth.

Your partner will be able to return to the same job after paternity leave.

Statutory Paternity Pay

Statutory Paternity Pay (SPP) is paid by employers for up to two weeks.

Who gets it?

Your partner can get SPP if they:

- are the baby's father or your husband/partner and are responsible for the baby's upbringing (your partner must live with you and your baby if they are not the biological father and are not married to you or in a civil partnership with you)
- have worked for an employer for 26 weeks by the 15th week before the baby is due
- are still employed by the same employer when the baby is born
- earn at least £95 per week on average (before tax) in the eight weeks immediately before the week your baby is born.

How much is it?

£123.06 per week or 90% of your partner's average weekly earnings, whichever is less.

How do I claim?

Your partner must give their employer at least 28 days' notice of the date when they want their SPP to start – or notify them as soon as is reasonably practicable.



Parental leave

Parental leave is designed to give parents more time with their young children. It entitles you to take 13 weeks' leave per parent per child, usually unpaid, up to your child's fifth birthday. Parents of disabled children are entitled to 18 weeks' leave, to be taken before the child is 18. For parental leave, a disabled child is a child who gets Disability Living Allowance (DLA). It is also available for adoptive parents, in which case you can take it either within five years of the placement for adoption or before your child's 18th birthday, whichever is earlier.

Who gets it?

Employees who have been employed for a year by the time they wish to take leave to care for a child.

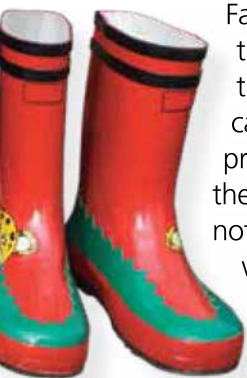
You cannot usually take all your 13 weeks in one go. Your employer may limit the amount of leave you can take to four weeks per child in any one year.

How do I claim?

You must give your employer 21 days' notice of the dates when you want to take your leave. Your employer can postpone the leave, but only if their business would be disrupted unduly.

Fathers wanting to take time off at or around the birth of their baby can take parental leave, providing they give their employers 21 days' notice of the expected week of childbirth.

An employer cannot postpone leave in these circumstances.



More information

Visit www.direct.gov.uk/workandfamilies

Time off for dependants

Every employee is also entitled to emergency unpaid leave to make arrangements for the care of a child who falls ill, gives birth or is injured. This leave can be used if there is a sudden problem with care arrangements for your child – for example, if your childminder falls ill.

Flexible working arrangements

Parents have the right to ask for flexible working arrangements. If you need to change your working hours because of childcare, you also have the right to have your request considered seriously under sex discrimination law.

Follow the procedure outlined on page 173. If your request is refused, you should get advice about whether you have a claim for compensation under the new right and under sex discrimination law.

Your rights

You have the right to request flexible working arrangements if you have or expect to have parental responsibility for:

- a child under 17 (from April 2009), or
- a disabled child under 18 who is entitled to Disability Living Allowance (DLA).

Parental responsibility means that you are a:

- mother
- father
- adopter
- guardian

Flexible working

Flexible working covers a wide variety of working practices. It can be any working pattern other than the normal working pattern in an organisation. Most people are familiar with working part time for pro-rata pay or working different shift patterns. Other ways of flexible working include the following:

- **Flexitime.** Employees may be required to work within core hours, but outside these times they get flexibility in how they work their hours.
- **Job sharing.** Typically, two employees share the work normally done by one employee.
- **Working from home.** New technology makes work possible by telephone, fax and email from home, or other remote locations.
- **Term-time working.** An employee on a permanent contract takes paid or unpaid leave during school holidays.
- **Staggered hours.** Employees in the same workplace have different start, finish and break times – often as a way of covering longer opening hours.
- **Compressed working hours.** Employees work their total agreed hours over fewer working days – for example, a five-day working week is compressed into four days.

There is a clear procedure that you and your employer must follow. Your employer must seriously consider your request and can only refuse for one of the business reasons set out in the legislation. Any reduction in the number of hours worked will result in pay being reduced.

- special guardian
- foster parent
- private foster carer, or
- person who has been granted a residence order in respect of a child

or

- you are married to, or the partner or civil partner of, one of the above.

The change that you ask for can relate to the hours that you work, the days that you work or your place of work.

Who does it apply to?

You can ask for flexible working if:

- you are an employee
- you have worked for your employer for 26 continuous weeks prior to your request (continuous employment generally means working for the same employer without a break, but this is not always the case. Further information is available at www.direct.gov.uk)
- you have parental responsibility for a child under 17 (from April 2009) or a disabled child under 18 who is entitled to DLA (or you are married to, or the partner or civil partner of, that person).

You cannot ask for flexible working if:

- you have made a request in the last 12 months

- you are an agency worker
- you are a member of the armed forces.

How do I ask to change my hours?

Your request/application must:

- be in writing (whether on paper or by email). Find out if your employer has a standard form for making an application. If not, sample letters can be downloaded from www.direct.gov.uk
- state that the application is being made under the statutory right to request a flexible working pattern
- confirm that you are applying as someone who has or expects to have parental responsibility for the upbringing of a child under 17 or a disabled child under 18 who is entitled to DLA and that you are the parent, adopter, guardian or foster parent of the child (or that you are married to, or the partner or civil partner of, that person)
- state the flexible working pattern you are asking for and the date you want it to start. The proposed date should allow time for the application to be considered and implemented. There is no set time, but the process can take up to 14 weeks or longer where issues arise
- explain how you think your new working pattern may affect your employer and how you think this could be dealt with
 - state whether you have made an application to your employer before, and if so when
 - be signed and dated.

Your application should be as clear as possible.

You should also keep a copy.

When your employer receives the application

Your employer must:

- hold a meeting with you within 28 days of your application. You are allowed to bring a companion but your employer does not have to let you bring someone who is not employed by them. This meeting should discuss your application. If your employer does not think that the proposed working pattern can be accommodated within the needs of the business, they should discuss any possible compromise arrangements
- give you notice of their decision within 14 days of the meeting and tell you about your right of appeal
- give a reason for refusing, which must be one of those allowed by the regulations, with an explanation of why that reason applies in your case.

Refusing your request

Your employer can only refuse your request for one of the following business reasons:

- the burden of additional costs
- the detrimental effect on the ability to meet customer demand
- an inability to reorganise the work among existing staff
- an inability to recruit additional staff
- the detrimental effect on quality
- the detrimental effect on performance
- not enough work during the periods when the employee wants to work
- planned structural changes.

Your employer must also explain why that reason applies in your circumstances.





Appeal

You have the right to appeal within 14 days of receiving notification of your employer's refusal. To appeal, you must write to your employer stating your reasons for appealing. You must sign and date your letter. Your employer must hold the appeal meeting within 14 days of receiving your notice of appeal. You have the right to be accompanied during the meeting if you wish, usually by another worker employed by the same employer, although your employer may agree to let someone else attend. Your employer must:

- allow your companion time off to accompany you without it affecting their pay
- hold the meeting at a convenient time and place for both parties, and
- notify you of their decision in writing within 14 days of the appeal meeting, giving reasons for their decision.

Tribunals

You can make a claim in a tribunal if your employer does not follow the procedure or refuses for a reason not stated in the rules or without an explanation.

You must complete the appeal procedure and wait for the decision before you can make a tribunal application.

An employment tribunal or an Acas binding arbitration that finds in your favour can order your employer to:

- reconsider your application by following the procedure correctly
- pay you an award (up to a maximum of eight weeks' pay (up to the statutory maximum of £350 per week) in compensation).

Legal help

The legal help scheme allows people on a low income to get free legal advice and assistance when preparing for a tribunal. Funding for general legal advice (not advocacy) is available, to those who qualify financially, under the legal help scheme. Full representation is available under legal aid (to those who qualify financially) for cases brought in the Employment Appeal Tribunal.

More information is available at www.adviceguide.org.uk

YOUR RIGHTS UNDER SEX DISCRIMINATION LAW

It may be indirect sex discrimination if an employer refuses a woman's request to change her working pattern. It may be direct sex discrimination if an employer refuses a man's request when they allow a woman to work differently.

Your employer will only know if they have a good reason for refusing your request if they give it a lot of thought. Refusing even to consider your request or having a policy of refusing part-time work could be seen as sex discrimination by an employment tribunal. An employer must consider each individual request in order to avoid discriminating against a woman or a man with childcare responsibilities.

People often assume that a job has to be done full time or at certain fixed times of day, but if you and your employer look carefully at your job you may be able to work out a more child-friendly option – perhaps one that neither of you had considered before.

Who does the law apply to?

Sex discrimination law applies to all employers and all employed parents with childcare responsibilities. It only applies if you would be disadvantaged by not being allowed to work the child-friendly hours you need. You must have a good reason for asking to work differently – just as an employer must have a good reason for refusing. A good reason might be:

- you cannot find or afford full-time childcare
- you cannot find or afford childcare outside 9am–5pm, Monday–Friday
- you have to be there when your child or children come home from school
- your parents or relatives cannot look after your child full time
- you are suffering from severe stress from working long hours
- you are distressed or disadvantaged by having to work your old hours.

The difference between rights under sex discrimination law and the right to request flexible working

The new statutory right to request flexible working only applies to employees who are parents of children under 17 (or under 18 if disabled), who have not made an application within the last 12 months, and who have worked for their employer for 26 weeks at the time of making the application.

Sex discrimination law may help you if you need to change your working pattern in order to care for your child but cannot use the statutory procedure. This may be because you have made a request under the procedure within the last 12 months or have worked for your employer for less than 26 weeks.

The procedure

There is no specific application procedure under sex discrimination law. If you can, initially make your request under the new right to ask for flexible working (see page 172).

If your employer refuses your request

If your new working pattern will cause major problems, then your employer may be justified in refusing your request. You can get further advice from your trade union representative or local Citizens

Advice Bureau or the Equality and Human Rights Commission (EHRC).

If you want advice on whether you might have a good case for a tribunal, you should see a specialist employment lawyer.

If this doesn't work, you can make a claim in an employment tribunal if your employer refuses your request without a good business reason. The tribunal will look at your employer's reasons and will question them carefully about whether they were justified in refusing

your request. They can also award unlimited compensation for loss of pay (if you had to leave your job) and for injury to feelings.

You must make a tribunal claim within three months of the refusal under the new right and under sex discrimination law.



Have you claimed everything?

You can claim → If you get ↓	Child Benefit	Free prescriptions	Free dental treatment	£500 Sure Start Maternity Grant*	Social Fund loans***	Council Tax Benefit (not NI and Housing Benefit)	Help with mortgage	Healthy Start**	Fares to hospital
Income-based JSA	Y	Y	Y	Y	Y	Y	Y	Y	Y
Income Support	Y	Y	Y	Y	Y	Y	Y	Y	Y
Low income	Y	Y****	Y****	Y*	N	Y	N	N	Y
All mothers	Y	Y****	Y****	N	N	N	N	N	N

- * You can claim if you get Pension Credit, income-related Employment and Support Allowance, Working Tax Credit, where a disability or severe disability element is included in the award or Child Tax Credit at a rate higher than the family element.
- ** You can also claim if you get Child Tax Credit but not Working Tax Credit with an income of £16,040 or less. The qualifying criteria for Healthy Start are: Income Support/income-based JSA/income-related Employment and Support Allowance/Child Tax Credit without Working Tax Credit (unless Working Tax Credit run-on only is in payment) and annual family income of £16,040 or less.
- *** You have to be on Income Support, income-based JSA, income-related Employment and Support Allowance or Pension Credit to get a Social Fund loan (called a Budgeting Loan) unless there is an emergency or disaster and you are without resources to prevent risk to health (this is called a Crisis Loan).
- **** Free prescriptions and free dental are only available for low income/all mothers during pregnancy and for one year after birth.
- ***** Some people will get full help, other people may only get partial help – it all depends on how low income is.

THE NHS CONSTITUTION

The NHS belongs to us all. It touches our lives at times of basic human need, when care and compassion are what matter most. Pregnancy is one of these times. So it is important that you know what you and your baby can expect from the NHS, and what is expected from you in return.



The NHS Constitution was launched on 21 January 2009. It brings together for the first time in one place what staff, patients and the public can expect from the NHS. It explains that by working together we can make the very best of finite resources to improve our health and well-being, to keep our minds and bodies well, to get better when we are ill, and when we cannot recover to stay as well as we can to the end of our lives. The Constitution reaffirms that everyone has a role to play in the success of the NHS.

As well as capturing what is important to the NHS (the principles and values that determine how the NHS should act and make decisions), the Constitution brings together a number of rights, pledges and responsibilities for staff and patients alike.

These rights, pledges and responsibilities are the result of extensive discussion and research with staff, patients and the public and they reflect what matters to them most.

Rights

The NHS Constitution sets out the legal rights of the public, patients and staff. Some of the rights that may be of interest to you are listed below:

- **You have the right** to receive NHS services free of charge, unless Parliament has sanctioned charges.
- **You have the right** to be treated with dignity and respect.
- **You have the right** to be treated with a professional standard of care.
- **You have the right** to be given information about your care.
- **You have the right** to privacy and confidentiality.
- **You have the right** to be involved in discussions and decisions about your care.
- **You have the right** to have any complaints you make properly investigated.



Pledges

The NHS Constitution sets out a number of pledges for the public, patients and staff. These are things that the **NHS is committed to achieving**. Some of the pledges that may be of interest to you are listed below:

- **The NHS commits** to make sure that it is easy to access health services.
- **The NHS commits** to inform you about the services that are available to you.
- **The NHS commits** to offer you information that helps you to take part in making decisions about your care.
- **The NHS commits** to work in partnership with you, your family, carers and representatives.
- **The NHS commits** to treat you with courtesy and to be supportive when you make a complaint.

Responsibilities

There are a number of things we can all do to help the NHS deliver quality services. These are set out as responsibilities in the NHS Constitution. Responsibilities are the things **we can all do to help the NHS work effectively**. You should always think about your responsibilities when you are receiving NHS services. You have nine responsibilities to keep in mind:

- Do what you can yourself to stay healthy and feel well.
- Register with a GP.
- Treat NHS staff and patients with respect.
- Give accurate information about yourself.
- Keep appointments, or let the NHS know when you cannot keep them.
- Follow the course of your treatment, or speak to someone if you feel you cannot.
- Take part in important public health immunisation programmes.
- Make sure people close to you know about your wishes for organ donation.
- Give feedback on your treatment and care.

The NHS Constitution sets out all of these rights and pledges, together with the principles and values, in more detail. The NHS Constitution Handbook contains further information.



Want to know more?

The **NHS Constitution Handbook** gives further information about the NHS Constitution and further advice on what to do if you are not happy with the service you receive. The **Statement of NHS Accountability** summarises how the NHS is structured and what the responsibilities of individual parts of the NHS are.

How do I get a copy of the NHS Constitution?

You can get copies of the NHS Constitution from libraries, doctors, dentists and town halls. You can also obtain a copy from:

Telephone:

0300 123 1002

Website:

www.orderline.dh.gov.uk

Email:

dh@prolog.uk.com

Or write to:

DH Publications Orderline

PO Box 777

London SE1 6XH

The NHS Constitution, NHS Constitution Handbook and the Statement of NHS Accountability are also available online at **www.nhs.uk/aboutnhs/Constitution**

GLOSSARY OF USEFUL TERMS

TERM	MEANING
Albumin	A protein that can appear in your urine when you are pregnant. It can be a sign of an infection or pre-eclampsia. Your midwife will test your urine for albumin at your antenatal check-ups.
Amniocentesis	A test in which a thin needle is inserted into the uterus through the abdominal wall to take a sample of the fluid surrounding the baby. The fluid is then tested for certain chromosomal and genetic disorders. An amniocentesis is usually carried out between 15 and 18 weeks into your pregnancy. It may be used later in pregnancy to find out if your baby's lungs are mature.
Amniotic sac	The bag of fluid that surrounds and cushions your baby in the uterus. Before or during labour the sac breaks and the fluid drains out. This is called the 'waters breaking'.
Anaesthetics	Medicines that reduce or take away pain.
Antenatal	This literally means 'before birth' and refers to the whole of pregnancy, from conception to birth.
Baby blues	Feeling sad or mildly depressed a few days after your baby is born. The baby blues are very common – eight out of 10 new mothers feel like this. They can be caused by hormone changes, tiredness or discomfort and usually only last a week. More severe depression or anxiety that lasts longer than a week could be postnatal depression (see page 181).
Balanced diet	A diet that provides a good balance of nutrients.
Bereavement	The loss of a person. Coping with a bereavement can be particularly difficult if you are pregnant or have just had a baby, and even harder if it is your baby who has died.
Birth plan	A written record of what you would like to happen during pregnancy, labour and childbirth.
Breech birth	When a baby is born bottom rather than head first.
Caesarean section	An operation to deliver a baby by cutting through the mother's abdomen and then into her uterus. If you have a caesarean, you will be given an epidural or general anaesthetic.
Catheter	A thin, flexible, hollow plastic tube that can be used to perform various diagnostic and/or therapeutic procedures. Catheters may be used for the injection of fluids or medications into an area of the body or for drainage, such as from a surgical site. They are also frequently used to allow physicians to access the body with surgical instruments.
Cervix	The neck of the uterus. It is normally almost closed, with just a small opening through which blood passes during monthly periods. During labour, your cervix will dilate (open up) to let your baby move from your uterus into your vagina.
Chorionic villus sampling	A test to detect genetic disorders, particularly chromosomal disorders such as Down's syndrome. It is usually carried out at around 11 weeks.
Colostrum	The milk that your breasts produce during the first few days after your baby is born. It is very concentrated and full of antibodies to protect your baby against infections. Colostrum has a rich, creamy appearance and is sometimes quite yellow in colour.
Conception	The start of a pregnancy, when an egg (ovum) is fertilised and then moves down the fallopian tube to the uterus, where it attaches itself to the uterus lining.
Contraception <i>(also known as birth control)</i>	Contraception prevents or reduces your chances of getting pregnant. See page 135 for the different types of contraception that are available.
Cot death <i>(also known as Sudden Infant Death Syndrome)</i>	The sudden and unexpected death of an apparently healthy infant during their sleep. For information on what you can do to avoid cot death, go to pages 129 and 140.

TERM	MEANING
Down's syndrome	A lifelong condition caused by an abnormal number of chromosomes. People with Down's syndrome have some degree of learning disability and an increased risk of some health problems. It also affects their physical growth and facial appearance. For more information about screening or tests for Down's syndrome, see page 50.
Ectopic pregnancy	An ectopic pregnancy occurs when a fertilised egg begins to grow in the fallopian tube, cervix, ovaries or abdomen, not in the lining of the uterus. The fertilised egg cannot develop properly and has to be removed.
Embryo	The term used for the developing baby in the very early weeks up until eight weeks of pregnancy.
Entonox (also known as 'gas and air')	A form of pain relief offered during labour. It is a mixture of oxygen and another gas called nitrous oxide, which is breathed in through a mask or mouthpiece.
Epidural	An anaesthetic that numbs the lower half of the body. It can be very helpful for women who are having a long or particularly painful labour, or who are becoming very distressed. A thin catheter is placed between the vertebrae so that medicine can be delivered to the nerves in the spinal cord.
Episiotomy	A surgical incision made in the area between the vagina and anus (perineum). This is done during the last stages of labour and delivery to expand the opening of the vagina to prevent tearing during the birth of the baby.
Fallopian tubes	Branch-like tubes that lead from the ovaries to the uterus. Eggs are released from the ovaries into the fallopian tubes each month. Fertilisation takes place in one of the fallopian tubes.
Fertilisation	Fertilisation takes place if a man's sperm joins with a woman's egg and fertilises it in the fallopian tube.
Fetal alcohol syndrome (FAS)	A syndrome that can cause children to have restricted growth, heart defects and facial abnormalities as well as learning and behavioural disorders. It is caused if your baby is exposed to too much alcohol (via the placenta) when they are in the uterus.
Fetus	The term used for the developing baby from week eight of pregnancy onwards.
Folic acid	One of the B group of vitamins, which is found naturally in foods, including green leafy vegetables, fortified breakfast cereals and brown rice. Folic acid is important for pregnancy as it can help prevent birth defects known as neural tube defects. If you are pregnant or trying to get pregnant, you should take a 400 microgram folic acid tablet every day until you are 12 weeks pregnant.
Fontanelle	A diamond-shaped patch on the front and top of a baby's head where the skull bones have not yet fused together. During birth, the fontanelle allows the bony plates of the skull to flex, so that the baby's head can pass through the birth canal. The bones usually fuse together and close over by a child's second birthday.
Formula milk	Cows' milk that has been processed and treated so that babies can digest it. It comes in powder or liquid form.
Fundus	The top of the uterus.
Haemoglobin (Hb)	Haemoglobin is found in red blood cells and carries oxygen from the lungs to all parts of the body. Pregnant women need to produce more haemoglobin because they produce more blood. If you don't produce enough, you can become anaemic, which will make you feel very tired. Your haemoglobin levels are tested during antenatal check-ups.
Home birth	Giving birth at home, with care provided by a midwife. This is usually planned!

TERM	MEANING
Induction	A method of artificially or prematurely stimulating labour. A baby can be induced if they are getting too big, if the pregnancy has gone past the 42-week mark or if there are health risks to either the baby or the mother if the pregnancy continues.
Jaundice	The development of a yellow colour on a baby's skin and a yellowness in the whites of their eyes. It is caused by an excess of the pigment bilirubin in the blood. Jaundice is common in newborn babies and usually occurs approximately three days after birth. It can last for up to two weeks after birth or up to three weeks in premature babies. Severe jaundice can be treated by phototherapy, where a baby is placed under a very bright light. Babies who are jaundiced for longer than two weeks should be seen by a doctor as they may need urgent treatment. See page 149 for more information.
Lanugo	Very fine, soft hair that covers your baby at approximately 22 weeks. The lanugo disappears before birth.
Mastitis	An infection in the breasts caused by blocked milk ducts. Symptoms include hot and tender breasts and flu-like symptoms. See page 109 for how to treat it.
Maternity team care	A team of midwives, obstetricians, anaesthetists, neonatologists and other specialists who provide care to women who have complex pregnancies.
Meconium	The first stools that your baby passes. Meconium is made up of what a baby has ingested during their time in the uterus, including mucus and bile. It is sticky like tar and has no odour.
Midwifery care	Care for pregnant women where the midwife is the lead professional. Midwifery care is suitable for women who have an uncomplicated pregnancy.
Morning sickness/nausea	Morning sickness affects more than half of all pregnant women. Symptoms include nausea or feeling sick, as well as actually being sick. Morning sickness can occur at any time of the day, though it occurs most often in the morning because blood sugar levels are low after a night without food. The symptoms usually start after the first month of the pregnancy, peaking in weeks five to seven, and continuing until weeks 14 to 16.
Neonatal care	The care given to sick or premature babies. It takes place in a neonatal unit, which is specially designed and equipped to care for them.
Nuchal translucency scan	An ultrasound scan to help identify whether you are at risk of having a baby with Down's syndrome. The scan is carried out at 11 to 13 weeks of your pregnancy and measures the amount of the nuchal translucency, which is fluid behind the neck of the baby. Babies at risk of Down's syndrome tend to have a higher amount of fluid around their neck. The scan may also help confirm both the accuracy of the pregnancy dates and whether the baby has any other health problems.
Obstetric cholestasis	A potentially dangerous liver disorder. Symptoms include severe generalised itching without a rash, particularly in the last four months of pregnancy.
Obstetrician	A doctor specialising in the care of women during pregnancy and labour and after the birth.
Oedema	Another word for swelling, most often of the feet and hands. It is usually nothing to worry about, but if it gets worse suddenly it can be a sign of pre-eclampsia.
Ovulation	Ovulation occurs when an egg (ovum) is released from one of a woman's ovaries during her monthly menstrual cycle. If the egg is fertilised during this time, she will get pregnant. This is the time of the month when you are most likely to conceive.
Paediatrician	A doctor specialising in the care of babies and children.
Perinatal	The time shortly before and after the birth of a baby.

TERM	MEANING
Perinatal mental health	Mental health problems that develop during pregnancy and that can last for up to one year after childbirth.
Placenta	The organ attached to the lining of the uterus, which separates your baby's circulation from your circulation. Oxygen and food from your bloodstream are passed to your baby's bloodstream through the placenta and along the umbilical cord. Waste is also removed this way.
Postnatal	The period beginning immediately after the birth of a baby until they are about six weeks old.
Postnatal care	The professional care provided to you and your baby, from the birth until your baby is about six to eight weeks old. It usually involves home visits by midwives to check that both mother and baby are well. Classes may also be available.
Postnatal depression	Feelings of depression and hopelessness after the birth of a baby. These feelings are more severe than the 'baby blues' (see page 178). Postnatal depression affects one in 10 women and can be serious if left untreated. See page 82 for more information.
Pre-eclampsia	A condition that only occurs during pregnancy. Symptoms include high blood pressure, protein in urine, bad headaches, vision problems and the sudden swelling of the face, hands and feet. It usually develops after the 20th week of pregnancy but can occur earlier. Although most cases are mild and cause no trouble, it can be serious for both mother and baby. For more information, see page 67.
Premature birth	The birth of a baby before the standard period of pregnancy (37 weeks) is completed.
Premature labour	When labour starts before 37 weeks of pregnancy.
Rhesus disease	A woman who is rhesus negative (see below) can carry a baby who is rhesus positive if the baby's father is rhesus positive. This can cause problems in second or later pregnancies. If she gets pregnant with another rhesus positive baby, the immune response will be quicker and much greater. The antibodies produced by the mother can cross the placenta and attach to the D antigen on her baby's red blood cells. This can be harmful to the baby as it may result in a condition called haemolytic disease of the newborn, which can lead to anaemia and jaundice.
Rhesus negative	People with a certain blood type are known as rhesus negative. It means that they do not have a substance known as D antigen on the surface of their red blood cells. This can cause problems in second or later pregnancies (see above).
Rhesus positive	People with a certain blood type are known as rhesus positive. This means that they have a substance known as D antigen on the surface of their red blood cells.
Rubella (German measles)	A virus that can seriously affect unborn babies if the mother gets it during the early weeks of pregnancy. Most women have been immunised against rubella, so they are not at risk.
Ultrasound/scans	An imaging technique that uses high-frequency sound waves to create an image of your baby in the uterus. It shows your baby's body and organs as well as the surrounding tissues. Also called sonography, this test is widely used to estimate delivery dates and check that your developing baby is healthy and growing normally.
Umbilical cord	The cord that attaches the baby to the placenta, linking the baby and mother. Blood circulates through the cord, carrying oxygen and food to the baby and carrying waste away again.
Vernix	A sticky white coating that covers a baby when it is in the uterus. It mostly disappears before birth but there may be some left on your baby when they are born.
Vertebrae	Your spine is made up of 33 irregularly shaped bones called vertebrae. Each vertebra has a hole in the middle through which the spinal cord runs.

USEFUL ORGANISATIONS

INFORMATION

Acas (Advisory, Conciliation and Arbitration Service)

23rd floor
Euston Tower
286 Euston Road
London NW1 3JJ
08457 47 47 47 (helpline, Mon–Fri 8am–8pm;
Sat 9am–1pm)
www.acas.org.uk

Improves organisations and working life through better employment relations. Provides up-to-date information and independent advice on a wide range of employment relations issues, including the rights and issues around working parents – such as parental leave and pay and requests for flexible working. Provides high-quality training and works with employers and employees to solve problems and improve performance. An independent, publicly funded organisation; many of its services are free.

Action on Pre-eclampsia (APEC)

2C The Halfcroft
Syston
Leicestershire LE7 1LD
020 8427 4217 (helpline, Mon–Fri 9am–5pm)
info@apec.org.uk
www.apec.org.uk

Helps to answer any questions about pre-eclampsia. Provides pre-eclampsia leaflets for the general public and ships leaflet orders to any health organisation that asks.

Active Birth Centre

25 Bickerton Road
London N19 5JT
020 7281 6760 (helpline, Mon–Fri 9am–5pm)
info@activebirthcentre.com
www.activebirthcentre.com

Complete preparation for active and water birth, including yoga for pregnancy, courses, workshops, professional training, postnatal and baby massage classes and tuition. An empowering way to prepare for an optimal birth and early parenting. Has a complementary therapy clinic for pregnancy and the postnatal period which offers acupuncture, reflexology, cranial osteopathy, aromatherapy, homeopathy and nutritional guidance.

Association for Improvements in the Maternity Services (AIMS)

5 Ann's Court
Grove Road
Surbiton
Surrey KT6 4BE
0300 365 0663 (helpline, Mon–Fri
10.30am–5.30pm)
helpline@aims.org.uk
www.aims.org.uk

Offers information, support and advice to parents about all aspects of maternity care, including parents' rights, the choices available, technological interventions, normal physiological childbirth and the complaints procedures.

Association of Breastfeeding Mothers (ABM)

PO Box 207
Bridgwater
Somerset TA6 7YT
0844 412 2949 (helpline, 9.30am–10.30pm)
counselling@abm.me.uk
www.abm.me.uk

Provides information and support for breastfeeding mothers and their families, and training for breastfeeding counsellors and mother (peer) supporters.

Caesarean Support Network

55 Cooil Drive
Douglas
Isle of Man IM2 2HF
01624 661269 (Mon–Fri after 6pm;
weekends)

Offers support and advice to women who have had or may need a caesarean delivery. The Network can also offer advice and support to women who wish to have a vaginal delivery with future pregnancies. They have a directory of support groups and contacts.

Child Law Advice Line

Children's Legal Centre
University of Essex
Wivenhoe Park
Colchester
Essex C04 3SQ
0808 802 0008 (freephone, Mon–Fri
9am–5pm)
clc@essex.ac.uk
www.childrenslegalcentre.com

Ensures that parents, carers and professionals can get accurate information on child law and access the support and services to which they are entitled.

Citizens Advice

Myddelton House
115–123 Pentonville Road
London N1 9LZ
020 7833 2181 (administration and
information on local Citizens Advice
Bureaux only; no advice given)
www.citizensadvice.org.uk

Online advice and information services. Get help online or find your local Citizens Advice Bureau.

Cry-sis

BM Cry-sis
London WC1N 3XX
0845 122 8669
(helpline, 9am–10pm seven days a week)
info@cry-sis.org.uk
www.cry-sis.org.uk

Offers non-medical, emotional support for families with excessively crying, sleepless and demanding babies.

Diabetes UK

Macleod House
10 Parkway
London NW1 7AA
020 7424 1000 (helpline, 9am–5pm)
0845 120 2960 (careline)
info@diabetes.org.uk
www.diabetes.org.uk

Equality and Human Rights Commission

Freepost RRL1–GHUX–CTRX
Arndale House
Arndale Centre
Manchester M4 3AQ
0845 604 6610 (Mon–Fri 9am–5pm)
0845 604 6620 (textphone)
info@equalityhumanrights.com
www.equalityhumanrights.com

The helpline provides information and guidance on discrimination and human rights issues. All helpline staff have been specially trained to provide this service.

Family Action

501–505 Kingsland Road
London E8 4AU
020 7254 6251
www.family-action.org.uk

Tackles some of the most complex and difficult issues facing families today, including domestic abuse, mental health problems, learning disabilities and severe financial hardship. Works with whole families to help them find solutions to problems, no matter how difficult, so that they become safer, stronger and more optimistic about their future.

Family Rights Group

The Print House
18 Ashwin Street
London E8 3DL
0808 801 0366 (helpline, Mon–Fri
10am–3.30pm)
Textphone: dial 18001 then freephone
number
advice@frg.org.uk
www.frg.org.uk

Support for parents and other family members whose children are involved with or need social care services.

Independent Midwives UK

PO Box 539
Abingdon OX14 9DF
0845 4600 105 (local rate)
information@independentmidwives.org.uk
www.independentmidwives.org.uk

Free advice given to women thinking about a home birth. Members offer woman-centred pregnancy, birth and postnatal midwifery to women who book with them, mostly for home births. Fees vary. See website to find local midwives.

Infertility Network UK

Charter House
43 St Leonards Road
Bexhill-on-Sea
East Sussex TN40 1JA
0800 008 7464
www.infertilitynetworkuk.com

Provides a voice for those with fertility problems. Works to improve awareness and access to treatment.

Institute for Complementary and Natural Medicine (ICNM)

Can-Mezzanine
32–36 Loman Street
London SE1 0EH
020 7922 7980 (Mon–Fri 10am–4pm)
info@icnm.org.uk
www.icnm.org.uk

Can provide the public with lists of members of the British Register of Complementary Practitioners, a professional register of practitioners and therapists who have completed a recognised course and are insured. (Always check with your GP/midwife before using a complementary discipline.)

La Leche League (Great Britain)

PO Box 29
West Bridgford
Nottingham NG2 7NP
0845 120 2918 (helpline)
www.laleche.org.uk

An international, non-profit, non-sectarian organisation which, for over 50 years, has been dedicated to providing education, information and mother-to-mother support and encouragement to women who want to breastfeed. LLL Leaders are mothers who have themselves breastfed for 12 months or longer and have undertaken extensive training to provide telephone counselling and email support, and to run local group meetings.

Life

1 Mill Street
Leamington Spa
Warwickshire CV31 1ES
0800 915 4600 (helpline)
info@lifecharity.org.uk
www.lifecharity.org.uk

Offers counselling and support for men and women in a crisis pregnancy or experiencing difficulties after an abortion, adoption, ectopic pregnancy, miscarriage or stillbirth. Also provides accommodation for homeless and unsupported mothers.

Multiple Births Foundation

Hammersmith House, Level 4
Queen Charlotte's and Chelsea Hospital
Du Cane Road
London W12 0HS
020 8383 3519 (helpline, 9am–4pm)
info@multiplebirths.org.uk
www.multiplebirths.org.uk

Offers specialised support to parents of twins, triplets and higher multiple births, and gives relevant advice and training to the medical, educational and other professional groups which are concerned with them.

National Childbirth Trust (NCT)

Alexandra House
Oldham Terrace
London W3 6NH
0300 330 0770 (enquiry line,
Mon–Thu 9am–5pm; Fri 9am–4pm)
0300 330 0772 (pregnancy and
birth line, Mon–Fri 10am–8pm)
0300 330 0771 (breastfeeding line,
8am–10pm seven days a week)
enquiries@nct.org.uk
www.nct.org.uk

Supports 1 million mums and dads every year through helplines, courses and a network of local support. With evidence-based information on pregnancy, birth and early parenthood, it can provide support from when you first discover you are pregnant to when your baby turns 2. Visit the website for information on becoming a parent or to find your nearest NCT group.

NHS Direct

0845 4647
www.nhsdirect.nhs.uk

Provides a 24-hour, 365 days a year, nurse-led health advice and information service, online and over the telephone.

NSPCC (National Society for the Prevention of Cruelty to Children) (now incorporating ChildLine)

Weston House
42 Curtain Road
London EC2A 3NH
0808 800 5000 (24-hour national helpline)
0800 056 0566 (textphone)
help@nspcc.org.uk
www.nspcc.org.uk

ChildLine is a safe place where children and young people can share their worries with a trained counsellor. Children and young people can call confidentially on 0800 1111 to find out more about how to seek help, or visit the website www.childline.org.uk. The NSPCC's helpline provides counselling, information and advice to anyone concerned about a child at risk of abuse. It also offers a bilingual Welsh helpline and an Asian helpline in five Asian languages.

Patient Advice and Liaison Services (PALS)

www.pals.nhs.uk
Available in every NHS trust, PALS provide information and advice about NHS and health-related services to patients, carers, families and the public. Staff can also help to resolve problems and concerns relating to health services through liaison and negotiation. Feeds back to trusts about problems experienced by those using services and about gaps in services, and helps make changes which benefit patients and carers. For more details, contact the local NHS trust or see the website.

Patients Association

PO Box 935
Harrow
Middlesex HA1 3YJ
0845 608 4455 (helpline, Mon–Fri 10am–4pm)
helpline@patients-association.com
www.patients-association.com

A wide variety of helpful healthcare information on the website as well as ways for patients to make their views known about services. Sign up as an e-member and take part in patient surveys.

Relate (National Marriage Guidance)

Relate Central Office
Premier House
Carolina Court
Lakeside
Doncaster DN4 5RA
0300 100 1234
www.relate.org.uk

Offers advice, relationship counselling, sex therapy, workshops, mediation, consultations and support, face-to-face, by phone and through its website.

Royal College of Obstetricians and Gynaecologists (RCOG)

27 Sussex Place
Regent's Park
London NW1 4RG
020 7772 6200
library@rcog.org.uk
www.rcog.org.uk

Samaritans

PO Box 9090
Stirling FK8 2SA
0845 790 9090
www.samaritans.org

A confidential emotional support service for anyone in the UK and Ireland. The service is available 24 hours a day for people who are experiencing feelings of distress or despair, including those that may lead to suicide.

Shelter

88 Old Street
London EC1V 9HU
0808 800 4444
info@shelter.org.uk
www.shelter.org.uk

Helps more than 170,000 people a year to fight for their rights, get back on their feet, and find and keep a home. Also tackles the root causes of bad housing, by campaigning for new laws, policies and solutions.

ADDICTIVE DRUGS**Narcotics Anonymous**

0845 373 3366 (helpline)
ukso@ukna.org
www.ukna.org

A voluntary organisation. Membership is open to anyone with a drug problem seeking help, regardless of what drug or combination of drugs has been used. It is a completely anonymous, non-religious service, encouraging each member to cultivate an individual understanding, religious or not, of a 'spiritual awakening'. There are no fees for membership. The primary service provided is local weekly self-governing meetings.

ALCOHOL

Alcohol Concern

64 Leman Street
London E1 8EU
020 7264 0510
contact@alcoholconcern.org.uk
www.alcoholconcern.org.uk

Does not operate a helpline nor provide actual services to individuals with alcohol problems; for further help and advice contact Drinkline on 0800 917 8282 (freephone). Use the services directory to find an alcohol advice or counselling service in your area. All information enquiries should be submitted by email. Please give a brief outline of the information enquiry, your telephone number and full address. A member of the team will get back to you within 10 working days.

Alcoholics Anonymous (AA)

General Service Office
PO Box 1
10 Toft Green
York YO1 7NJ
01904 644026
0845 769 7555 (helpline)
www.alcoholics-anonymous.org.uk

Has over 4,000 groups throughout the UK, which are designed to help those with a serious alcohol problem. Through mutual support, sufferers assist one another in coping with their problem. There are no fees for membership and anonymity is carefully preserved.

Drinkaware Trust

7–10 Chandos Street
London W1G 9DG
020 7307 7450
www.drinkaware.co.uk

Provides consumers with information to make informed decisions about the effects of alcohol on their lives and lifestyles. Its public education programmes, grants, expert information and resources help to create awareness and effect positive change.

Drinkline

0800 917 8282 (Mon–Fri 9am–11pm)
Freephone helpline offering free, confidential information and advice on alcohol problems, support and direction to treatment services.

CHILDCARE

Daycare Trust

21 St George's Road
London SE1 6ES
0845 872 6251 (Mon, Tue, Thu, Fri 10am–1pm and 2pm–5pm; Wed 2pm–5pm)
info@daycaretrust.org.uk
www.daycaretrust.org.uk

Provides information and support to parents and carers about childcare and paying for childcare.

Families Information Service Helpline

0800 234 6346
www.direct.gov.uk

National Childminding Association (NCMA)

Royal Court
81 Tweedy Road
Bromley
Kent BR1 1TG
0800 169 4486 (information line)
0845 880 0044 (9am–5pm)
info@ncma.org.uk
www.ncma.org.uk

Charity and membership organisation supporting home-based childcarers in England and Wales. Works in partnership with government and other childcare organisations to ensure that registered childminders, over-7s childminders and nannies have access to services, training, information and support.

Pre-school Learning Alliance

The Fitzpatrick Building
188 York Way
London N7 9AD
020 7697 2500
www.pre-school.org.uk

Delivers a full range of high-quality childcare services for parents. As the largest voluntary sector provider of childcare services, it works closely with families to offer more choice, flexibility and affordability to ensure that their requirements are met.

COPING ALONE

Meet A Mum Association (MAMA)

54 Lillington Road
Radstock BA3 3NR
0845 120 3746 (helpline, Mon–Fri 7pm–10pm)
www.mama.co.uk

Support for mothers suffering from postnatal depression or who feel lonely and isolated. It will try to put you in touch with another mother who has experienced similar problems, or with a group of mothers locally, or help you to find ways of meeting people.

One Parent Families/Gingerbread

255 Kentish Town Road
London NW5 2LX
0800 018 5026 (Mon–Fri 9am–5pm;
Wed extended opening to 8pm)
www.gingerbread.org.uk

Charity for single parent families. It offers a range of support services direct to single parents, including a telephone helpline, publications, training programmes and a membership scheme, and campaigns on single parents' behalf.

Parentline Plus

520 Highgate Studios
Highgate Road
Kentish Town
London NW5 1TL
0808 800 2222 (24-hour helpline)
0800 783 6783 (textphone)
parentsupport@parentlineplus.org.uk
www.parentlineplus.org.uk

Charity providing support to parents. Gives you the support you need, on any issue, when you want it and in a way to suit you.

DOMESTIC ABUSE AND RAPE

Rape Crisis

c/o WRSAC
PO Box 39
Bodmin
Cornwall PL31 1XF
info@rapecrisis.org.uk
www.rapecrisis.org.uk

Supports the work of rape crisis centres nationally and acts as a referral service for women seeking advice and/or support around issues of rape or sexual abuse. Find the nearest Rape Crisis Centre on the website, or email for more information.

Refuge

4th Floor, International House
1 St Katharine's Way
London E1W 1UN
0808 2000 247 (24-hour freephone helpline)
www.refuge.org.uk

The National Domestic Violence Helpline is run in partnership between Refuge and Women's Aid. Provides emergency accommodation and support for women and children experiencing domestic violence.

Women's Aid Federation of England

Head Office
PO Box 391
Bristol BS99 7WS
0808 2000 247 (24-hour freephone helpline)
helpline@womensaid.org.uk
www.womensaid.org.uk

The National Domestic Violence Helpline is run in partnership between Women's Aid and Refuge. Provides help, information and support for women and children experiencing domestic violence, or for their friends and families calling on their behalf.

FAMILY PLANNING

Brook

421 Highgate Studios
53–79 Highgate Road
London NW5 1TL
0808 802 1234 (helpline, Mon–Fri 9am–5pm)
www.brook.org.uk

Provides free and confidential sexual health information, contraception, pregnancy testing, advice and counselling, testing and treatment for sexually transmitted infections and outreach and education work.

FPA (Family Planning Association)

50 Featherstone Street
London EC1Y 8QU
0845 122 8690 (helpline)
www.fpa.org.uk

The UK's leading sexual health charity, enabling people in the UK to make informed choices about sex and to enjoy sexual health.

Marie Stopes International**Head Office**

1 Conway Street
London W1T 6LP
0845 300 80 90 (24-hour information
and appointments)
services@mariestopes.org.uk
www.mariestopes.org.uk

Provides support for women with an unplanned pregnancy and for those seeking abortion services. Nine clinics nationwide, with no wait for an appointment. Counselling services, abortion pill and surgical abortion available. NHS and private.

HEPATITIS**British Liver Trust**

2 Southampton Road
Ringwood BH24 1HY
0800 652 7330 (helpline, Mon–Fri 9am–5pm)
info@britishlivertrust.org.uk
www.britishlivertrust.org.uk

National liver disease charity for adults with all forms of liver disease. It is dependent on voluntary donations from individuals, companies, charitable trusts and legacies. It aims to reduce the incidence of liver disease, and to help everyone affected by it, through the provision of information, support and research. Also provides a helpline providing medically equipped telephone support for patients and their carers, encourages and supports local liver support groups for patients and provides funding for research into liver disease.

Hep C Awareness

0800 451 451 (helpline, Mon–Fri 7am–11pm)
hep@nhs.uk
www.nhs.uk/hepatitis

The helpline is an information, advice and referral service for callers concerned about hepatitis C. The line deals with avoidance, testing and treatment enquiries and signposts individuals to local services.

HIV AND AIDS**Positively Women**

347–349 City Road
London EC1V 1LR
020 7713 0222 (helpline, Mon–Fri 10am–1pm
and 2pm–4pm)
info@positivelywomen.org.uk
www.positivelywomen.org.uk

Women who are living with HIV answer the helpline, and will ring you back free of charge.

Sexual Health Line

0800 567 123 (24 hours a day, seven days
a week)

Free and confidential telephone helpline advice about HIV, AIDS, sexual health, sexually transmitted infections, contraception, local services, clinics and support services.

ILLNESS AND DISABILITY**Action for Sick Children**

Unit 6, High Lane Business Court
Rear of 32 Buxton Road
High Lane
Stockport SK6 8BH
0800 074 4519 (Mon–Fri 9am–5.30pm)
enquiries@actionforsickchildren.org
www.actionforsickchildren.org

Promotes equality of healthcare services for children in hospital, at home and in the community. Gives information and support to parents and carers with a problem or query regarding their child's healthcare, from how to register your child with a GP or a dentist to what to expect when they need to go into hospital.

Assist UK (Disability Living Centres)

Redbank House
4 St Chad's Street
Cheetham
Manchester M8 8QA
0870 770 2866
0870 770 5813 (textphone)
general.info@assist-uk.org
www.assist-uk.org

Leads a UK-wide network of centres that introduce people to products and solutions which make life easier and safer, creating greater choice and control.

Bliss

9 Holyrood Street
London Bridge
London SE1 2EL
0500 618 140 (helpline, Mon–Fri 10am–10pm)
enquiries@bliss.org.uk
www.bliss.org.uk

UK charity dedicated to ensuring that premature and sick babies survive and go on to have the best possible quality of life. Provides practical and emotional support to families during an extremely difficult time, so that they can give the best care to their babies. Its specialist study days and training support doctors and nurses to develop their skills and it funds research to improve the care of all sick and premature babies.

Contact a Family

209–211 City Road
London EC1V 1JN
0808 808 3555 (helpline, Mon–Fri
10am–4pm and Mon 5.30pm–7.30pm)
0808 808 3556 (textphone)
info@cafamilly.org.uk
www.cafamilly.org.uk

UK-wide charity providing advice, information and support to parents of all disabled children, no matter what their condition or diagnosis. Brings parents of children with the same condition together through support groups and a one-to-one linking service.

Disability, Pregnancy and Parenthood International (DPPI)

National Centre for Disabled Parents
Unit F9, 89–93 Fonthill Road
London N4 3JH
0800 018 4730
0800 018 9949 (textphone)
info@dppi.org.uk
www.dppi.org.uk

Provides information, awareness and support for disabled parents/parents to be and those who support them, including those with a physical or sensory impairment, deaf parents, parents with learning difficulties or long-term illness, or those dealing with mental distress.

Disabled Living Foundation (DLF)

380–384 Harrow Road
London W9 2HU
0845 130 9177 (helpline, Mon–Fri
10am–4pm)
020 7432 8009 (textphone)
advice@dlf.org.uk
www.dlf.org.uk

A national charity that provides free, impartial advice about all types of daily living equipment for disabled adults and children, older people, their carers and families.

Genetic Interest Group (GIG)

Unit 4D, Leroy House
436 Essex Road
London N1 3QP
020 7704 3141 (9am–5pm)
mail@gig.org.uk
www.gig.org.uk

A national alliance of patient organisations with a membership of over 130 charities which support children, families and individuals affected by genetic disorders.

Group B Strep Support

PO Box 203
Haywards Heath
West Sussex RH16 1GF
01444 416176 (helpline, Mon–Fri
9.30am–3pm)
info@gbss.org.uk
www.gbss.org.uk

A national charity providing information materials to health professionals and individuals on how to prevent most group B Streptococcal infection in newborn babies.

Mind (National Association for Mental Health)

PO Box 277
Manchester M60 3XN
0845 766 0163 (Mon–Fri 9am–5pm; BT
textdirect users add the prefix 18001)
www.mind.org.uk

Help for people experiencing mental distress. The information line offers confidential help and information.

Newlife Foundation for Disabled Children

Newlife Centre
Hemlock Way
Cannock
Staffordshire WS11 7GF
0800 902 0095 (helpline, Mon–Fri
9.30am–5pm)
info@newlifecharity.co.uk
www.newlifecharity.co.uk

Action to help disabled and terminally ill children in the UK. Provides equipment to help individual children, nurse-led support services, pioneering medical research, awareness and campaigning.

Phab

Summit House
50 Wandle Road
Croydon
Surrey CR0 1DF
020 8667 9443
info@phab.org.uk
www.phab.org.uk

A national charity dedicated to promoting the integration of people with and without physical disabilities, at all levels of society.

YoungMinds

48–50 St John Street
London EC1M 4DG
0808 802 5544
ymenquiries@youngminds.org.uk
www.youngminds.org.uk

A national charity committed to improving the mental health of all children and young people under 25 by giving advice, training, campaigning and distributing publications.

LOSS AND BEREAVEMENT

Antenatal Results and Choices (ARC)

73 Charlotte Street
London W1T 4PN
020 7631 0285 (helpline, Mon–Fri
10am–5.30pm)
info@arc-uk.org
www.arc-uk.org

Non-directive support and information for parents throughout antenatal testing, especially when a serious abnormality has been diagnosed and a choice has to be made about the continuation or ending of the pregnancy. Ongoing support given to parents via publications, a helpline, parent contacts, email groups, parents' meetings and newsletters. Support is offered to health professionals by way of training, conferences and publications.

Child Death Helpline

York House
37 Queen Square
London WC1N 3BH
0800 282 986 (Mon, Thu and Fri
10am–1pm; Tue and Wed 10am–4pm;
every evening 7pm–10pm)
contact@childdeathhelpline.org
www.childdeathhelpline.org.uk

Helpline for anyone affected by the death of a child of any age, from pre-birth to adult, under any circumstances, however recently or long ago. Staffed by trained volunteers, all of whom are bereaved parents.

Compassionate Friends

53 North Street
Bristol BS3 1EN
0845 123 2304 (helpline, 10am–4pm
and 6.30pm–10.30pm)
helpline@tcf.org.uk
www.tcf.org.uk

An organisation of bereaved parents and their families that offers understanding, support and encouragement to others after the death of a child or children. Also offers support, advice and information to other relatives, friends and professionals who are helping the family.

Cruse Bereavement Care

PO Box 800
Richmond
Surrey TW9 1RG
0808 808 1677 (young person's helpline)
0844 477 9400 (Day by Day helpline,
Mon–Fri 9.30am–5pm)
helpline@cruse.org.uk
www.crusebereavementcare.org.uk

A nationwide service providing emotional support, counselling and information to anyone bereaved by death, regardless of age, race or belief. Also provides information on local groups.

Foundation for the Study of Infant Deaths (Cot Death Research and Support)

11 Belgrave Road
London SW1V 1RB
020 7802 3200
0808 802 6868 (helpline, Mon–Fri
9am–11pm; Sat–Sun 6pm–11pm)
helpline@fsid.org.uk
www.fsid.org.uk

Charity working to prevent sudden deaths and promote health. It funds research, supports bereaved families and promotes safe baby care advice.

Miscarriage Association

c/o Clayton Hospital
Northgate
Wakefield
West Yorkshire WF1 3JS
01924 200799 (helpline, Mon–Fri 9am–4pm)
info@miscarriageassociation.org.uk
www.miscarriageassociation.org.uk
Information, advice and support for women who have had, or who are having, a miscarriage. Local contacts and groups.

Stillbirth and Neonatal Death Society (Sands)

28 Portland Place
London W1B 1LY
020 7436 5881 (helpline)
support@uk-sands.org
www.uk-sands.org

Supports anyone affected by the death of a baby through a network of support groups run by bereaved parents throughout the UK, a telephone helpline and support literature.

SMOKING

NHS Smoking Helpline

0800 022 4 332
www.gosmokefree.co.uk
Counsellors offer confidential help and advice about every stage of quitting.

NHS Pregnancy Smoking Helpline

0800 169 9 169 (12pm–9pm)
www.gosmokefree.co.uk
Trained advisers are available to answer any questions you have about smoking during pregnancy or about the free services available to help you quit.

NHS Asian Tobacco Helpline (Bengali)

0800 169 0 885

NHS Asian Tobacco Helpline (Gujarati)

0800 169 0 884

NHS Asian Tobacco Helpline (Hindi)

0800 169 0 883

NHS Asian Tobacco Helpline (Punjabi)

0800 169 0 882

NHS Asian Tobacco Helpline (Urdu)

0800 169 0 881

SPECIALISED ORGANISATIONS

Association for Post-Natal Illness (APNI)

145 Dawes Road
Fulham
London SW6 7EB
020 7386 0868 (Mon–Fri 10am–2pm)
0808 800 2222 (Parentline 24-hour helpline)
www.apni.org
Network of telephone and postal volunteers who have experienced postnatal illness, offering information, support and encouragement.

Association for Spina Bifida and Hydrocephalus (ASBAH)

ASBAH House
42 Park Road
Peterborough PE1 2UQ
0845 450 7755 (helpline, Mon–Fri
10am–4pm)
helpline@asbah.org
www.asbah.org

Voluntary sector organisation providing information and advice about spina bifida and hydrocephalus in England, Wales and Northern Ireland.

British Thyroid Foundation

2nd Floor, 3 Devonshire Place
Harrogate
North Yorkshire HG1 4AA
01423 709707
01423 709448
www.btf-thyroid.org

Provides support and information to people with thyroid disorders through literature, newsletters and information events.

Child Growth Foundation

2 Mayfield Avenue
Chiswick
London W4 1PW
020 8995 0257
info@childgrowthfoundation.org
www.childgrowthfoundation.org

Creates awareness of child growth disorders.

Cleft Lip and Palate Association (CLAPA)

First Floor, Green Man Tower
332b Goswell Road
London EC1V 7LQ
020 7833 4883
info@clapa.com
www.clapa.com

Offers and provides support to patients, their family and friends, health professionals and anyone affected by a cleft lip and/or a cleft palate.

Climb (Children Living with Inherited Metabolic Diseases)

Climb Building
176 Nantwich Road
Crewe CW2 6BG
0800 652 3181 (helpline, Mon–Fri
10am–4pm)
0845 241 2172 (enquiries)
info.svcs@climb.org.uk
www.climb.org.uk

Supports families and professionals, with information on over 700 metabolic diseases.

Cystic Fibrosis Trust

11 London Road
Bromley
Kent BR1 1BY
020 8464 7211 (switchboard)
0845 859 1000 (helpline, 9am–5pm)
enquiries@cftrust.org.uk
www.cftrust.org.uk

Information and support for parents of children with cystic fibrosis and for people worried about the possibility of passing on the illness.

Down Syndrome Education International

The Sarah Duffen Centre
Belmont Street
Southsea PO5 1NA
023 9285 5330 (helpline, Mon–Fri
9am–5pm)
enquiries@downsed.org
adviceline@downsed.org
www.downsed.org

Helps people with Down's syndrome to achieve more in all areas of their development, by informing progress through research and education. Delivers information and services to families to help them provide the best care and support for their children with Down's syndrome.

Haemophilia Society

First Floor, Petersham House
57a Hatton Garden
London EC1N 8JG
0800 018 6068 (helpline, Mon–Fri
10am–4pm)
info@haemophilia.org.uk
www.haemophilia.org.uk

Information, advice and practical help for families affected by haemophilia and other bleeding disorders. Some local groups.

Jennifer Trust for Spinal Muscular Atrophy

Elta House
Birmingham Road
Stratford-upon-Avon
Warwickshire CV37 0AQ
0800 975 3100 (helpline, 9am–5pm)
jennifer@jtsma.org.uk
www.jtsma.org.uk

The only charity in the UK dedicated to both supporting people affected by spinal muscular atrophy and investing in essential research.

Meningitis Research Foundation

Midland Way
Thornbury
Bristol BS25 2BS
08088 00 33 44 (24-hour helpline)
info@meningitis.org
www.meningitis.org

Promotes education and awareness to reduce death and disability from meningitis and septicaemia, and supports people affected by these diseases. Funds research to prevent the diseases, and to improve survival rates and outcomes.

Muscular Dystrophy Campaign

61 Southwark Street
London SE1 0HL
0800 652 6352 (helpline, Mon–Fri
9am–5pm)
020 7803 4800
info@muscular-dystrophy.org
www.muscular-dystrophy.org

Provides support, advice and information for people with muscle disease and their families and carers.

National Society for Phenylketonuria (NSPKU)

PO Box 26642
London N14 4ZF
020 8364 3010 (helpline)
020 7099 7431 (recorded information line)
info@nspku.org
www.nspku.org

Help and support for people with phenylketonuria, their families and carers.

Pelvic Partnership

26 Manor Green
Harwell
Oxon OX11 0DQ
01235 820921 (helpline)
support@pelvicpartnership.org.uk
www.pelvicpartnership.org.uk

Provides information and advice about the management of pelvic girdle pain (PGP), formerly known as symphysis pubis dysfunction (SPD), to women, their families and carers, including healthcare professionals. It produces written leaflets which are sent to all callers. The helpline and email support are staffed by volunteers who all have personal experience of PGP. PGP is a very treatable condition if women access care early, and the focus is to support women to do this early in their pregnancy, as well as supporting those with more long-term problems. Aims to raise awareness of PGP and how treatable it is.

Reach (Association for Children with Hand or Arm Deficiency)

Reach Head Office
PO Box 54
Helston
Cornwall TR13 8WD
0845 130 6225 (9am–5pm)
reach@reach.org.uk
www.reach.org.uk

Information and support for parents of children with hand or arm problems. Local groups.

Scope

6 Market Road
London N7 9PW
0808 800 3333 (Mon–Fri 9am–5pm)
Text from mobile – text SCOPE plus
your message to 80039 (texts are free
to the sender)
response@scope.org.uk
www.scope.org.uk

A national disability organisation whose focus is people with cerebral palsy. Provides information, advice and support services.

Sense (National Deafblind and Rubella Association)

101 Pentonville Road
London N1 9LG
0845 127 0060
0845 127 0062 (textphone)
info@sense.org.uk
www.sense.org.uk

Advice and support for families of deaf, blind and rubella-disabled adults and children. Provides information on local groups.

Sickle Cell Society

54 Station Road
London NW10 4UA
020 8961 7795
info@sicklecellsociety.org
www.sicklecellsociety.org

Information, advice and counselling for families affected by sickle cell disease or sickle cell trait. Provides financial help when needed and information on local groups.

Tamba (Twins and Multiple Births Association)

**2 The Willows
Gardner Road
Guildford
Surrey GU1 4PG**

**0800 138 0509
enquiries@tamba.org.uk
www.tamba.org.uk**

Services include a freephone helpline, Twinline, membership and specialist support groups, including bereavement.

Tommy's

**Nicholas House
3 Laurence Pountney Hill
London EC4R 0BB**

**0870 777 30 60 (advice and information)
020 7398 3460 (donation line)
info@tommys.org
www.tommys.org**

Provides pregnancy health information for the public and health professionals with the aim of helping all parents to have the best possible pregnancy outcomes. Operates a pregnancy information line staffed by midwives, and publishes books and leaflets on pregnancy and pregnancy complications.

UK Thalassaemia Society

**19 The Broadway
Southgate Circus
London N14 6PH**

**020 8882 0011
office@ukts.org
www.ukts.org**

Information and advice for families affected by thalassaemia.

Young Minds Parents' Information Service

**48–50 St John Street
London EC1M 4DG**

**0808 802 5544 (Mon–Fri 10am–4pm;
Wed 6pm–8pm)
ymenquiries@youngminds.org.uk**

www.youngminds.org.uk

Service for any parent who is worried about their child's mental health.

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USEFUL NUMBERS

Doctor:

Midwife:

Partner:

Birth partner:

Hospital:

Hospital reference number:

Health visitor:

Local taxi:

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