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NSW DEPARTMENT OF HEALTH
73 Miller Street
North Sydney NSW 2060
Tel. (02) 9391 9000
Fax. (02) 9391 9101
TTY. (02) 9391 9900
www.health.nsw.gov.au

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For further copies of this document please contact:
Better Health Centre – Publications Warehouse
Locked Mail Bag 5003
Gladesville NSW 2111
Tel. (02) 9816 0452
Fax. (02) 9816 0492

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December 2006

Having a baby

Message from the Premier

I've never experienced anything more amazing than the birth of our four children. To see the miracle of life unfolding before your eyes is one of the greatest joys of human existence.

But to tell the truth, pregnancy, childbirth and the early months of a new baby's life are also a huge challenge for even the best prepared mothers and families.

For others whose child is born with chronic illness or disability, and especially those who face the enormous trauma of losing a child, it can be a time of grief and deep anxiety.

To help understand and cope with these challenges, new mothers receive a lot of advice from family and friends or from other sources like the Internet. Such advice, though well-meaning, can sometimes be dubious or even risky.

New mothers deserve better than that. They deserve quality information from a reliable source based on facts and evidence, and that is what this publication is designed to provide.

This free book – *Having a baby* – has been prepared by some of the State's best experts and provides a comprehensive guide to most of the situations that expectant and new mothers will confront.

Of course, reading this book is no substitute for having a close, ongoing relationship with your GP, midwife, obstetrician and early childhood health services. That is essential because every pregnancy and every child is different, and in the end nothing beats face-to-face care from a professional you know and trust.

I sincerely hope this book will be a source of real help and encouragement for women, their partners and families as they face the long and complex journey of having a baby. Remember you do not face that journey alone. There is plenty of good advice and assistance out there, and this book is a great place to start.

Morris Iemma MP
Premier

Foreword

This book, published under the auspices of the NSW Department of Health, is dedicated to all NSW women who are pregnant or planning to have a baby and their families.

In addition to describing aspects of pregnancy care that are widely applicable throughout Australia, it also deals with some issues that have been raised specifically within NSW and considered by the State Government's Advisory Committee on maternity services – the NSW Maternal and Perinatal Health Priority Taskforce.

It is a pleasure to gratefully acknowledge health and other professionals from many disciplines and community representatives who have contributed to the contents of the book.

Members of the NSW Maternal and Perinatal Health Priority Taskforce join me in hoping that you will find this book helpful in your understanding and enjoyment of pregnancy, culminating in the birth of a healthy baby.

Emeritus Professor William AW Walters, AM
Chair, New South Wales Maternal and Perinatal Health Priority Taskforce

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Acknowledgments

A book such as *Having a baby* can only be produced with help from many people. Along with writers, many health professionals have been involved. These include midwives, doctors, nutritionists, genetic counsellors and physiotherapists, just to name a few. And, of course, consumers also play an important part. Many have shared stories from their own pregnancies and compared their experiences with the guide provided by the experts.

A number of organisations also had input into the text of this book. The NSW Maternal and Perinatal Health Priority Taskforce, The National Health and Medical Research Council, the Australian Breastfeeding Association, Sports Medicine Australia, Family Planning Australia, the NSW Genetics Education Program and the Australasian Society of Clinical Immunology and Allergy were among the many professional bodies that advised on areas within their expertise.

There are other people and associations, too many to name, who have also provided their thoughts on pregnancy and childbirth throughout the publication process. The input of each one has added to the development of this document.

Some words you may need to know

Abdomen Belly or stomach.

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

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

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

Amniotomy A midwife or doctor breaks the bag, which holds the fluid and the baby inside the uterus.

Antenatal The period before giving birth ie pregnancy.

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

Augmentation Medical treatment which helps labour to progress.

Birth canal Vagina.

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

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

Braxton-Hicks contractions Contractions that some women feel in late pregnancy. But they're not the real thing – more like the body 'practising' for labour.

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

Caesarean When the baby is delivered by a doctor cutting into the uterus through the abdomen.

Cervix Neck of the womb.

Contraction When the muscle in the uterus (womb) tightens. This may be painful.

Ectopic pregnancy When a fertilised egg attaches to the fallopian tubes, instead of the uterus.

EDC Short for 'expected date of confinement' – meaning the date when your baby is due.

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

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

Episiotomy A surgical cut in the area between the vagina and the anus that may be done during birth.

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

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

Folate An important B vitamin found in many fruits, dark green leafy vegetables and wholegrain foods.

Genetic counsellor A health professional who estimates the risk of your baby having an inherited condition and helps you decide what to do if the baby does have a serious condition.

Hypertension High blood pressure.

Induction Using a medical treatment to start the labour rather than waiting for it to happen naturally.

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

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

Jaundice When a baby's skin looks slightly yellow in the first few days of life.

Lactation consultant A health professional (often a midwife) trained to help women breastfeed and provide help with problems with breastfeeding.

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

Mastitis Infection in the breast during the period of breastfeeding.

Midwife Health professional who specialises in caring for women during pregnancy, labour, birthing and the postnatal period.

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

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

Neonatologist Doctor who specialises in caring for newborn babies.

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

Ovary Women have two ovaries. They produce eggs or ova.

Ovum Egg produced by the ovary.

Paediatrician Doctor who specialises in caring for babies and children.

Pelvic floor The muscles that keep the bladder from leaking.

Perineum The area between the vagina and anus.

Placenta The afterbirth. This provides the baby with food and oxygen. It's attached to your baby by the umbilical cord.

Postnatal After pregnancy and birthing– as in postnatal care or postnatal exercise.

Postnatal depression Feelings of sadness and inadequacy which continue for weeks after the birth.

Postpartum haemorrhage Heavier than normal bleeding after giving birth.

Pre-eclampsia Serious condition with symptoms of very high blood pressure and rapid swelling of the hands and feet.

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

Quickening The baby's first movements in pregnancy felt by the mother.

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

Spontaneous abortion Medical words for a miscarriage.

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

Toxoplasmosis An infection, which can cause blindness and brain damage in the unborn baby.

Trimester Pregnancy is divided into three 'trimesters' – one-12 weeks, 12-28 weeks and 28-40 weeks.

Ultrasound A procedure that looks inside the body using soundwaves. Used in pregnancy to check how many weeks old the unborn baby (foetus) is. Also used to check baby's growth and for some problems.

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

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

Vagina Birth canal.

Stages of pregnancy

Now that you're pregnant, you'll have lots of questions. How can I help make my pregnancy as healthy as possible? What choices do I have for giving birth – and how will I cope with being a parent?

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

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

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

To make it easy for you to get the most out of this book, we've divided it into two parts. The first section has important information about what happens in pregnancy, how your baby grows and things you need to know about having a baby. The second section provides more details about the things you may wonder about during your pregnancy and suggests places you can turn to for more information.

"There is nothing quite like finding out you're pregnant. You walk down the street feeling like you have this fantastic secret inside you" Kit

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

This book is for you too. It has information on what you can do *before* you get pregnant to lower the risk of problems in pregnancy. Things to think about include:

- See your doctor for a full health check especially if you have any health problems as they maybe made worse by the pregnancy eg diabetes, depression, high blood pressure or epilepsy – see *Complications in pregnancy* on page 102.
- Have a dental check-up. Bleeding gums happen when a substance called plaque builds up on teeth and irritates your gums. In pregnancy, hormone changes can make gums more easily irritated and inflamed. Keep gums healthy and avoid infection (gingivitis), which can eventually cause tooth loss.
- Do you need to be immunised against rubella (German measles)? This needs to be done three months prior to becoming pregnant. Having rubella in pregnancy can cause serious problems for the baby – see *Stages of pregnancy* on page 18. Also think about being immunised against influenza and whooping cough (pertussis), as these illnesses can cause problems. You may also need a blood test to see if you have immunity to chickenpox if you have never had it before.
- Do you or your partner have a family history of a genetic problem, such as cystic fibrosis or thalassaemia? You may want to have genetic counselling – see *Will the baby be healthy? Genetic counselling and prenatal testing* on page 80.
- Does your diet have enough folate (folic acid)? Having enough of this important vitamin in your diet before and during pregnancy can help prevent some birth defects – see *Stages of pregnancy* on page 7.
- Cigarettes, alcohol and other drugs can harm unborn babies. If you need help to quit smoking, or information on how alcohol and other drugs can affect pregnancy – see *Stages of pregnancy* on page 11.
- Most workplaces are safe in pregnancy, but some people work with substances or equipment that can harm an unborn baby or damage male sperm. If you want to make sure the equipment and substances you work with are safe, ask your doctor, occupational health and safety officer, union representative or employer – see *Stages of pregnancy* on page 14.

Information you can count on

There's lots of information around about pregnancy – some of it's good and some of it's not so good. *Having a baby* has reliable information at the time of publication that's either based on research or that many women have found helpful. If you can't find what you need, *Having a baby* shows you where to find it.

Very early pregnancy

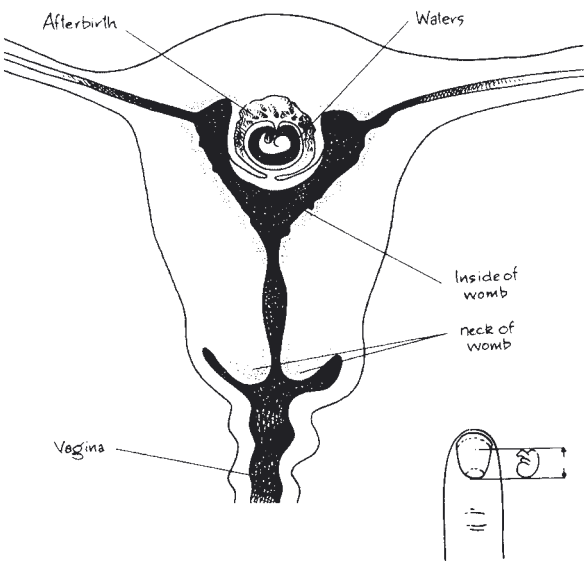
How the baby grows

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

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

By 6 weeks your baby is about 13-16mm long. Its heart is starting to beat. Its brain, stomach and intestines are developing. There are little bumps or buds where arms and legs are starting to grow.

6 weeks



What's happening to me?

You don't look pregnant on the outside, but on the inside your baby is growing fast. You're now looking after the baby as well as yourself. Eat the right food to help you and your baby and get to know what things may harm the baby's health – *see Stages of pregnancy – healthy eating* starting on page 8. You're now in the 'first trimester' (weeks one to 12).

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

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

A few things to expect

Many women feel really well in pregnancy. But there are big changes happening in your body. These changes can make you feel uncomfortable, especially in the first three months. A few things to expect:

- **Feeling queasy** Nausea is common in early pregnancy, but it doesn't happen to everyone. Although it's called 'morning sickness', it can happen at any time of the day or night. It usually lasts from around week six to week 14. There's a good reason for this nausea. It's because your body produces extra hormones in the early weeks to help keep the pregnancy going. But by 12 to 14 weeks, your placenta (afterbirth) has grown enough to take over and support the baby. The hormone levels decrease and you usually start to feel better. For tips on coping with morning sickness see page 5. If nothing works, or if nausea makes you really ill, see your midwife or doctor. There are a few safe medications that may help.
- **Your sense of smell alters** Certain smells that never bothered you before may make you feel nauseous.
- **Feeling tired and less energetic** It's common in the first 12 weeks or so, but doesn't usually last. The chances are you'll bounce back at around 14 weeks (though you may again feel tired in the last few weeks of pregnancy). Rest as much as you can during these

tired times – especially if you're working and/or have other children. It helps to put your feet up during the day if you can – try to do this in your lunch hour at work. You may need to go to bed earlier than usual. Resting more or asking for help with cooking and other chores doesn't mean you're not coping. It's what your body needs.

- **Feeling moody** Don't be surprised if you feel irritable sometimes as there's a lot happening in both your body and your life that can affect your mood. Hormone changes in the early months can make you moody. Feeling tired and nauseous can make you irritable. Knowing your life is about to change can affect you, especially if there are problems with your partner or worries about money. These feelings are normal. Don't keep them to yourself – talk to your partner or a friend. If you feel down or anxious a lot of the time, tell your midwife or doctor.
- **Going to the loo… again** In the first three months of pregnancy, you may want to pass urine more often. This is caused by hormonal changes, as well as your uterus pressing on your bladder. See your doctor or midwife if there's any burning or irritation when you pass urine, or if you have to pass urine very frequently, as it could mean a urine infection.
- **Your breasts are getting bigger** Wear a bra with plenty of support. After the third month of pregnancy you may need maternity bras. But if you can't afford them, don't worry. The main thing with any bra in pregnancy is that it's comfortable, gives good support and doesn't put pressure on any part of your breast. If you buy a new bra, get one that fits on the tightest fastening. It gives you room to grow. Front fastening bras make breastfeeding easier later on. If your breasts feel uncomfortable at night, try a sports bra.

"I was surprised at how difficult the first three months was. I didn't expect to be so tired at that stage of the pregnancy. I coped by collapsing on the couch as soon as I got home from work" Carolyn

Settling morning sickness

There are lots of things that may help you to feel better during the early months. Here are a few ideas some women have found helpful. Not all things work for everyone, so keep experimenting to see what is right for you. If nothing helps, talk to your midwife or doctor.

- Try to avoid any triggers (like certain smells or even looking at certain things) that make you feel sick.
- Drink plenty of fluids. It's best to drink small amounts often instead of a lot at once. You may find it's best to drink between meals rather than with them.
- Avoid an empty stomach – have frequent small, dry snacks like unbuttered toast, crackers or fruit.
- Avoid fatty food.
- Eat small meals often rather than eating a lot of food all at once.
- Try to eat at times when you feel least nauseous. Try eating fresh cold foods like salads if the smell of cooking makes you feel sick.
- Eat something before you get out of bed in the morning (keep some water and crackers beside the bed). Get out of bed slowly and take your time in the morning rather than rushing.
- Rest when you can – fatigue can make nausea worse.
- Try taking vitamin B6.
- Acupressure wristbands for travel sickness (available from pharmacies) can help.
- Try ginger tablets, dry ginger ale, peppermint tea or ginger tea (put three or four slices of fresh ginger in hot water for five minutes).
- Do not brush your teeth right after eating as this can cause nausea.
- Rinse your mouth out with water or a mouth rinse if you suffer from morning sickness and have bouts of frequent vomiting.

Healthy eating for you and your baby

Why is healthy eating so important in pregnancy?

- It helps the baby grow and develop.
- It helps keep you healthy while you're pregnant – and helps you stay that way to care for your baby.

All you have to do is:

Eat foods from each of these food groups every day:

- bread, rice, pasta, noodles and other grain foods
- vegetables and legumes (legumes means dried beans and peas, lentils and soy foods such as tofu)
- fruit
- milk, yoghurt, cheese
- meat, fish, poultry, eggs, and nuts.

Drink water Go for eight glasses of fluid a day – more in hot weather. All drinks (except alcohol) can count towards your fluid intake, but water is the best thirst quencher. When it comes to cost and convenience, nothing beats tap water, especially if it's fluoridated. If you are concerned about the quality of your water supply, boil the water before drinking it.

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

FAQ
Q: Do I need extra vitamins or minerals in pregnancy?

A: Apart from folate tablets, most pregnant women don't need extra vitamin or mineral supplements (though it's okay to try vitamin B6 to help with morning sickness, if you like). Ask your midwife or doctor before taking supplements – in some cases (eg with overdoses of vitamin A), there may be a risk to the baby.

Foods that help keep you and your baby healthy

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

You can get enough folate by:

- Eating folate-rich foods – eg wholegrain bread, wholegrain breakfast cereals with extra folate, dark green leafy vegetables, dried beans, chick peas and lentils (great in soups or added to curries and casseroles), oranges, orange juice, bananas, strawberries, avocado and yeast spreads like Marmite or Vegemite. Aim to eat two servings of fruit on the above list, as well as five servings of vegetables and seven servings of bread or cereals each day. For more details on folate-rich foods, see Healthy eating for pregnancy on page 74.
- Having a low-dose folic acid tablet (0.5mg) each day, as well as high-folate foods. You can buy folic acid tablets at the supermarket, chemist or health food shop.

Health problems linked to not having enough folate early in pregnancy are called neural tube defects. They can affect the baby's spinal cord or brain and will cause serious problems. For more information about this and other problems, see section *Will the baby be healthy? Genetic counselling and prenatal test starting* on page 80.

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

- recommend a folic acid tablet with a higher dose of 5mg daily
- suggest genetic counselling and tests to check for neural tube defects in pregnancy.

Don't take folic acid tablets without talking to your doctor or midwife, if you:

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

Health alert!!! Off the menu – foods to avoid in pregnancy

Be extra careful with food safety when you're pregnant. Some bacteria (germs) in food can cause illnesses that harm an unborn baby. That's why it's safer to avoid certain foods in pregnancy. These foods include unpasteurised milk, soft cheeses, and some types of seafood. It's okay to eat them once the baby is born. It's best to eat freshly prepared food, and avoid pre-prepared food if possible.

For more foods to avoid in pregnancy and simple ways to keep food safe, see *Healthy eating for pregnancy* starting on page 74.

Listeria

Listeria is the name of a bacteria that can cause a type of food poisoning (listeriosis). It's not common and doesn't usually cause problems for healthy people. But if a pregnant woman has it, she may pass it to her baby. This can cause miscarriage, stillbirth, premature birth or make a newborn baby very ill. Antibiotics can often prevent an unborn or newborn baby becoming infected if the mother has listeriosis.

What are the symptoms of listeriosis? In adults there may be no symptoms at all, or there may be a fever and you may feel tired (but these are symptoms of lots of other things). Always tell your doctor or midwife if you have a fever in pregnancy.

How much should I eat?

If your diet is already healthy, there won't be much change in pregnancy – just an extra serve of vegetables, two extra serves of fruit and a half serve of meat per day. For a guide, see the table in the section *Healthy eating for pregnancy* on page 74.

How much weight will I put on in pregnancy?

The average weight gain in pregnancy is about 12kg. You can expect to put on around 1-2kg in the first three months (really!) and about 1-2kg each month after that.

As long as you eat healthy foods and stay active, you shouldn't put on any excess weight. Although you might feel hungrier, you don't need to 'eat for two' – some extra serves of fruit and vegetables and healthy snacks should be enough. If you're already above your recommended weight range and are concerned about weight gain in pregnancy, talk to your midwife or doctor.

For more about healthy eating including healthy snacking, good ways to get more calcium, and healthy eating for teenagers and vegetarians, see the more detailed section *Healthy eating for pregnancy*, on page 74. You can also talk to the dietitian at your local hospital or community health centre.

Exercise

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

Regular exercise can:

- help you stay at a healthy weight
- help you relax
- help make you stronger and fitter – good for coping with pregnancy, labour and being a parent
- help decrease discomforts like back pain and varicose veins that affect some pregnant women
- help decrease the chance of getting a type of diabetes (gestational diabetes) some women get in pregnancy, when combined with a healthy diet.

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

If you were active before pregnancy or if you play sport:

- Talk to your midwife or doctor about your exercise routine/sport. You need to make sure there are no health problems to prevent you from doing some activities, and that your exercise routine won't cause problems in pregnancy.
- Pregnancy can increase your risk of injury. This is because your joints loosen up to let your body grow bigger and make it easier to give birth. Prevent injury in pregnancy by avoiding high impact exercise, jumping up and down, repetitive bouncing movements, and any movements that over-stretch your hip, knee, ankle or elbow joints.

For more about exercising safely in pregnancy, see *Handle with care – looking after yourself in pregnancy*, on page 62.

FAQ
Q: Is it okay to have sex during pregnancy?

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

Later in pregnancy, you may get contractions that are the body's way of 'practicing' for birth. They're called Braxton-Hicks contractions and may be more noticeable after an orgasm. They're harmless.

Health alert!!!
Things that may harm the baby

Still smoking? Now's the time to quit

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

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

- be premature (born before the end of the 37th week)
- be underweight. When you smoke, carbon monoxide and other chemicals from cigarettes enter your baby's bloodstream. The baby then gets less oxygen and doesn't grow as well. Underweight babies are more likely to have health problems after birth
- have lung problems such as asthma after they're born
- die from SIDS (Sudden Infant Death Syndrome).

When you need help to quit

For many women, this is a time when they really want to stop smoking (and may feel less like having a cigarette anyway). If you want to quit, talk to your midwife or doctor, or call the Quit information line on 13 18 48. You can dial from anywhere in Australia for the cost of a local call.

Can I use nicotine gum or patches in pregnancy?

Nicotine patches, gum and inhalers are a way of helping smokers quit. They're called nicotine replacement therapy (NRT for short). They give you a small amount of nicotine that helps reduce the craving for cigarettes. Although it's best to have no nicotine in your body at all, using NRT to help you quit is better than smoking cigarettes.

NRT is less harmful than cigarettes because:

- the nicotine dose is lower
- you don't take in any carbon monoxide or other harmful chemicals
- other people around you won't be breathing in smoke from your cigarettes.

Heavy smokers are also more likely to stop smoking if they use NRT.

If you want to try NRT, it's best to use the gum or inhaler. They only give you small doses of nicotine. Patches give a continuous dose of nicotine, and no-one knows how this might affect the baby. But it's important to use these products in the right way. Ask your doctor or pharmacist.

If you're breastfeeding, using NRT gums or an inhaler is better for you and the baby than smoking. If you continue to smoke, you should feed your baby before you have a cigarette.

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

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

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

A: Many people who smoke less (or smoke lower tar cigarettes) make up for it by inhaling more smoke, causing more health problems for themselves. Not smoking at all is the best option.

Helpful hint: Stay away from other people's smoke

Try to avoid other people's cigarette smoke while you're pregnant.

Once the baby is born, don't let anyone smoke anywhere near your baby.

Keep the baby out of places (eg the club, a party) where people smoke.

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

No-one knows the answer to this question – that's why it's best not to drink alcohol at all while you're pregnant (or trying). The current* advice on alcohol in pregnancy is:

- **Consider not drinking it all.**
- It's very important not to drink so much that you get drunk.
- If you choose to drink, have fewer than seven standard drinks over a week.
- Don't drink more than two standard drinks (spread over at least two hours) on one day.
- Have two alcohol-free days per week.

When you drink, alcohol goes from your bloodstream into the baby's bloodstream and may harm the baby, especially in the early weeks of pregnancy. This includes the time when you may not know you're pregnant.

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

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

What if you had a few drinks in early pregnancy when you didn't know you were pregnant?
Don't panic – so far it seems that it's more likely to be continued heavy drinking over a long period that causes problems.

If you're worried, speak to your midwife or doctor or contact MotherSafe, a free service based at the Royal Hospital for Women in Sydney. Tel. (02) 9382 6539 (Sydney metropolitan area) or 1800 647 848 (regional NSW).

* Australian Alcohol Guidelines (Department of Health and Ageing)

MotherSafe gives information and counselling to women concerned about how their baby may be affected in pregnancy or breastfeeding by:

- alcohol or other drugs (prescription drugs, over the counter medications or illicit drugs)
- traditional or herbal medicine.

To find out about illicit drugs in pregnancy, see the section *Handle with care – looking after yourself in pregnancy* on page 62.

What's a standard drink?

This means any drink that contains 10 grams of alcohol. This means any of these:

- 1 schooner light beer
- 1 middy full strength beer
- 1 x 100ml glass wine
- 1 nip (30ml) spirits.

Some things make it difficult to know how many standard drinks you're drinking, for example:

- sharing jugs and casks
- other people topping up your glass
- drinks mixed with unknown amounts of alcohol, such as punch or cocktails (some cocktails can contain four or five standard drinks).

Be careful with caffeine

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

This equals **any** of these:

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

The amount of caffeine in some soft drinks can vary – check the label. Some soft drinks also contain guarana, a stimulant that's similar to caffeine. It's not known what the effects of guarana are in pregnancy.

Can I drink herbal tea in pregnancy?

If you drink them in normal amounts, most herbal teas are harmless. But be careful with raspberry leaf tea – there are some concerns that it may contribute to premature labour. For more information, see the section *Handle with care – looking after yourself in pregnancy*, on page 62.

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

Some drugs (either prescription drugs or medication you buy from the chemists without a script) may be harmful in pregnancy.

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

- Check with your pharmacist, midwife or doctor first.
- Use the lowest effective dose.
- Be aware that some common painkillers including aspirin and non-steroidal anti-inflammatory drugs (eg Nurofen) may cause problems in pregnancy. Paracetamol is considered the safest option.
- Avoid taking a variety of medications.
- Avoid over-the-counter drugs if possible.
- Call MotherSafe. Tel. (02) 9382 6539 (Sydney metropolitan area) or 1800 647 848 (regional NSW).

For more about the effects of other prescription drugs, including anti-depressants, in pregnancy, as well as herbal remedies and vitamin and mineral supplements, see the section *Handle with care – looking after yourself in pregnancy* on page 62.

What to do if:

Your doctor prescribes medicines for you Tell him or her if you're pregnant or trying.

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

Helpful hint

If you have a fever, tell your doctor as soon as possible.

It's safer to take paracetamol to help reduce fever rather than have a high fever for too long, especially in the first few weeks of pregnancy.

Risks at work

Some jobs bring you into contact with things that may harm an unborn baby. There are some examples below – but they're not a full list. To make sure your work is safe in pregnancy, ask your midwife, doctor, occupational health and safety officer, union representative or employer.

You can also contact the WorkCover Authority of NSW, 92-100 Donnison St, Gosford NSW 2250. Tel. (02) 4321 5000 or go to www.workcover.nsw.gov.au for a copy of a free booklet, *Pregnancy and work*. WorkCover also has information on your rights as an employee – eg to be able to do other work for your employer that is safe, or to have unpaid maternity leave.

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

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

Radiation Working around x-rays or radioactive material may be harmful, but radiation levels from computer screens aren't thought to cause problems.

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

To find out about other things to be wary of in pregnancy (including illicit drugs, lead and household chemicals) see the more detailed section *Handle with care – looking after yourself in pregnancy*, which starts on page 62.

Risks at home

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

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

- avoid raw or undercooked meat
- wash your hands after petting animals
- avoid contact with cat faeces
- wear gloves for gardening.

Antenatal care – keeping you and the baby healthy

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

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

As soon as you're pregnant or think you are, see your GP or midwife. He or she may do some tests, though these may be done at your first antenatal checkup at the hospital.

Most women have their first visit to the hospital between weeks 10 and 16. At this time, you also book into the hospital to have your baby. It is recommended that you book into the hospital as early as possible.

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

- talk with you about your pregnancy and health
- check your blood pressure
- check the baby's growth and wellbeing
- provide educational information about pregnancy, birth and parenting.

You may also want to have prenatal tests to check your baby's health – see *Will my baby be healthy? Genetic counselling and prenatal testing,* on page 80.

If you're worried about anything or have any questions, you can contact your midwife, hospital antenatal unit, delivery suite or doctor between visits.

Where do I go for antenatal care?

This depends on:

- where you plan to have your baby – in hospital, a birth centre or at home. See the section *Choices for pregnancy care and birth*, on page 110
- what services are in your area (ask at the antenatal clinic or maternity unit of your local hospital, your Area Health Service or your GP).

Best outcomes for mothers and babies are achieved through the provision of a range of options provided through primary, secondary and tertiary services. Primary services can be provided in the hospital, community or home for women who are well and do not have any anticipated complications.

Secondary maternity services provide additional care during labour, birth and the postpartum period. Tertiary maternity services provide a multidisciplinary specialist team for women and babies with complex needs and who require specialised services.

Continuity of care models have a philosophy of developing a meaningful relationship with the same carer(s) which promotes confidence and trust and provides consistent information that is essential to the provision of care that is safe effective and appropriate. This relationship continues throughout antenatal, birth and postpartum period.

Continuity of care models include:

- **Caseload midwifery** This model of care provides one-to-one midwifery care. The model maintains a focus on individual needs and priorities for each woman and baby through the concept of having one midwife coordinate care and one or two midwives provide care throughout pregnancy, labour and early postnatal period. The midwives work with doctors in the maternity service.
- **Team midwifery** This means a small team of midwives cares for you at a hospital antenatal clinic, as well as during labour and after the birth. The midwives work with doctors in the maternity unit. You will usually get to know all the midwives on the team, and one of them will always be available for your care.

- **An obstetrician or GP in private practice** You will see the obstetrician or GP for most of your antenatal care at his or her surgery. The birth is usually attended by the obstetrician or GP, but midwives will care for you in labour. You need a referral from your GP to see an obstetrician. You may need private health insurance to help cover the cost of private care. It is recommended that you book into the hospital as early as possible.
- **A midwife in private practice** Private midwives (also known as Independent Midwives) provide homebirth services. To find a private midwife in your area, contact the Independent Midwives' Association on (02) 9888 7829. Some health funds provide benefits for a midwife.

Other models of care include:

- **An antenatal clinic in a public hospital** The maternity unit at your local hospital usually has an antenatal clinic. It is recommended that you book into the hospital as soon as possible. At your first visit to the clinic, a midwife will help you book in. This involves answering questions and filling in forms. If you or your midwife have identified any potential complications you may also see a doctor for a full medical examination. If you need specialist care, you may see different doctors during your pregnancy. If you have any concerns, talk to your midwife or doctor. You will also be referred to other health workers (eg social workers, physiotherapists, dieticians) who can help as appropriate.
- **Midwives' clinic** These clinics are in many large public hospitals, including birth centres, or in the community (eg community health centres). Midwives are qualified to care for women with normal pregnancies and during their labour and birthing. If there are problems, the midwife will refer you to a doctor. The doctor and midwife will work with you together to plan the best possible care.
- **Shared antenatal care** This means your care is shared between a GP and a hospital antenatal clinic. It's another option for women with normal pregnancies. If you have shared care, most check-ups will be at your doctor's surgery. Not all GPs do shared care. If your doctor doesn't share care, ask at the hospital if it has a shared antenatal care program or a Midwives Clinic. The staff can give you a list of GPs in your area.

Obstetricians, midwives and some GPs are skilled to attend the birth of your baby.

If you're healthy and have a normal pregnancy, a midwife is fully qualified to:

- care for you in pregnancy
- attend the birth of your baby
- care for you after the birth.

If problems arise during labour or birth, an obstetrician will be consulted.

Special services

Some hospital antenatal clinics may have extra services for:

- Aboriginal women
- women who speak little or no English
- teenagers.

What if I prefer a female doctor or midwife to provide care in pregnancy and birth?

Many women prefer a female doctor or midwife. Hospital staff understand this, and try to provide female staff if they can. Most hospital midwives and many doctors are female, and staff will try to provide a female practitioner.

However, it's also true that most hospitals have staff of both sexes so there may be times when it's not possible to see a female practitioner if the only suitable person available is male. In an emergency, the most important thing is to provide the most skilled care available – this may mean that a male doctor, male midwife, or male nurse may be involved.

Male staff treat women with respect. If you're being treated by a male health professional, you can ask for a female staff member to be there too. In an emergency or where there's a serious medical need for a woman to be treated, the only suitable practitioner available may be a male.

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

What happens at the first antenatal visit?

You'll be offered some tests (to check for anything that may cause problems during pregnancy or after the birth). These tests will be discussed with you and are done only with your consent – see *It's okay to ask questions* on page 18.

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

General health check-up, which may include:

- checks to make sure your heart, lungs and blood pressure are okay
- a urine test, to make sure your kidneys are healthy and check for signs of diabetes and infection
- a Pap test (unless you've had one in the last 12 months before pregnancy) and a breast examination.

Blood tests

A blood test will check your health in a number of areas:

Anaemia Some women have anaemia in pregnancy. This is caused by a decrease in the level of iron as your body uses more iron in pregnancy. Anaemia makes you tired and less able to cope with any blood loss in birthing. Your midwife or doctor can tell you if you need iron tablets to prevent or treat anaemia. There will be more tests to check for anaemia throughout your pregnancy.

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

So why are they asking me all this?

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

All women in NSW (not just you) are asked these things. The reason isn't to pry into your personal life – just to make sure you get help or support if you need it.

Rh positive or Rh negative – what does it mean?

Most people of all blood types have a substance in their blood called the Rh factor. Their blood is called Rh positive. But about 15 per cent of people don't have the Rh factor – so their blood is called Rh negative. If your blood is Rh negative, it isn't usually a problem, unless your first baby happens to be Rh positive.

If it is, there's a risk that your body will produce antibodies against your baby's blood. This isn't a problem with your first baby. However, if you get pregnant again with another Rh positive baby, those antibodies may cross the placenta and harm that baby's blood cells.

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

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

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

Checking for infections

There are a number of infections that can affect pregnancy and the unborn baby. Tests offered can vary from hospital to hospital, and may include:

- some common childhood illnesses eg rubella and chickenpox
- some sexually transmitted infections (STIs) eg chlamydia, herpes, gonorrhoea, syphilis and hepatitis B
- some infections that can be passed on through blood-to-blood contact including sharing needles and other equipment for injecting drugs, eg hepatitis C, hepatitis B and HIV (virus that causes AIDS).

Rubella (German measles) Most of the time rubella infection isn't serious. But having it in pregnancy can harm the brain, sight and hearing of the baby, especially in the first three months. It can also increase the risk of miscarriage and stillbirth. Even if you've been vaccinated against rubella in your teens, you need a blood test to make sure you're still immune. You will be offered this test at your first antenatal visit. While you're pregnant, try to avoid anyone who has rubella. You can't be vaccinated against rubella while you're pregnant, but you'll be offered vaccination after the birth. If you have contact with someone who has rubella or any other virus, tell your midwife or doctor as soon as possible.

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

It's okay to ask questions

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

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

Questions you might want to ask your midwife or doctor include:

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

Helpful hint

Jot your questions down ready for your next visit to your doctor or midwife.

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

- don't use condoms
- have more than one sexual partner
- have changed sexual partners in the last six months
- your partner has more than one sexual partner
- your partner has changed sexual partners in the last six months
- you are from a country with high levels of STIs.

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

For more details about these and other infections that may cause problems in pregnancy, see *Infections that may affect pregnancy*, on page 67.

What about special tests for the baby?

There are tests you can have in pregnancy to check for some problems that may affect your baby. You don't have to have them, it's up to you. A doctor or midwife may suggest these tests if you are:

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

For more about these tests and what to think about before you decide to have them, see the section *Will the baby be healthy? Genetic counselling and prenatal testing* on page 80.

What if you have mixed feelings about pregnancy?

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

Even if the baby is planned, it's still normal to feel anxious and uncertain sometimes. You may worry about:

- giving birth (Will I cope with the pain? Will the baby be normal?)
- life after birth (Can we live on one wage instead of two? Will I like being a parent? How will I cope with lack of sleep and less time for myself? How will a baby change our relationship? How will we cope with another child in our family? How will it affect my work or study? Will my body ever look okay again?).

On top of all this, changes to your body may make you feel tired. Talk to your partner, your friends or family. See *Your feelings in pregnancy and early parenthood*, on page 134 and *Relationships in pregnancy and early parenthood*, on page 140.

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

Pregnancy and early parenthood can be great. But these are also times when there can be:

- more risk of domestic violence
- more stress on relationships
- difficulties for women who have been sexually abused in the past. Some women find that the effects of this abuse bring extra problems to pregnancy, birth and early parenting.

Parenting is hard work even when all's going well. It can be much harder if there are other stresses such as these in your life, or if you don't have family or friends around. But there are services to help you cope with problems that affect many women in pregnancy. These include:

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

If you have any other problems or concerns, don't be afraid to talk to your midwife or doctor about them.

You can read more about sexual abuse and depression in *Your feelings in pregnancy and early parenthood,* on page 134. For information about domestic violence and relationship issues, read *Relationships in pregnancy and early parenthood*, on page 140.

At your first antenatal visit, there may also be questions about whether you smoke or use other drugs. Again it's not about judging you, but about supporting you and caring for your baby's health.

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

Sexual abuse and pregnancy

Some women have had experiences in childhood – such as sexual abuse – which may cause difficulties for them in pregnancy and birth. A hospital social worker or counsellor may be able to help you plan ways to cope with this. They can discuss your concerns and let you know some of the things other women have found helpful in their birth plans. Talk to your midwife or doctor, who can refer you. There are specialist sexual assault services across NSW. For more information, see *Your feelings in pregnancy and early parenthood,* on page 134.

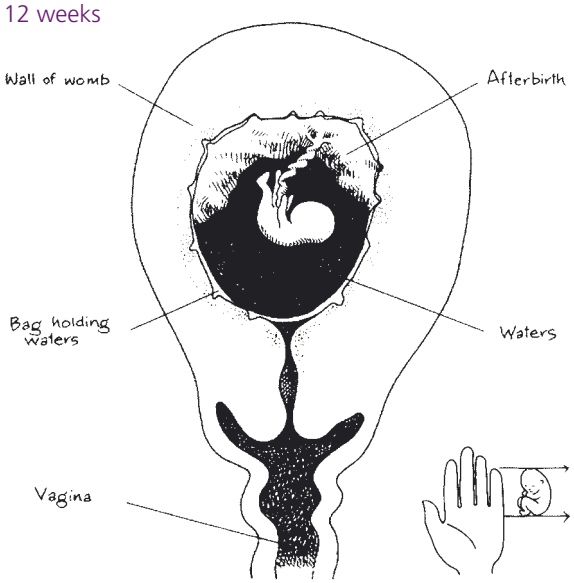
12–16 weeks

How the baby grows

By 12 weeks, the baby is about 11cm long and weighs about 45g. Its organs have formed, including its ovaries or testicles. Although you can't feel it yet, the baby is moving around.

At 16 weeks, the baby is about 18cm long and weighs about 200g. In the next four weeks, you may feel the baby move (it feels like fluttering). If you could see your baby now, you could tell his or her sex. The baby is gaining weight fast, and has eyebrows, hair and fingernails. Your baby's teeth begin to develop between the third and sixth month of pregnancy.

12 weeks



What's happening to me?

- You're into the middle part of your pregnancy. It's the 'second trimester', which goes from week 12 to week 28. By about 16 weeks you may be gaining weight and beginning to look pregnant. Although the baby only weighs a few hundred grams, other things are adding to your weight. There's extra blood and fluid, as well as your growing breasts, uterus and placenta.
- Your breasts and legs may look like a road map. The increased blood supply and hormones makes your veins stand out more.
- You're probably feeling better. You're likely to feel less tired and queasy in this part of your pregnancy. Your uterus has moved up and isn't pressing on your bladder so much. This means fewer trips to the toilet – at least for now.
- You'll soon be struggling to do up your jeans. This doesn't mean spending big on maternity clothes. The chances are there are clothes in your wardrobe you can still wear – and maybe some in your partner's too (bigger shirts and T-shirts? Jeans and shorts that are roomier around the waist?). Friends may be happy to lend you clothes, and there's always your local pre-loved clothes shop. Some women use an 'expander' – a big stretchy band that fits across the opening of normal pants and skirts so they can keep on wearing them through pregnancy.
- Are you feeling warmer? Many women do. It's caused by the extra blood in your body. This extra warmth can be a bonus in mid-winter, but not in summer. Loose, cotton clothes are cooler than synthetic fabrics.

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

Health alert!!! Teeth and gums need extra care in pregnancy

Changes in pregnancy can increase the risk of gum disease (gingivitis). Your gums are more easily irritated and inflamed. If you already have gum disease (many women do without knowing it), pregnancy can make it worse. If it's not treated, gum disease can cause tooth loss.

Signs of gum disease may include:

- bleeding gums
- tender swollen gums
- bad breath that won't go away.

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

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

Tell your dentist if you're pregnant, or planning to be, as x-rays may not be safe at this time.

When is the baby due?

Only pregnant for nine months? That's what you think … The average length of pregnancy is 280 days – and if you do the maths, this works out more like 10 months than nine. Here's a way to work out when your baby is due. **But remember it's a guide not a guarantee**, as most babies don't arrive on the due date.

1. Write down the date of the first day of your last period.
2. Add seven days to the date. For instance, if it was February 7, adding seven days gives you February 14.
3. Count back three months (January 14, December 14, November 14).
4. Your baby is due around November 14.

Ultrasound test

Your midwife or doctor may suggest an ultrasound test at about 18-20 weeks. This ultrasound can:

- check for some problems with the baby (but not all – it can't guarantee a perfect baby)
- see if there's more than one baby.

Although this ultrasound test is routine, it's up to you whether you want to have it.

You may be asked to have a number of ultrasounds through the pregnancy, but this is only necessary if there are complications. In a normal, healthy pregnancy, one ultrasound at around 18 weeks is enough.

As with any test or treatment in pregnancy, it's good to ask questions – why do you need it, and are there any side effects?

One baby or two?

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

- you may need more tests in pregnancy (including more ultrasounds)
- you may not be able to have low-risk birth choices like a birth centre or homebirth. That doesn't mean you and the babies aren't healthy. But because there's a risk of complications with more than one baby, you need to take extra care.

For more information, see *When it's twins or more – multiple pregnancy*, on page 94.

Health alert!!! Have you seen your doctor or had your first antenatal visit yet?

No? Make an appointment now. Good antenatal care is *very* important to lessen the risk of problems for you and the baby. Even more so if you're:

- aged 19 or younger
- aged 35 or older.

Health alert!!! Cystitis and other urinary tract infections

These infections are more common in pregnancy. Be aware of symptoms like:

- going to the toilet more often (though this is normal in the first and last three months of pregnancy)
- feeling unwell
- pain or burning when you pass urine.

Tell your midwife or doctor if you suspect an infection: early treatment is important.

Preparation for childbirth classes

Ask your midwife or doctor about these classes (sometimes called antenatal classes or programs). These are available:

- at some hospitals or community health centres (some areas have classes for teenage mothers too)
- through private organisations such as the Childbirth Education Association at (02) 8539 7188, PO Box 240, Sutherland 2232, or www.cea-nsw.com.au

Your partner or other support people are welcome to go.

Some people find these classes provide valuable information and help them prepare for the demands of birth and parenthood. They can also give you the chance to ask questions and discuss your feelings about pregnancy and parenthood. Classes are also a good way to meet other parents-to-be.

Courses can vary, but usually include:

- what to expect in labour and birth
- relaxation techniques and other skills to help you during pregnancy and birth
- pain relief in labour
- exercises for pregnancy, birth and back care
- feeding your baby
- caring for your new baby at home
- the chance to talk about how you and your partner feel about pregnancy, childbirth and parenthood.

Some courses also include visits to the hospital or birth centre and delivery suite so you have a better idea of where to go and what to expect. You may be asked to pay a fee.

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

Health alert!!! Mind your back

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

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

See *Give me strength – pre and postnatal exercises*, on page 96 for good ways to protect your back.

FAQ
Q: Now that I'm pregnant, can I still wear my ... Navel ring?

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

High heels?

A: If you wear high heels, it's time to come down to earth – just for a few months. You'll be more comfortable, feel less tired and be less likely to fall in heels no more than 5cm high. Lower heeled shoes are also kinder to your back.

FAQ
Q: Is it okay to use aromatherapy oils in pregnancy?

A: Some women like to use essential oils for massage or in an oil burner during pregnancy or labour. There's not a lot of research about this, but some oils such as chamomile and lavender are thought to be calming. Check with your hospital to find out if an oil burner is available in the delivery suite (hospitals don't allow you to bring your own oil burner).

Some oils may not be safe in pregnancy. Check with your midwife, doctor or a qualified aromatherapy practitioner. Some oils to avoid include basil, cedarwood, clary sage, cypress, fennel, jasmine, juniper, sweet marjoram, myrrh, peppermint, rosemary, sage and thyme.

How will I feed my baby?

Breastfeeding is best for the health of your baby. Deciding whether to breast or bottle feed is a personal decision. If you haven't made up your mind yet, talk it over with your midwife or doctor.

- Breastmilk is the only food your baby needs for the first six months of life.
- If you still prefer to bottle feed, it's good if you can breastfeed even for a little while.

Breastfeeding is good for you too, because it:

- helps you lose some of the weight gained in pregnancy
- helps your uterus get back to normal faster
- may help reduce the risk of breast cancer.

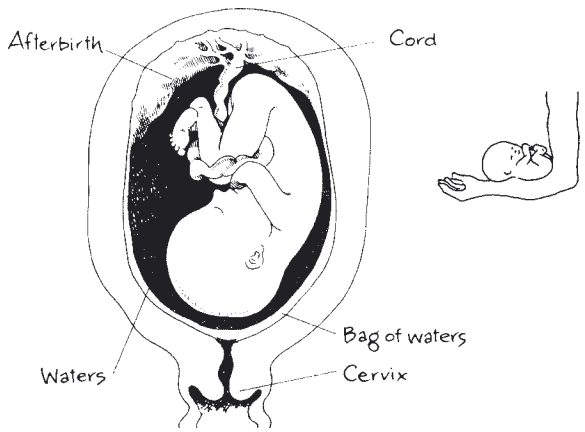
For more information, see *Feeding your baby*, on page 125.

24 weeks

How the baby grows

The baby is now about 31cm long and weighs about 700g. The skin is covered in fine hair and protected with a waxy coating. The top of the uterus is about level with your naval. A baby born at this time has about a 50 per cent chance of survival. But this depends very much on where the baby is born, how problem-free the pregnancy was and if there is expert care. Babies who do survive at this stage have a high risk of a serious disability such as blindness or cerebral palsy.

24 weeks



What's happening to me?

- Congratulations – you're more than halfway there. As you get bigger it can be harder to find a comfy position to sleep in. Some women find it helps to try lying on their side, with a pillow between their legs as well as under the head.
- As your baby gets bigger, your balance can be affected – let someone else do the heavy lifting or perching on ladders. Be careful when bending – remember your joints are softer in pregnancy and you're more likely to injure yourself.
- By now your baby may be kicking enough for your partner to feel the movements. It's not always easy for partners to feel as if they are part of the pregnancy – but this is a great way for them to share the experience and get to know the baby.

FAQ
Q: How do I fasten my seatbelt?

A: Worn properly, a seatbelt can protect you and the baby if there's an accident. Wear the lap part of the seatbelt under your bump. It should be fastened as tightly as possible, but you should still feel comfortable.

Q: Is air travel safe in late pregnancy?

A: Check with the airline. There's usually no health reason why you can't fly in pregnancy, but generally it's not recommended after 32 weeks. Check with your midwife or doctor. Some airlines have restrictions that mean you can't get travel insurance. However they can't prevent you from flying if you want to.

Countdown to parenthood

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

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

Think about a birth plan

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

- let your midwife or doctor know what kind of care you'd like in labour, birth and afterwards (if possible), and if you're planning to breastfeed
- be more involved in decisions about your care
- help you be prepared for the big event.

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

- going to antenatal 'preparation for childbirth' classes
- talking to your midwife or doctor, ask about any issues or concerns about the approaching labour and birth
- ask about who will be involved in your care, how many people will be involved and who has access to your medical records
- reading about birth – see the sections about *Choices for pregnancy care and birth,* on page 110 and *Labour and birth – what to expect,* on page 33
- talking to other mothers
- talking to your partner or other relatives or friends who'll be there to support you at the birth.

For more ideas to help you with a birth plan, see section in *Choices for pregnancy care and birth*, starting on page 110. Just remember that things may not go according to plan! There may be complications or you may change your mind about something. Some women say they want to give birth without pain-relieving drugs, for instance, then find they need them after all – and that's okay.

Will you need childcare after the baby is born?

Childcare is in short supply in some areas. You may need to book a place well before the baby is born. Your local council can give you information about childcare in your area.

28 weeks

How the baby grows

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

What's happening to me?

- You're on the home run. This is the first week of the last part of your pregnancy, called the 'third trimester' (weeks 28 to 40).
- In some ways, these final three months are a bit like the first three – you may be more tired and more emotional. Aches and pains in your belly and back are more common. Try to rest as much as you can.
- You may have pains at the top of your legs – this is caused by the ligaments in your pelvis stretching.
- If heartburn is a problem, see *Common concerns in pregnancy*, on page 87.
- You may have extra tests (or have already had them). One may be for gestational diabetes – a type of temporary diabetes that affects some women in pregnancy (see *Complications in pregnancy*, on page 102). In the last three months of pregnancy, your midwife or doctor may also offer a test to check for bacteria in your vagina called group B strep. Although group B strep doesn't cause problems for women themselves, it can infect the baby during birth and cause serious problems. The test is done by taking a vaginal swab. If you do have group B strep, you'll be advised to have antibiotics in labour to protect the baby.

FAQ
Q: I'm getting stretch marks on my breasts and tummy – can anything prevent them?

A: Stretch marks look like thin stripes on your skin (red, purple, pink or brown depending on your skin type). They happen when your body grows rapidly (bodybuilders get them too!). In pregnancy they're common on breasts, abdomen and thighs and sometimes the upper arms.

Some products claim to prevent them and some people say vitamin E or other oils massaged into the skin help too. There's no harm in trying, but there's no real evidence that anything helps except time. They do fade to a faint silvery white and become less noticeable.

Plan what you'll need to take to hospital

Here's a basic list. Your hospital may suggest a few extra things. If you're having the baby at home, your midwife will tell you what to have ready.

You'll need:

- nightdresses and a dressing gown
- some loose, comfortable day clothes
- comfortable footwear
- underwear, including nursing bras – some women use disposable briefs
- nursing pads
- toiletries
- sanitary pads – either 'super' size or maternity size (you can buy maternity pads in supermarkets)
- something to wear while you're in labour – a big T-shirt or an old nightdress (they may need to be thrown out afterwards)
- clothes for you to wear to come home (something loose – you won't be back to your normal shape yet)
- wheat pack or hot pack for pain relief in labour (ask the hospital if you can use these in labour – some hospitals don't allow them in case of burns)
- anything you want with you in labour (eg CDs/tapes, CD/cassette player, massage oil).

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

Things for the baby include:

- disposable nappies, if you plan to use them, as some hospitals only supply cloth nappies (check with your midwife or doctor about your hospital's policy)
- nappy, clothes and hat for the baby to wear to come home
- baby blanket.

Check with your midwife or doctor about other requirements.

Things for your partner

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

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

Find out about tests and injections for your baby after birth

Before leaving hospital, all babies are offered:

- tests to check for a number of health problems – these problems aren't common, but it's good to check for them just in case. They're more easily treated if they're found early
- injections – these are a vitamin K injection and immunisation to protect the baby against hepatitis B.

You'll be given information about these tests and injections during pregnancy. At one of your antenatal visits, you may be asked to give your consent for the baby to have them.

For more information see section *After the baby is born – what happens in hospital*, on page 46.

32 weeks

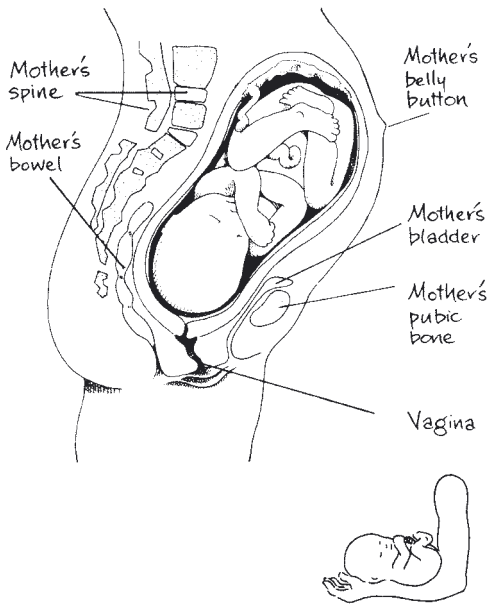
How the baby grows

The baby is about 41cm and weighs about 1800g. A baby born at this time will have difficulty sucking. For more information, see *Complications in labour and birthing*, which starts on page 114.

What's happening to me?

- You may be feeling uncomfortable. Rest is important, but try to stay active too – you'll cope better in labour if you stay fit with gentle exercise.
- You may feel breathless. This is because your baby is growing so well. It's pressing against your diaphragm, the muscle between your chest and your abdomen.
- Sleeping problems are more common from now on – for tips to help you sleep see *Common concerns in pregnancy* starting on page 87.

32 weeks



Before the baby arrives ...

If this is your first baby, you'll be amazed at how one tiny person can turn your life upside down. New babies demand a lot of time – and if there's any time left over, you'll be too tired to do much. Having twins will mean even less time. Do anything you can now to make life easier after the birth, eg:

- prepare and freeze meals
- stock up on groceries and other supplies (don't forget sanitary pads)
- organise a baby capsule if you're bringing the baby home by car. All babies must travel in a baby capsule or restraint in the car. It's not safe for babies to travel in your arms – if there's an accident, you won't be able to hold onto your child. You can hire a capsule or restraint, rather than buy one if you want. The maternity unit can give you details of organisations that hire them. For more information about baby capsules and car restraints for children, contact the Roads and Traffic Authority on 13 22 13 or go to www.rta.nsw.gov.au

Have your bag packed and ready to go to hospital – just in case. If you're having twins, they're more likely to arrive early. Pack a bag even if you're having a homebirth – there's still a chance you may need to go to hospital.

Have you made up your mind how you'll feed your baby yet? If you're undecided or have any questions, talk to your midwife.

36–41 weeks

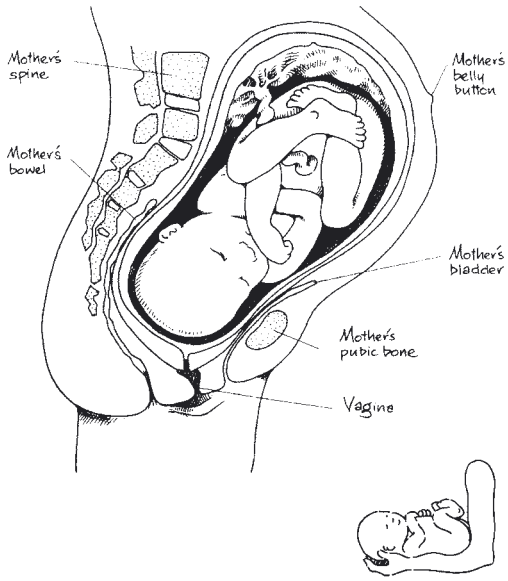
FAQ
Q: Why are my breasts leaking?

A: In the last months of pregnancy, it's normal for your breasts to leak a little colostrum (an early form of milk). Wearing nursing pads (available from pharmacies and supermarkets) will mop up the leaks.

How the baby grows

By 36 weeks, the baby is about 47.5cm and weighs about 2800g. By 40 weeks, it's grown to 50cm and weighs about 3200g. The brain can now control the baby's temperature, and the growing body has now caught up with the size of the head. Your baby is ready to be born.

40 weeks



What's happening to me?

- Only been pregnant for nine months? By now it may seem like forever. Many women have given up work by this stage. It's normal to slow down, but you may also get a bonus burst of energy. It's all part of 'nesting' – the urge some women have to get things ready before the baby comes.
- The baby may have dropped down into your pelvis – this may make it easier to breathe. But the extra pressure on your bladder means you'll want to go to the toilet more often. If you're not sure what the signs of labour are and when to go to hospital, ask your midwife or doctor.
- Your baby may arrive anywhere between 37 and 42 weeks (only 5 per cent of babies arrive on their due date).

Going over your due date

As long as you have a normal pregnancy with no complications, it's best to wait for the baby to arrive in its own time. The midwife or doctor will keep a close eye on you and your baby. This may include extra tests such as monitoring the baby's heartbeat and activity. A risk of carrying an overdue baby may be that the placenta may work less efficiently.

For information about induction of labour, see the section *Medical intervention and birth – things to know before labour starts,* on page 39.

FAQ
Q: Should I be counting the baby's kicks?

A: Counting how often the baby moves in a 24-hour period is a good way to check that the baby is okay. But babies are like people – some move around more than others. It's also easy to miss feeling movements if you're busy doing something else. Talk to your midwife about the best way to count kicks. Each baby is different. You are the best judge of how active your baby usually is. It is important to let your midwife or doctor know if there has been any change in your baby's usual movements.

Health alert!!!

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

Labour and birth

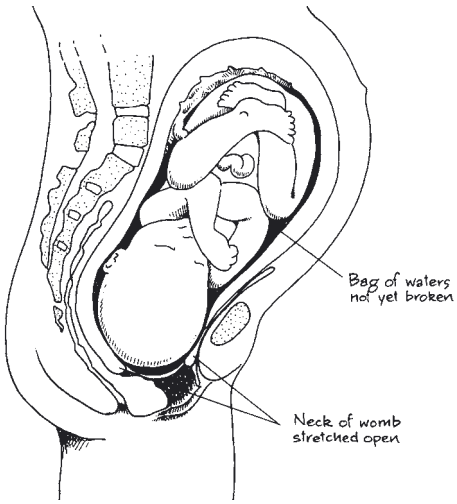
First stage

Every labour and birth is different and varies depending when it starts and how long it takes. Your midwife or doctor can answer any questions you might have about your labour and birth and what you and your partner can do to prepare.

What happens in labour?

There are three main stages of labour. The time taken for each stage will vary from woman to woman. Everyone's different.

First stage



This is when the contractions of your uterus are opening up your cervix (neck of your womb). They gradually open up the cervix until it's about 10cm open, enough to let the baby through. On average, the first stage lasts from 10 to 14 hours for a first baby, and about eight hours for a second baby.

How can I tell if I'm in labour?

The signs include:

Contractions
These may feel like:

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

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

In early first stage, they mean your uterus is working to help make your cervix shorter and thin out, as well as open so the baby can come out. For your first labour, this shortening and thinning of the cervix can be hard work and can make you really tired so it's important to rest when you can. This process may take up to a few days.

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

You may feel anxious or even out of control when contractions become stronger and closer together. It helps to try and focus on relaxation techniques and breathing at this time.

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

FAQ
Q: Can children be with me in labour?

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

FAQ
Q: Will perineal massage help prevent tearing?

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

Your waters break

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

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

Should I go to hospital straight away?

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

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

During this time, it's helpful to:

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

It's okay to eat or drink normally, unless you have been told not to. During your pregnancy, your midwife or doctor will have discussed with you when you should go to hospital, and who to contact when the time comes.

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

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

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

What happens when I get to hospital?

This depends on the hospital, so this is only a guide. When you arrive, a midwife would normally:

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

The midwife will continue to regularly check your progress and the baby's condition from time to time during the first stage. You may feel like changing positions frequently, using hot packs on your back or belly, a back rub, warm showers or bath/spa/birth pool. If your waters have broken, you may not be able to use the bath/spa/birth pool due to the risk of infection to your unborn baby. There are more ideas in the following section.

Ask your midwife and your support person to help you find a position that is comfortable for you and experiment e.g. standing, squatting or kneeling on all fours. Progress of labour depends on a few things, including the baby descending or going down through the pelvis, and the cervix or neck of the womb opening up (dilating) with strong regular contractions.

Helping your labour along

There are many ways that you can help your labour along. Labouring is hard work. Unless your midwife or doctor advises you not to eat or drink in labour it's important to eat and drink small amounts in the early stages of labour, as you may not feel like it later. Other ideas include:

Feeling as relaxed as possible

Things that may help include:

- music or relaxation tapes
- aromatherapy
- relaxation and breathing techniques.

Heat

Hot packs placed on the lower abdomen and/or back. Some hospitals don't allow these in case of burns, so check first with your midwife.

Hot showers. Some delivery suites and birth centres have baths too.

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

Keeping active
Walk around the room or up and down corridors while you can.

Being active can help keep your mind off the pain. Lean on your partner or support person if it helps.

Changing positions

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

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

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

Pain relief in labour

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

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

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

Many of the suggestions in *Helping your labour along*, on page 36, such as staying active and changing positions, will help you to cope with pain. But if you want to use medication that's OK too. Here's a summary of the common types of medication available. For further information on this topic including different options and side effects talk to your midwife or doctor.

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

Drug	Description	Main advantages	Main disadvantages	Effect on baby
Paracetamol	Tablets.	• You can take them at home • Safe to use in pregnancy.		No known effect.
Gas	Mixture of nitrous and oxygen gas, which you breathe through a mouthpiece or mask.	• You control how much you use. • Short-term – effect doesn't last if you want to stop using it.	• Takes edge off pain, rather than blotting it out. • May make you feel nauseous, drowsy or confused.	No known effect.
Pethidine	Narcotic drug, which is injected.	• Provides good pain relief.	• May make you feel nauseous or drowsy.	If given close to when the baby is born, baby may be sleepy and slow to breathe (this can quickly be reversed).
Epidural	Anaesthetic, which numbs you from the waist down. A small tube is inserted into your lower back and the epidural is 'topped up' when needed.	• Gives more long lasting pain relief.	• You won't be able to move around during labour. • Can make it harder for you to push the baby out during labour. • Increases likelihood of other interventions, eg oxytocin to progress labour; forceps delivery or vacuum extraction. • May leave your legs numb for a while after the birth.	Unknown.

Medical intervention and birth – things to know before labour starts

For many women, the ideal birth is one that's as natural as possible. But some women need – or choose – some form of medical technology to help them through.

There are some concerns that technology is used too often in childbirth in Australia. Again, there are different opinions. Some people say using technology makes childbirth safer. Others say that having one intervention can mean you end up needing extra interventions. One example is that having a labour induction may make it harder to cope with contractions. This means you may need stronger pain relief than if you went into labour naturally.

If you're healthy and your pregnancy and labour are normal, there's little need for any intervention.

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

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

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

Induction (of labour)

This means trying to start labour artificially rather than letting it happen naturally. Reasons for induction may include a multiple birth, diabetes, kidney problems, high blood pressure or when a pregnancy is overdue – past 41 weeks.

Remember that your due date is an estimate of when the baby is due and that term is anywhere between 37-42 weeks.

Medical ways to induce labour and start contractions include:

- **Sweeping the membranes** This is a relatively simple technique. During an internal examination, the midwife or doctor makes a circular movement with a finger to disturb the membranes. The evidence suggests that sweeping does promote the onset of labour and does reduce the need for other methods of induction.
- **Prostaglandin gel** Prostaglandin is a hormone your body produces. It helps your cervix soften. Applying a synthetic hormonal gel near the cervix can do the same. It may also start contractions. It can take six to 18 hours to take effect. One of the risks is that it can over-stimulate your uterus and create difficulties for the baby.
- **Breaking the waters (called an amniotomy)** It is done by the doctor or midwife inserting an instrument into the vagina and through the open cervix, to gently puncture the membrane holding the amniotic fluid that surrounds the baby. This allows the baby's head to press down on the cervix more, increasing the hormones and contractions. It may take about 12 hours to take effect.

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

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

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

Monitoring the baby in labour

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

The heartbeat can be monitored by:

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

Augmentation

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

Episiotomy – the pros and cons

An episiotomy is a surgical cut in the area between the vagina and the anus that may be done during birth.

During the birth, there's a chance that your perineum (the place between your vagina and anus) may tear when the baby's head comes through. This is more likely to occur when forceps are used.

Not everyone agrees on the best way to deal with this. Some experts think it's best to make a neat surgical cut in the perineum (episiotomy), if it looks like it's going to tear. Others say it can be better to let the perineum tear naturally. Although it may not be as neat as a cut, it may go through fewer layers of tissue and cause less damage, bleeding and pain.

Talk to your midwife or doctor about this before labour.

Delivery using forceps or vacuum extraction (instrumental delivery)

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

- the mother is having difficulty pushing the baby out
- the baby is in an awkward position
- the baby isn't getting enough oxygen.

There are two methods of instrumental delivery:

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

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

Health alert!!!

The risk of respiratory problems is increased in babies born by caesarean section before or without labour but this risk decreases significantly after 39 weeks. Therefore, planned caesarean section should not routinely be carried out before 39 weeks.

Caesarean birth

This means the baby is born through a cut (incision) through the abdomen into the uterus. The caesarean is usually done with a low horizontal cut just below the bikini line so the scar is hidden by pubic hair. Some caesareans are 'elective' (this means they're planned), others are emergencies.

Caesareans are done for different reasons, eg:

- the baby's head is too big for your pelvis
- the baby is an awkward position – bottom or feet first, or lying sideways
- for some multiple births
- the baby is distressed during labour
- you or your baby is at risk for some reason, and birthing needs to be quick.

A caesarean is usually done with an epidural or spinal anaesthetic, or sometimes under general anaesthetic. In the event that you require a caesarean, you will find it helpful to have information about the procedure including anaesthetic options.

For example, with an epidural anaesthetic you're conscious (awake) when your baby is born. Another advantage is that, unlike a general anaesthetic, your partner may be allowed into the operating theatre so you can both see the baby at birth. It's also an excellent way to provide post-operative pain relief. Just in case you do need a general anaesthetic, you could ask for your partner to be allowed to hold the baby and accompany it to the nursery after the birth.

After a caesarean, your baby may need extra care. You'll feel uncomfortable for a few days (it's hard to stand up straight). This may make it difficult to care for your baby. You'll usually have a IV drip for one to two days. You may need longer in hospital – this varies. Exercises are very important after a caesarean to get your muscles working again. Your midwife, doctor, physiotherapist will advise you when to start.

Transition period

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

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

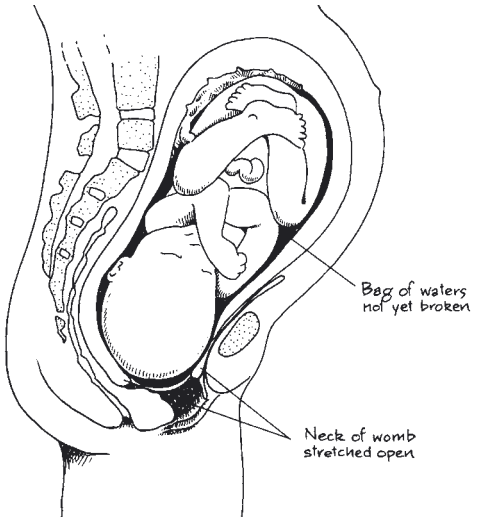
- shaky
- hot and cold
- nauseous (you may even throw up)
- irritable or anxious
- you can't cope any more
- out of control.

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

How long does this last?

This usually lasts anywhere between five and 45 minutes.

Transition



Second stage

This is when it's your job to help push the baby out. You will probably feel a strong urge to push as if you need to go to the toilet. There may be a stretching, burning feeling as the baby's head gets to the entrance of the vagina. This is when some women tear along the perineum (the part between the vagina and anus) – see the section on *episiotomy* on page 40. You may want to use a mirror to watch the baby's head come out.

How long does this last?

There is no hard and fast rule about length of second stage while you and the baby remain well. The second stage usually lasts about an hour for a first baby and between 15 and 30 minutes in second babies, but epidural blocks may prolong this stage.

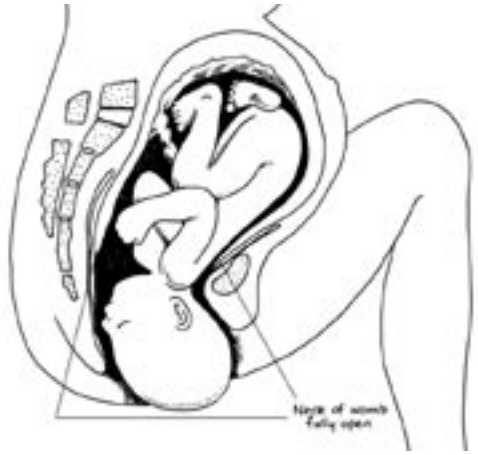
What's the best position for giving birth? The one *you* find most comfortable. Use the position that feels best for you and also uses gravity such as sitting, squatting, straddling a chair or standing.

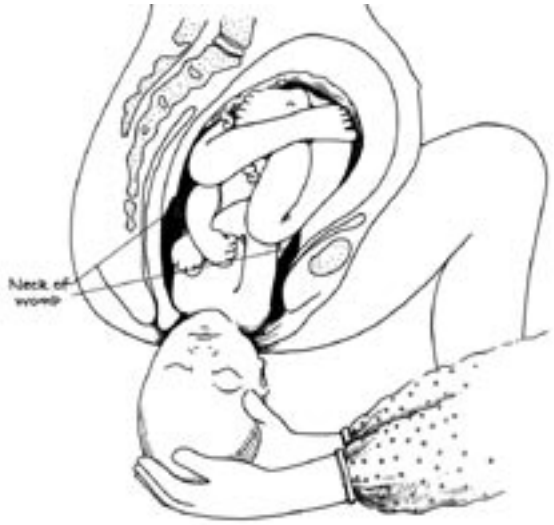
These positions are better than lying down. You have gravity to help you. They also make the baby's head press down more on your cervix. This makes you release a hormone that helps the contractions.

You might prefer to be on your hands and knees. This position can help with pain relief as it takes the pressure off your back.

Compared to giving birth lying down, these positions may make labour a little shorter and less painful. Lying on your back can be especially uncomfortable if you have lower back pain with the contractions.

Second stage





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

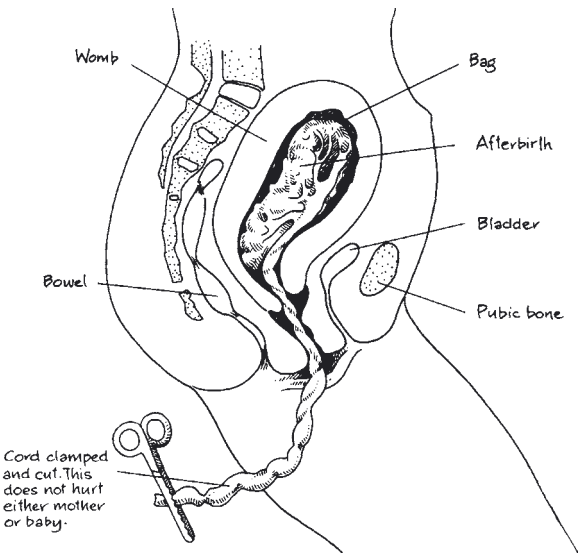
Third stage

The third stage of labour is from when your baby was born until the uterus pushes out the placenta. This part is usually much easier – shorter and less painful. However, it is a very important stage and must be complete before everyone can relax.

How long does this last?

Most women have an injection to help the uterus push out the placenta more quickly (in about 20-30 minutes). Some women may want to wait and let the placenta come out naturally without an injection. This can take up to 70 minutes and can increase the risk of heavy bleeding. Talk to your midwife or doctor when you are pregnant – this will help you make an informed choice. Some women who have had previous babies find that the 'after pains' are more painful with each birth.

Third stage



Support in labour

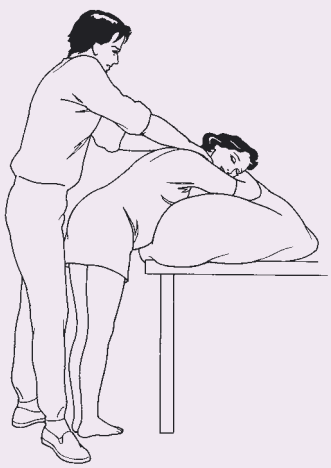
Who will support you?
Studies show that women who have someone with them all the time through labour (midwife, doctor, partner, friend or relative) are less likely to need medication for pain relief to help them to labour and have a shorter length of labour.

It can be helpful to have people around you who can provide both emotional and physical support during labour. This might be your partner, mother, sibling or a close friend. You can have more than one person with you.

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

They can:

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



What happens to the baby after birth?

Usually the baby will be put onto your tummy (still attached by the cord). You can have skin-to-skin contact and be close. This is good for the baby because it:

- keeps the baby warm
- lets the baby feel your heartbeat and smell your skin. This tells the baby you're there and helps him or her adjust to life outside your body
- encourages the baby to breastfeed (this early skin-to-skin contact is important even if you're not breastfeeding).

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

Can I breastfeed after the birth?

Yes, if you and the baby are well. Putting your baby to the breast soon after the birth:

- helps get breastfeeding off to a good start
- helps your uterus contract and push the placenta out
- helps reduce your bleeding.

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

What if I'm not planning to breastfeed?

It's still good for your baby to have skin-to-skin contact. Hold the baby between your breasts (this prevents the baby from stimulating the nipple thus encouraging your milk supply).

Checks after your baby is born

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

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

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

After a while, your baby will be examined, weighed, measured and given identification bracelet/s. If you have agreed/consented, he or she will also be given Vitamin K and Hepatitis B injections. The baby will be dressed and wrapped in a blanket. If there are concerns about your baby keeping warm, he or she may be put on a warmer (a little bed with a heat lamp).

After the baby is born – what happens in hospital

How long will I stay in hospital?

This varies from hospital to hospital – check with your midwife or doctor. As a guide, you'll probably stay in hospital for about three days if there are no problems and the baby is feeding well. If you had a caesarean, you may be in hospital for five or six days.

Some hospitals have postnatal care at home, which lets you go home earlier – perhaps in 24 hours or less. A midwife will ring and/or visit you at home for up to 14 days. This includes postnatal checks for you and your baby, making sure the baby is feeding well, advice on postnatal exercises, and on caring for yourself and your baby. Early discharge means less disruption to family life, and less separation from other children. It may be a good option if:

- you and the baby are well
- you have a partner or someone else to give you good support at home (so you can rest).

The midwife may also recommend midwifery home visiting if you need additional support.

Your uterus Don't expect to have a flat tummy for a while. It takes a few weeks for your uterus to get back to normal – this happens faster if you breastfeed. You'll feel some cramps as your uterus contracts down to its normal size. They can be more noticeable when the baby is sucking.

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

Your vagina and perineum If you had a vaginal birth, sitting down can be uncomfortable, especially if you have stitches. Dissolving stitches are used, so you don't need to have them removed. The midwives will check the area to make sure it's healing normally. Keep the area clean and dry by washing two or three times a day and after a bowel movement. Change pads frequently. The best remedies for pain relief are cold packs and anti-inflammatory painkillers.

Your breasts Don't panic if they become huge, lumpy and painful in the first few days when your milk 'comes in'. It means they're engorged with milk – they don't stay this way. Frequent feeds and warm showers will settle them down. Breast engorgement can be more of a problem if your baby has difficulty latching on. Your midwife will help you with this. See *Feeding your baby,* starting on page 125 for more information.

If you've decided not to breastfeed, your breasts will gradually get back to normal by themselves after a few days. To help suppress your milk:

- avoid touching your nipples
- keep the baby away from the nipple (you can still have skin to skin contact by putting the baby between your breasts)
- keep the breasts as cool as possible. Use ice packs and keep hot water away from your breasts in the shower.

If your breasts hurt, a good supporting bra and painkillers will help.

Your caesarean scar The caesarean scar is usually a low horizontal cut on your tummy, below your bikini line. Small clips are mostly used these days instead of stitches. The scar can be sore and uncomfortable up to a few weeks. You will be given pain killers in the first few days to help ease the pain as you gently and slowly move around and lift your baby. The clips will be taken out around day 4 or 5. You will be encouraged to cough to prevent lung problems. The midwife or physiotherapist will show you exercises without putting a strain on the scar. The midwives will help you care for the baby.

Your feelings Even though you feel tired, you may be on a high for the first day or so after the birth. This is sometimes called the postnatal pinks – and they can soon be replaced by the blues. You may feel:

- sensitive
- weepy
- irritable.

Most women go through this for a few days after the birth or even up to two weeks. If it lasts longer than this, talk to your doctor. See *At home with your baby – the first few weeks of parenthood* on page 53 and *Your feelings in pregnancy and early parenthood* on page 134.

FAQ
Q: Do I need immunising against rubella?

A: If the blood tests you had early in pregnancy showed you had little or no immunity to rubella, it's a good idea to be immunised before you leave hospital. It's important not to get pregnant for three months after vaccination.

Looking after your baby in hospital

Routine checks for newborn babies

Before you go home your baby will have:

- A careful examination by a doctor or midwife specially trained to do this. This is called the newborn examination. It's in addition to the examination done just after the baby is born.
- A blood test to check for some disorders. Most babies are healthy and don't have these disorders, but it's best to make sure.

Remember that these examinations and tests can't rule out all possible problems with your baby. If your baby is unwell, or you are worried about a health problem, take your baby to your doctor, Child and Family Health Nurse or the nearest hospital Emergency Department as quickly as possible. The condition of a new baby can change very rapidly.

Tests to protect your baby

All babies born in NSW have tests for the following problems. These disorders are rare. Before leaving hospital, a few drops of blood are taken from the baby's heel. These are put on to special paper and sent to a laboratory for testing. Make sure the baby has this test (Newborn Screening Test) – if you have a home birth or go home early, check with your midwife.

Congenital Hypothyroidism This is caused by problems with the thyroid gland. Early treatment means children develop normally.

Phenylketonuria This means the baby can't properly use a substance (in milk and food) called phenylalanine which helps make protein in the body. If the problem isn't treated, phenylalanine builds up in the blood and causes brain damage. Treatment will help the baby develop normally.

Galactosaemia This is caused when a type of sugar in milk (galactose) found in both breast and cow's milk builds up in the blood. Prompt treatment with special galactose-free milk will prevent serious illness. Without treatment, a baby may become very sick and die.

Cystic Fibrosis This disorder makes the body produce mucus that is thicker than normal in the bowel and lungs. This can cause chest infections and diarrhoea and may stop the baby gaining weight. Improved treatment means people with cystic fibrosis now have a longer lifespan.

Early diagnosis and treatment are important for all these disorders.

Other disorders It's possible to detect some other extremely rare disorders, using the same blood sample. This means treatment can be started quickly.

Will I get the results of these tests? Not if the result is normal (most test results are).

About one baby in every 100 will need a second blood test if the first test did not give a clear result. Parents will be contacted if a second test is needed. The second test almost always gives a normal result. Your doctor will be sent the result.

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

After the dried blood has been tested, it will be stored in the laboratory. Rarely, it may be used at a later time to provide new medical information that your family may need. The stored blood sample may be used for research (but without identifying your baby). The sample will not be tested for any other problems in your baby unless a parent or guardian gives consent in writing.

There are simple treatments that can minimise the baby's pain during procedures such as this.

Hearing test for babies

Why does my baby need a hearing check?
About 1 to 2 in every 1000 babies has a problem with hearing that needs help. The NSW Statewide Infant Screening – Hearing (SWISH) Program aims to make sure these babies are identified.

Like all babies in NSW, your baby will be offered a series of routine health checks in the first few weeks of life. These checks will include a test for hearing loss. The test will be offered as soon as possible after birth. If the test

can't be done in hospital for some reason, it can be done in hospital outpatients or at a local community health centre soon after you leave hospital.

The test takes about 10-20 minutes and is done when your baby is asleep or resting quietly. You can stay with your baby while the test is done. The test doesn't usually upset the baby. You will get the results as soon as the test is finished. These results will be written in your baby's Personal Health Record (see page 52).

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

Injections to protect your baby

Newborn babies need two injections in hospital before they go home. These are a vitamin K injection, and immunisation against hepatitis B. It's up to you whether the baby has these injections – but they're strongly recommended to protect your baby. These injections are free in public hospitals. You will usually receive information about these injections during the pregnancy.

Vitamin K injection

This vitamin helps prevent a rare but serious disorder called Vitamin K Deficiency Bleeding (or VKDB). This can cause serious bleeding which may affect the brain. Newborn babies may not have enough vitamin K in their bodies to prevent VKDB. By six months of age, they usually build up their own supply.

Vitamin K can be given by injection or by mouth. An injection is more convenient because it's one dose only and lasts for months. Babies need the injection if:

- they are premature or sick
- their mothers took medication in pregnancy for epilepsy, blood clots or tuberculosis. Tell your doctor or midwife if you take any of these medications.

Vitamin K can be given by mouth but the effect doesn't last as long. This means the baby needs three separate doses: at birth, at three or five days after birth, and at four weeks of age. *The third dose is very important for parents to remember! Without it, the baby may not be fully protected.*

Does vitamin K have side effects? Vitamin K has been given to babies in Australia since 1980 and Australian health authorities believe vitamin K injections are safe. Although one overseas study in 1992 suggested a link between vitamin K injections and childhood cancer, six other studies have found no link.

Parents who decide against vitamin K should look out for any symptoms of VKDB. These include:

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

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

Hepatitis B immunisation

Hepatitis B is a serious chronic liver disease caused by a virus affecting the liver. Some people with this virus may have no symptoms or only mild symptoms. But up to 25 per cent of people affected may get serious liver disease later in life, especially if they caught hepatitis B as children. Immunisation helps prevent this.

Why immunise babies at birth? It's important to start hepatitis B immunisation as soon as possible after birth to make sure the immunisation is as effective as possible. Babies need three further hepatitis B injections, at two months, four months and six or 12 months of age. These are given with other routine childhood immunisations.

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

Newborn babies: common features and problems

Birthmarks and skin

Telangietatic nevi – 'Stork bites' These are pale pink or red spots found around the eyelids, nose or neck. They appear more prominent when the baby cries. They don't cause any problems and will fade over time.

'Mongolian spots' These are bluish-black pigmentations found around the buttocks. They are common in dark-skinned races. They don't cause any problems and will fade by the first or second birthday.

Nevus flammeus – 'Port wine stain' These are red-to-purple sharply defined areas that usually appear on the face. They do not grow but they do not fade with time.

Nevus vasculosus – 'Strawberry mark' A raised, clearly defined, dark red area that usually appears on the head. They initially increase in size and then will gradually shrink over time.

Milia White raised spots that a baby may have over their nose and sometimes face. These are exposed sebaceous glands and are considered normal and will fade over time.

Yellow/white pustules – 'Erythema toxicum' Small white or yellow pimples or pustule type of rash that may appear suddenly, usually over the trunk and nappy area within the first 12 – 24 hours of life. The cause is unknown and no treatment is necessary. The pustules disappear in a few hours or days.

Eyes

Some newborn babies have sticky eyes in the early days and weeks after the birth. This isn't serious and will usually goes away by itself, or after regularly using cool boiled water to cleanse the baby's eyes. If it persists, you should consult your doctor.

Genitals

Female babies
Sometimes, newborn female babies may have a small vaginal discharge composed of thick white mucus, which may sometimes be tinged with blood. This is called pseudomenstruation and is caused by the withdrawal of maternal hormones. This is considered perfectly normal. A white cheese-like substance called smegma is often found under the labia, again this is considered normal.

Male babies
There is no need to retract the baby's uncircumcised foreskin – it will roll back by itself when the child is about 3-4 years of age. There are conflicting points of view about the risks as well as the possible benefits of circumcision. The Royal Australasian College of Physicians (RACP) recommends that there is no medical indication for routine male circumcision. More information is available at www.racp.edu.au/hpu/paed/circumcision

Jaundice

Many newborn babies have what is commonly called jaundice where the baby's skin appears slightly yellow in the first few days of life. This isn't usually serious but in some cases a test maybe required to measure the level of bilirubin in the baby's blood. If the bilirubin is considered higher than normal then the baby will be encouraged to drink more, and may be placed under 'phototherapy lights' or placed on a BiliBed for a period of time until the jaundice has subsided. Babies should not be placed in direct sunlight, as it can be harmful causing sunburn.

For more information on jaundice and newborn babies, go to www.health.nsw.gov.au/health-public-affairs/mhcs/publications/7295.html

Umbilical cord care

Initially the umbilical cord is white, thick and gelatinous in appearance. However, the cord begins to dry within one or two hours of birth and will fall off within seven to ten days. The cord area does not need any special care except to be kept clean and dry.

Practical things

The Personal Health Record (Blue Book)

Before you leave hospital, your baby will be given a blue plastic folder. This Blue Book is for parents, doctors, Child and Family Health Nurses and other health workers to record details of your child's health from birth to the teenage years. It's a great way to keep important health information all in one place (keep it somewhere safe).

Take this book each time you take your child to the Child and Family Health Centre, hospital or doctor. The Blue Book also has:

- reminders about important health checks and immunisation for your child
- useful telephone numbers
- a page to write down phone numbers such as your hospital, doctor, Child and Family Health Centre or other health services.

Child and Family Health Centres and Home visits

Before you leave hospital, staff will put you in touch with your nearest Child and Family Health Centre (Early Childhood Health Centre). These centres have free services for families with children under five years of age, including health checks for your baby. They're the place to go for advice or information about:

- your baby's or preschooler's health and development,
- feeding your baby
- crying and settling your baby
- playing with your baby
- the immunisation schedule
- your own wellbeing
- other services in your area.

Maternity Payment and Family Tax Benefit

While you're in hospital, you will be given the Centrelink form that you use to claim the:

- Maternity Payment. This is a one-off, non-income tested payment for each child born to Australian residents. This payment is also made if the baby is stillborn or dies soon after birth.
- Family Tax Benefit. This is a payment to help families with the cost of raising children. It is worked out on your family's total annual income, and the ages and number of dependent children in your family.

Forms are also available from Centrelink. You can get further information about benefits from the Family Assistance Office on 13 61 50.

Registering the birth

The hospital will give you a form so you can register your baby's birth. By law, this must be done within 60 days of the birth.

Australian Childhood Immunisation Register

It's important to register your baby with Medicare as soon as possible after birth. This ensures your baby is on the Australian Childhood Immunisation Register. You'll receive reminder notices when immunisations are due or overdue.

At home with your baby – the first few weeks of parenthood

What's happening to me?

Bringing your baby home can be a wonderful time, but it can also be chaotic and exhausting.

Life with a new baby is demanding and unpredictable. This makes it hard to find time for your own needs – even things as basic as having a shower or making a sandwich. You'll be tired, and sometimes overwhelmed. It may feel as if you have no control over your life.

This is normal. It doesn't last. By six to eight weeks, you'll start to get more organised. By three to four months, this will be more settled.

Good ways to survive these early weeks include:

- Try and nap during the day when the baby sleeps.
- Do as little as possible. Keep housework to a minimum (you and the baby are more important).
- Get your partner to bath and change the baby – it gives you a break and helps the baby get to know both parents.
- Remember your relaxation techniques (see *Getting ready for labour – self-help techniques*, which starts on page 106). Use the techniques if you feel edgy or when you want to rest.
- Save energy by sitting down to do things. Sit on the floor or lounge to change a nappy; sit down to fold laundry; lie down to breastfeed.
- Keep food simple, as you won't have time or energy for much cooking. The simplest meals are often the healthiest, such as salads with some lean grilled meat or fish, canned fish or cold chicken with wholegrain bread. Snack on fresh fruit and yoghurt.
- If friends drop in, ask them to give you a hand if there are things to do like shopping or putting out the washing, as most people like to feel useful.
- Try to have 'time out' every day, even if it's only 20 minutes to have a bath, read a magazine, go for a walk, watch TV or phone a friend.
- Remember that if you don't care for yourself, you'll be in no shape to care for anyone else.

All new parents need support especially if you don't have family close by or you're a single parent. Don't be afraid to ask for help and accept all offers of support.

Some parents find it hard to sort out the different advice they get from friends, family and health professionals. Some advice may be good, some not so good. It's best to decide on a couple of people whose advice you trust. Then do what feels right for you and the baby – trust your intuition. If you're confused or don't know what to do, call your Child and Family Health Centre or one of the other services listed in the last section on page 59.

"You have no conception of how difficult that first week at home is going to be – you find yourself screaming at each other at 4am in the morning because the baby won't stop crying. The most helpful thing was my partner taking four weeks off after the birth. I know other women whose partners only took a week off and they cried when they returned to work.

The other thing that made a huge difference was cooking and freezing meals for two weeks in advance – it's even better if you can get your mother in-law to make her lasagna as well." Kate

Looking after you

Your body

Vaginal bleeding (lochia) This will continue until about two to four weeks after the birth. After the first few days it should be pinky brown, rather than red. See your doctor if the bleeding becomes brighter, heavier, you pass clots or the bleeding is smelly.

Constipation This may be a problem but there are simple solutions. Some of the fastest foods – big salads with raw mixed vegetables, fresh fruit, dried fruit, wholegrain bread, baked beans on toast – are big on fibre. Drinking plenty of fluids (less tea and coffee) and walking help too.

Vaginal or perineal stitches If you have stitches, you'll still be sore. Keep up the cold packs and use anti-inflammatory painkillers (eg Nurofen) if necessary. Some people may suggest bathing the area with salt water, but there are concerns that salt may weaken the stitches. See your doctor if the area becomes more painful or inflamed. Don't worry if you shed bits of brown stitches over the next few weeks. The repairs aren't falling apart – it's just your stitches gradually dissolving as the area heals.

Sex It's okay to have sex when the bleeding has stopped – usually by four or six weeks. Some women do want to have sex at this time but there's a good chance that all you want to do in bed is sleep. Besides fatigue, other things that can make sex difficult are:

- **Stitches** If you've had stitches it may take longer than six to eight weeks before sex feels comfortable – if penetration still hurts after three months, see your doctor.
- **Less lubrication** Hormonal changes mean your vagina isn't as well lubricated as usual. This will get better after about 10 weeks – until then try a lubricant and more foreplay.
- **Your feelings about your body** Some women feel okay about their bodies at this time – but some don't. You may feel shapeless. You may feel like your body isn't your own. It's not your pregnant body – but neither is it the body you had before.

The good news is that in a few months your shape and your sex life should start to improve. Things that will help you through this time are:

- Talk to each other about how you feel.
- Have some 'couple time'.
- Don't expect too much the first time you have sex.
- If it's uncomfortable, wait for another week or so.
- Remember that there are other ways to feel close and enjoy each other.
- If you don't want your breasts to spurt milk when you have sex (though some couples are fine with this), feed your baby or express some milk first.

Six-week check See your GP (or obstetrician, if you had one) for a check-up six weeks after the birth – or you can wait until eight weeks when the baby's immunisation is due. This check is important to make sure everything's back to normal. You'll have an internal examination and a Pap test (if you didn't have a Pap test at the beginning of the pregnancy).

Contraception Don't wait until your six-week postnatal check to think about contraception – it's possible to get pregnant before that even if you are breastfeeding.

If you are breastfeeding, you won't be able to take the combined pill because it affects your milk supply. But there are some options that won't affect your milk. See your doctor or FPA Health clinic to talk about what would suit you best. You can get more information on the FPA Health website at www.fpahealth.org.au or call the FPA Healthline on 1300 658 886.

Contraceptives

Hormonal contraceptives

Depo-Provera (contraceptive injection) is the only hormonal contraception approved in Australia for women who are breastfeeding. Some other hormonal contraceptive methods are used, but aren't actually approved for breastfeeding. These contraceptives don't affect your milk supply, but small amounts of hormone will get into breast milk.

- **Contraceptive injection (Depo-Provera)** This is a hormonal injection that you have every three months to prevent pregnancy. Unlike the pill, you don't have to remember to take it every day. If you want to use it after having a baby, the best time to have the injection is five or six weeks after the birth. A small amount of the hormone will go into the breastmilk. Depo-Provera is effective straight away. It's important to make sure you're not pregnant before having the injection.
- **Progestogen-only pill (or mini pill)** This is a reliable contraceptive, as long as you remember to take it at the same time every day. You can start taking it shortly after birth (talk to your doctor). You need to use condoms for 48 hours until the mini pill takes effect.
- **Implanon** A small rod implant inserted under the skin of the inner arm. It releases small amounts of a hormone that prevents pregnancy with a less than 1% failure rate. It stays in place for three years. Implanon must be inserted by a doctor who has been trained to do this. It can take up to a week for Implanon to become effective. You need to use condoms until it takes effect. Some women have had irregular bleeding as a side effect.

IUCD (Intra Uterine Contraceptive Device or IUD)

A small plastic device is inserted inside your uterus (womb). You could have the IUCD put in at your six-week check after the birth, but it's usually done at least eight weeks after the birth. However, it may not be the best choice if you have painful or long lasting periods. It's not suitable for women who have more than one sexual partner, or whose partners have other sexual partners.

Condoms

Condoms are an effective contraceptive. They don't contain hormones. You may need to use extra lubrication with condoms while you're breastfeeding.

Female condom

Women can use this condom especially if they have a latex allergy. It lines the vagina and provides a barrier for sperm and infections (STIs). It is available through FPA Health and sexual health clinics.

Diaphragm or cap

If you normally use a diaphragm or cap, you may need a different size to the one you used before. Your doctor can check this at the six-week visit.

If you're not breastfeeding, you can use the combined pill, as well as the options above.

Getting back into shape

Don't expect to get back into your old jeans just yet. Accept that your belly will bulge for a while and the skin may look loose – but it's not forever. Healthy eating, regular exercise and time will get you back into shape. For information about postnatal exercise, see the sections *Give me strength – pre and postnatal exercises,* page 96 *and Handle with care – looking after yourself in pregnancy,* page 62.

Being active with a new baby is easier than you think. You can:

- Entertain your baby by letting him/her watch you do your postnatal exercises.
- Go for regular walks with the baby in a sling, backpack or stroller. Walking helps you get fitter and stronger, and gives you energy. Babies like getting out and seeing new things. It helps them learn about their world.
- Join a pram-walking group. These are groups of new mothers who get together to walk, talk and have fun. They're a great way of getting out and meeting people, lifting your mood and getting back into shape all at the same time. To find out if there's a pram-walking group near you, contact your Child and Family Health Centre or community health centre. For more information, contact the NSW Department of Sport and Recreation. Tel. 13 13 02, or visit website: www.dsr.nsw.gov.au
- Find out what other activities are available in your area – some community exercise programs and gyms offer childcare. Ask at your community health centre.

Helpful hint: More good reasons for doing your pelvic 'squeezes'

Don't forget to keep up the pelvic floor exercises – see *Give me strength – pre and postnatal exercises*, on page 96. As well as giving you good bladder control, strong pelvic floor muscles can help improve sexual pleasure for both partners.

FAQ
Q: Will breastfeeding prevent pregnancy?

A: The World Health Organisation (WHO), says breastfeeding can be 98 per cent effective at preventing pregnancy for the first six months after birth as long as:

- you breastfeed your baby during the day and night
- you don't go for more than four hours without breastfeeding – if you go without breastfeeding for longer than this for some reason, you'd need to express milk every four hours
- you don't give the baby any other food (babies only need breastmilk for the first six months)
- you haven't had a period.

FAQ
Q: When will I get my periods back?

A: This depends. If you breastfeed, you may not get them until after you stop breastfeeding. If you bottle feed, you may get a period four weeks after the birth. Just remember that you will ovulate before you get your period – this means you can get pregnant again unless you use contraception.

Feeling down after the baby is born

Signs that you may need help

There's nothing unusual about feeling down or overwhelmed when you're at home with a new baby. The chances are you're worn out, your body is recovering from childbirth, and you're learning a new and challenging job – parenting. But if you're still feeling depressed and inadequate more than two weeks after the baby is born, talk to your GP or your Child and Family Health Nurse as soon as possible. You may have postnatal depression (PND). If you do feel depressed:

- You're not alone.
- You don't have to feel this way – PND can be treated successfully. It's more easily treated if you get help soon.

Symptoms of PND may begin before the birth, or after the birth, or they may start some months later. For more information about PND, including symptoms, see *Your feelings in pregnancy and early parenthood*, on page 134.

The following information has been developed by the *beyondblue National Postnatal Depression (PND) Program* from the '*Frequently Asked Questions'* section and more information can be found at the following web site address: http://www.beyondblue.org.au/postnataldepression/

What is postnatal depression?

Postnatal depression is the name given to the mood disorder that occurs in approximately 14 per cent of women in the months following childbirth. It can develop at any time in the first year after your baby is born and can begin suddenly or develop gradually and may persist for many months. If left untreated, it could develop into a chronic depression or recur after a subsequent pregnancy.

Is postnatal depression and the baby blues the same thing? No. Postnatal depression is different from experiencing the baby blues. The baby blues is a relatively mild period of sadness, which peaks three to five days after birth and affects up to 80 per cent of women. Women with the baby blues cry more easily, may be more irritable and more easily upset than usual. There is usually no specific treatment aside from empathy and emotional support from family, friends and hospital staff.

Am I a bad mother if I become depressed? NO! The tasks of motherhood are enormous and there are lots of things to learn. Most women want to be good mothers and anything less than perfection can seem like an enormous disappointment. Some people have unrealistic expectations of pregnancy and motherhood.

These expectations may lead women to blame themselves and be reluctant to seek help. Mothers may worry that they will be labelled as an inadequate or poor mother, rather than recognising that it takes time to adjust to motherhood.

Fathers and postnatal depression

New fathers can get postnatal depression too. As a new father, you need to look after your own physical and emotional wellbeing. Suggestions include:

- Make sure you have some time to yourself, apart from work and family.
- Try to keep up important hobbies and interests as much as possible.
- Talk to close family and friends about your feelings and concerns.
- Talk to your Child and Family Health Nurse or GP.

Some helpful contacts

Local Women's Health and Community Centres
These centres provide information about services they offer and make referrals to other appropriate agencies. Many provide individual counselling and support groups. Telephone your local centre for more information (see the White Pages) or read more information on the Internet from the New South Wales Health website (www.health.nsw.gov.au).

Mothercraft advice contacts are as follows:

- Child and Family Health Centres
  See White Pages for contact details
- Karitane Cottages
  Randwick: (02) 9399 6999
  Liverpool: (02) 9821 4555
- Karitane Residential Unit
  Carramar: (02) 9794 1800
- Tresillian Family Care Centres
  Canterbury: (02) 9787 0800
  Wentworth: (02) 4734 2124
  Willoughby: (02) 8962 8300
  Wollstonecraft: (02) 9436 4086

Many new parents feel overwhelmed by the first few weeks of family life, and so do many babies. He/she has left his/her snug, dark place inside you and arrived in a strange and sometimes scary place full of unfamiliar sights and sounds. Important things to remember about new babies are:

- All babies cry. Some babies cry more than others. Some cry more than you would think possible. The afternoons and early evenings are often the worst. Comforting your baby quickly when he/she cries helps him/her feel safe.
- Babies who are comforted when they are upset and get what they need quickly – a feed, a dry nappy, a cuddle – tend to cry less.
- You can't spoil a newborn baby. Crying is your baby's only way of letting you know he/she needs you. Babies aren't old enough to be naughty or to get their own way.
- Remember that although this is your baby, the relationship between you both is new. Like anyone else you've just met it takes time to get to know how they behave, what makes them upset and how to comfort them – even if you've had a baby before.
- The chaos of the first few weeks doesn't last. Your baby will gradually get into a more regular pattern of sleeping and eating.

"We were really well prepared for the crying. One of the best things about the classes we went to in pregnancy was they really made a point of telling us how bad the crying could be and how it could go on and on for hours. We were psyched up to expect the worst and I think it really helped us cope." Tim

What if the baby won't stop crying?

All babies are different. It takes a while to know how to settle them. It can be very stressful when nothing you do seems to comfort your baby.

- Remember that babies are like anyone else – it can take time to calm down when you're upset.
- Put the baby in a safe place and go to another room for a short break. Make a cup of tea, or call a friend if you like. When you go back, you may find the baby is easier to calm.

Parents needing help with a crying baby can contact their local Child and Family Health Nurse or call for advice on the following 24-hour numbers:

- Tresillian Parent Helpline: Sydney (02) 9787 0855, or 1800 637 357
- Karitane Careline: 1300 227 464
- Child Abuse Prevention Services: 1800 688 009
- Men's Line: 1300 789 978

Regular checks for your baby

It's good if you can take your baby to the Child and Family Health Centre in your area regularly for the first few months. The nurse will:

- check your baby's growth, development and general health
- answer any questions you may have about caring for your baby
- help you with any problems or concerns you may have about yourself and refer you to other services that can help.

Your Child and Family Health Nurse can to link you into new parent groups, a great way to meet other new parents in your area and learn about parenting.

Health alert!!! Never shake your baby

Shaking your baby causes his/her head to jolt backwards and forwards and may cause bleeding in the brain. This can cause brain damage and may result in the death of the baby. If you feel yourself getting frustrated, upset or angry, put the baby in a safe place, walk away and take time to take care for yourself. Maybe go to another room for a short break. Remember, no matter how upset you get – never shake your baby.

Helpful hint: Don't share mouth bacteria

You may not think twice about putting something in your mouth that's meant for your baby – 'washing' your baby's dummy in your mouth, for instance, or sharing a spoon. But this can pass bacteria that cause tooth decay from your mouth to the baby. This can affect the baby's teeth in the future.

Reducing the risk of sudden infant death syndrome (SIDS)

Safe sleeping and your baby

It's important to know how to put your baby to sleep in a safe position. The risk of SIDS is highest in the first six months. There are three main ways to reduce the risk of SIDS:

1. Put baby on its back to sleep, from birth.
2. Make sure baby's head remains uncovered during sleep.
3. Keep your baby smoke-free, before birth and after.

Put your baby on the back to sleep, from birth

Sleeping on the back reduces the risk of SIDS. Babies are more likely to die from SIDS if they sleep on their tummies or sides. Put your baby on the back to sleep from birth unless your midwife, doctor or nurse tells you otherwise. Healthy babies placed to sleep on the back are less likely to choke on vomit than tummy-sleeping infants.

The side position is not recommended for babies as they may roll onto their tummies during sleep. If you choose to sleep your baby on the side, make sure that his or her lower arm is well forward to stop rolling onto the tummy.

When the baby is awake it's important to vary the baby's position from lying on the back. Tummy play is safe and good for babies when they are awake and an adult is present.

Older babies can turn over and move around the cot. Put them on the back but let them find their own sleeping position. The risk of SIDS in babies over six months is extremely low.

Make sure baby's head stays uncovered during sleep

Loose bedding can cover your baby's head. Tuck your baby in securely so that he or she can't slip under the bedclothes. Make up the bed so that the baby's feet are at the foot of the bed. Quilts, doonas, duvets, pillows, soft toys and cot bumpers should not be put where your baby sleeps during the first year.

Taking your baby into bed with you may be unsafe if he or she:

- gets caught under adult bedding or pillows
- is trapped between the wall and the bed
- falls out of bed
- is rolled on by someone who sleeps very deeply or who is affected by drugs or alcohol.

Keep your baby smoke-free, before birth and after

Cigarette smoke harms babies before birth and after. Parents who smoke during the pregnancy and after the baby is born increase the risk of SIDS for their baby.

If the mother smokes, the risk of SIDS doubles. If the father smokes too, the risk doubles again.

Make sure friends and relatives don't smoke near your baby.

If the baby is in the car, keep the car smoke-free.

Handle with care – looking after yourself in pregnancy

Exercising safely in pregnancy – and after the baby is born

If you exercise or play a sport regularly, check with your midwife or doctor that it's okay to continue while you're pregnant.

Some activities are safe, as long as you take things easy, stop when you feel tired and don't overheat. But some activities can pose problems, including contact sports that can cause injury, or anything with a risk of falling – eg: horse riding, cycling, gymnastics or skiing. Others include scuba diving (excess oxygen or carbon dioxide can harm the baby), water skiing, martial arts, lifting heavy weights, trampolining and parachuting.

- While you're pregnant, aim to stay fit and have fun – this isn't the time to push yourself or try to improve athletic performance.
- Your joints soften in pregnancy, making you more prone to injury in any sport/activity that involves jumping, twisting, changing direction or overstretching your joints
- Your growing baby makes your centre of gravity move forward. This can affect your balance.
- Avoid any kind of intense exercise that makes you overheat. Wearing loose, cool clothes, and drinking plenty of fluid will help keep you cool.
- Be careful with exercises done lying on your back – as the uterus and baby grows it can increase pressure on the main artery and vein that carries blood to and from your heart and may make you feel faint. If you feel dizzy, nauseous, short of breath or have symptoms like tingly fingers or spots before your eyes, roll onto your side. After the 20th week, avoid exercises lying flat on your back – it can reduce the blood flow to the growing baby.
- If you go to exercise classes, tell your instructor you're pregnant. You'll need to slow down your pace and avoid overheating. Remember to protect your joints by avoiding high-impact exercises, repetitive bouncing, or jarring movements or overstretching. Alternatively, look for a class that caters for pregnant women – ask your midwife or doctor.
- Avoid star jumps. Pregnancy weakens pelvic floor muscles – and star jumps can put even more pressure on them.
- Remember that exercise shouldn't cause pain. If it does, talk to your midwife, doctor or women's health physiotherapist.

Can I start yoga in pregnancy?

Yes. Just make sure it's a gentle form of yoga (and not the type of yoga done in a very hot room that may make you overheat). Tell the instructor you're pregnant and be sure not to overstretch.

How soon can I exercise after I've had the baby?

Although you've had your baby, your body isn't back to normal yet. Some of the changes that affected you in pregnancy stay around for a few weeks after the birth. Take things slowly.

If you've had a normal birth, it's okay to walk and do your abdominal, back and pelvic floor exercises as soon as you feel like it. See the section *Give me strength – pre and postnatal exercises*, starting on page 96.

It's best to avoid doing sit-ups until about six weeks after the birth. You can gradually get back to your normal exercise routine when the six-week period is up but avoid high impact exercise for 12 weeks after birth – just to make sure your ligaments are back to normal. If you've had a caesarean, check with your midwife or doctor to find out when you can return to normal exercise.

Warning signs to stop exercising

Stop exercising if you have symptoms such as:

- dizziness
- vaginal bleeding
- contractions
- pain
- unusual shortness of breath.

For more good (free) information on exercise and sport in pregnancy, see:

- *Mum's the Word,* a booklet available from the NSW Department of Sport and Recreation. Tel. 13 13 02 or visit www.dsr.nsw.gov.au
- *Exercise in Pregnancy* from Sports Medicine Australia. Tel. (02) 6230 4650 or visit www.sma.org.au

Health alert!!!

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

Helpful hint

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

More about drugs in pregnancy

Prescription drugs

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

Some medications to avoid in pregnancy

Medication	Use
Isotretinoin	To treat severe acne. Can cause serious birth defects and intellectual disability.
Misoprostol	Sometimes used with non-steroidal anti-inflammatories to treat joint pain. Can cause serious birth defects.
Ribavarin	To treat hepatitis C and pneumonia. May cause birth defects.

Are anti-depressants safe in pregnancy? Again talk to your doctor. For some women with depression, it's best to continue anti-depressants through pregnancy, rather than not treat the depression. Check with your doctor about the anti-depressant medication you are using.

Herbal remedies and aromatherapy

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

Another problem with herbal medicines is that it's hard to know what a safe dose is. Unlike drugs made in a lab, herbs made by nature can vary a lot in their strength. Again, the safest thing is to ask your doctor before you take anything, whether it's a herbal product or medication from the chemist.

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

What about St John's Wort? If you're taking this herb for depression, tell your midwife or doctor. If you have depression there may be services as well as other therapies that can help.

Can I drink herbal tea in pregnancy? If you drink them in normal amounts, most herbal teas are harmless. But be careful with raspberry leaf tea – there are some concerns that it may contribute to premature labour.

Is raspberry leaf tea safe in pregnancy? As with many traditional remedies, there isn't enough research to give a clear answer.

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

The bottom line? We need more research. Until then, be guided by your midwife or doctor and – to be on the safe side – use other remedies for morning sickness. Refer to the section *Settling morning sickness*, on page 5.

Illicit drugs

It's difficult to know exactly what's in illicit drugs such as speed, ice, cocaine, heroin, ecstasy or LSD. They may contain more than one type of drug and/or be mixed with other substances. This makes it hard to know what effect they may have on the pregnancy or the baby.

Using more than one drug, or using a street drug as well as alcohol is another concern because the effects on the pregnancy or the baby are unpredictable.

Regular use of some drugs, including cocaine, speed and heroin can cause withdrawal symptoms in the baby after birth.

Drug	How it affects pregnancy
Cannabis (pot, ganja, grass, weed)	• Not a lot is known about its effects on pregnancy or the baby – but that doesn't mean it's safe. Smoking pot with tobacco means you inhale carbon monoxide and other harmful chemicals that may cause problems for the baby. • Remember that THC (the ingredient in pot that makes you stoned) can stay in your body for weeks – it's not known how this might affect the baby in the long term.
Cocaine	• Increases risk of miscarriage and stillbirth. • Cocaine can narrow the blood vessels in both the mother's uterus and in the baby. This can reduce the blood supply to the baby, causing growth problems, and cause the placenta to detach from the uterus. • Smoking cigarettes can increase the effects of cocaine on the baby's blood vessels.
Amphetamines (speed)	• Like cocaine, speed can narrow the baby's blood vessels, causing growth problems, and cause the placenta to detach from the uterus. • Smoking cigarettes can increase the effect of speed on the baby's blood vessels.
Ecstasy	• Causes a rise in blood pressure and body temperature. This may cause complications in pregnancy and problems for the baby.
Heroin (see methadone)	• Increased risk of miscarriage, premature birth, stillbirth, low birthweight, and sudden infant death syndrome (SIDS) after birth (but these problems may be caused more by the lifestyle than heroin itself). • Narcan given to prevent overdose can cause miscarriage, premature birth and/or stillbirth.

Methadone in pregnancy

If you use heroin, talk to your midwife or doctor about replacing it with a methadone program as this can really help. Using methadone rather than heroin can:

- improve the health of you and your baby
- reduce risks to the baby
- reduce risks of complications in pregnancy.

Benzodiazepams

Benzodiazepams cross the placental barrier and can affect the growth and development of the baby. You should see a doctor before altering your dose. Benzodiazepams can produce withdrawal symptoms in newborn babies. Benzodiazepams can also be passed from mother to baby through breast milk. The baby's body cannot process these drugs quickly and they can accumulate in high doses. Some examples of benzodiazepams are valium, normison, serepax and rohypnol.

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

MotherSafe A free service based at the Royal Hospital for Women in Sydney. Information and counselling for women concerned about how alcohol or other drugs affect pregnancy or breastfeeding. Tel. (02) 9382 6539 (Sydney) or 1800 647 848 (regional NSW) during office hours.

ADIS (Alcohol and Drug Information Service): a 24-hour telephone line for anyone who wants help with a drug or alcohol problem, or information about drugs or alcohol. Tel. (02) 9442 5000 or 1800 198 024 (regional NSW).

Infections that may affect pregnancy

Although many infections cause no problems in pregnancy, some can be passed on to the baby and be harmful. Tell your midwife or doctor if there's a risk you may have one of these infections (see the chart on page 68).

Sexually transmissible infections

Some sexually transmissible infections (STIs) can affect pregnancy. It's possible to have an STI without knowing it – some infections don't have symptoms. If you need further information or help about STIs contact the Sydney Sexual Health Centre which provides free and confidential services on tollfree: 1800 451 624 or website www.sesahs.nsw.gov.au/sydhosp/sshc (see the chart on page 68).

Infection	How it's passed on	Symptoms	Effect on baby	What you should know
Rubella (German measles)	Close contact with an infected person – droplets spread by coughs or sneezes pass it on. These droplets can be in the air, on used handkerchiefs or on surfaces the person has touched.	May include faint rash, mild fever, runny nose, sore throat, swollen glands and joint pain.	Can cause miscarriage and serious birth defects, including intellectual disability and problems with sight, hearing and the heart.	It's best to have your immunity checked before pregnancy (even if you've been immunised). You can be immunised against rubella before you get pregnant (but not when you're already pregnant). Tell your doctor or midwife if you have been in contact with someone with rubella.
Chickenpox (varicella)	As above.	Sudden onset of slight fever, runny nose, feeling generally unwell and a skin rash which begins as small lumps before becoming blisters and finally scabs.	Can cause birth defects, as well as chickenpox infection in newborn babies.	Most women in Australia are immune to chickenpox. Ideally, see your doctor before you get pregnant to check your immunity. You can be immunised against chickenpox before you get pregnant (but not when you're already pregnant). Tell your doctor or midwife if you have been in contact with someone with chickenpox.
Hepatitis B	A chronic liver infection caused by a virus that lives in blood and body fluids. Can be passed on during sexual intercourse, by sharing needles, or can be passed on to the baby during birth.	Many people with hepatitis B virus have no symptoms, but can still pass the disease onto other people. Symptoms include a yellow tinge to the skin and whites of the eyes (jaundice), dark urine and pale stools, fever, loss of appetite, feeling tired, joint pains.	Can pass the infection on to the baby during birth.	All babies born in NSW are offered free hepatitis B immunisation in hospital after the birth. This helps protect the baby from hepatitis B generally. It also helps protect the baby from infection if the mother has hepatitis B.

Infection	How it's passed on	Symptoms	Effect on baby	What you should know
Hepatitis C	Another chronic liver disease caused by a virus in the blood. It mainly affects people who inject drugs. It's caught when blood from an infected person gets into the bloodstream of another person. This can happen through sharing needles and other equipment used for injecting drugs. Some people have caught the virus from blood transfusions or blood products before 1990.	As for hepatitis B.	There is a five percent risk of passing the infection onto the baby during pregnancy or birth. The chances of passing it to the baby in breastfeeding are very small, unless you have blood-to-blood contact with the baby (eg you have cracked nipples and the baby has scratches around the mouth).	For more information about hepatitis C in pregnancy, call the hepatitis C helpline on (02) 9332 1599 or 1800 803 990. This is a free, confidential service.
HIV	Many people have no symptoms in the early stages. You may be at risk of HIV if: • you have had unprotected sex • you or your partner are from a country where HIV is more common, including some African and Asian countries • you have shared drug injecting equipment • you had a blood transfusion in Australia between 1980 and 1985.	May include persistent flu-like symptoms – fever, sore throat, swollen glands, rash. Also unexplained diarrhoea, weight loss, recurrent rashes, or AIDS related illnesses such as pneumonia, skin cancers, brain infections and severe fungal infections.	HIV can be passed on to a baby during pregnancy (although thought to be the least common way), birth or breastfeeding. The risk of mother-to-baby infection is as low as 2% if the mother has treatment but risk increases if untreated. Baby has treatment after the birth. Breastfeeding is avoided.	Consider an HIV test, talk to your doctor or midwife about it, and ask any questions you have about HIV/AIDS. If you have HIV or AIDS in pregnancy, you need specialist advice on treatments to improve your health and reduce the risk to the baby. For more information, contact the AIDS Council of NSW, HIV & Women Support on (02) 9206 2012.
Parvovirus, also known as slapped cheek disease or fifth disease.	Close contact with an infected person. It's passed on by droplets from coughs and sneezes. Affects mostly preschoolers and schoolchildren.	Usually a mild illness with fever, lace-like rash (appearing first on the cheeks), sometimes joint pain.	May cause miscarriage.	Most adults are immune, but healthcare and childcare workers and teachers may be at risk. Be aware of any outbreaks in schools or preschools that you're in contact with. Tell your doctor or midwife if you've been in contact with a child with the disease.

Infection	How it's passed on	Symptoms	Effect on baby	What you should know
Cytomegalovirus (CMV)	Infection that's picked up from close person-to-person contact through saliva, urine, and other bodily fluids. Can be caught from children's nappies as well as droplet infection.	Usually no symptoms in healthy adults. May cause symptoms similar to glandular fever.	Babies infected by CMV in pregnancy are at risk of disease of the liver or spleen, hearing loss, and mental development and eyesight problems.	Many women are immune to this infection. Careful hand washing (eg after contact with children or handling nappies) can lower the risk. If you think you have been exposed to CMV, talk to your doctor or midwife.
Strep B (group B streptococcal infection)	Infection caused by bacteria (group B streptococcus). Around 12-15 percent of women carry the bacteria in the vagina.	No symptoms in women.	Can be passed to the baby during birth and cause a serious infection. If infected the baby will need antibiotics and may need intensive care.	NSW Hospitals have two different ways of handling Strep B. In most hospitals you'll be checked for Strep B. If you're carrying Strep B you'll be given antibiotics in labour. In other hospitals, women with risk factors will be given antibiotics in labour. Risk factors include labour before 37 weeks or having a high temperature.
Toxoplasmosis	Infection caused by a parasite found usually in cat faeces. Can also be caused by eating raw or undercooked meat.	Swollen lymph glands, muscle aches and pains, headaches, fever, generally feeling unwell.	Infection can be passed on in the uterus and potentially cause serious problems such as mental retardation and blindness in the baby.	Problems only occur if a woman becomes infected for the first time while pregnant. Precautionary measures include washing hands after handling raw meat, cooking meat thoroughly, and avoiding contact with cats – do not handle litter trays.

Infection	Symptoms	Effect on the baby	Treatment
Syphilis	Most women with syphilis have no symptoms. Symptoms may include painless sores in and around the vagina and rashes on the hands, feet or other parts of the body.	This STI isn't common in most women. But if a pregnant woman has it, she can pass it on to the baby. It can cause blindness in babies.	Antibiotics. Everyone should have a blood test in early pregnancy.
Chlamydia	Women may have this without knowing it, but there may be symptoms like discharge or irritation when you pass urine, or deep abdominal pain during vaginal sex. Apart from symptoms, other good reasons to have a test are: • being under 30 • if you or your partner have had a new sexual partner in the six months before you got pregnant • if you've been diagnosed with another STI. If untreated, chlamydia can also cause a serious infection (pelvic inflammatory disease) in the fallopian tubes or uterus. This can affect fertility.	Can be passed on to the baby during birth, causing eye infection (conjunctivitis) or pneumonia.	Antibiotics. If you think you may have chlamydia talk to your doctor or midwife.
Gonorrhoea	Extra vaginal discharge or irritation when you urinate; deep abdominal pain during vaginal sex.	If you're infected and not treated, the infection can be passed onto the baby causing eye infection (conjunctivitis) or upper respiratory tract problems.	Prompt treatment with antibiotics usually prevents harm to the baby.
Genital herpes	Painful, tingling or itchy blisters in the genital area. Some people get flu-like symptoms. Sometimes there are no symptoms. Tell your doctor or midwife if any of your partners have genital herpes.	Tell your doctor or midwife if you or any of your partners have had or has genital herpes. The risk of infecting the baby is highest when you have your first outbreak of blisters, or when you're recovering from this first outbreak. Further outbreaks during pregnancy rarely affect your unborn baby. But if you think you may have an outbreak when labour begins, go to the hospital as soon as possible. You may need a caesarean to prevent the baby getting sick. If you've had recurrent outbreaks before, the baby may have some immunity to genital herpes.	Medication can suppress outbreaks of herpes, and treat the symptoms. But because the virus stays in the system, symptoms can return.
Genital warts	Genital warts are often painless. They may start as tiny painless swellings on the genitals, sometimes turning into little cauliflower-like lumps especially during pregnancy. But sometimes genital warts are flatter and harder to see.	Although common in pregnant women, genital warts rarely cause problems.	Warts can be removed but the virus, which causes them, stays in the system. Warts may reappear.

Work and pregnancy

Unless your job involves heavy physical work or occupational hazards that may affect your baby, there's no reason why you can't work well into your pregnancy (see *Risks at work* on page 14). If you have any doubts, talk to your doctor or midwife.

If your job involves standing for long periods of time, make sure you take the chance to sit down during breaks (if possible, put your feet up on another chair). Standing for long periods may increase your chance of getting varicose veins in pregnancy (see *Common concerns in pregnancy* on page 87).

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

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

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

For more information about working while pregnant, contact WorkCover, tel. (02) 4321 5000 or visit www.workcover.nsw.gov.au

Some hazards around the home

Avoid lead in pregnancy

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

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

We don't know if these effects are reversible.

How pregnant women and children can avoid lead:

- Renovating houses can increase exposure to lead. If your house was built before 1971 (when lead-based paint was still available), get advice before doing anything that disturbs the paint. Disturbing lead-based paint can spread lead dust into the air and around the house. *It's important that pregnant women and children aren't around during renovations that disturb lead-based paint.*
- Other sources of lead include lead industries such as vehicle battery recyclers; clothes and dust on lead workers' clothes; hobbies which use lead, eg leadlighting, fishing (sinkers), and pottery (lead glazes); some traditional medicines such as pay-loo-ah, bali goli, rueda and azarcon; lead crystal glassware; and crockery from developing countries (lead can leach from the glaze).
- In areas near lead smelters or mines, lead contamination in the environment and the house will be higher than in most urban areas.

Be cautious with pets

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

Cleaning products, paints and other household chemicals

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

Toxoplasmosis

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

- avoid raw or undercooked meat
- wash your hands after petting animals
- avoid contact with cat faeces
- wear gloves for gardening.

Healthy eating for pregnancy

It's important to have a healthy diet while you are pregnant, so that:

- your baby grows and develops well
- your body copes well with pregnancy and later, with being able to care for your baby.

Which foods do I eat and how much?

If you already have a healthy diet, then you won't need to make many changes to the way you eat. This table shows how much to eat from each food group every day.

Food group	How many serves per day?
Bread, cereals, rice, pasta, noodles.	4-6 serves, where a serve is: • 2 x 60g slices of bread • 1 medium bread roll • 1 cup cooked pasta, rice, or noodles • ½ cup untoasted muesli • 1 cup cooked porridge • 1 1/3 cups breakfast cereal.
Vegetables, legumes.	5 serves, where a serve is: • ½ cup cooked vegetables or cooked dried beans • 1 cup raw salad vegetables • 1 small potato.
Fruit.	4 serves, where a serve is: • 1 whole medium fruit (eg 1 medium apple or banana) • 2 small fruits (eg plums or kiwi fruit) • 1 cup canned fruit • 1½ tablespoons sultanas • 4 dried apricots.
Milk, yoghurt, cheese and dairy alternatives.	At least 2 serves, where a serve is: • 1 cup milk (full fat, reduced or skim) • 2 slices cheese • 200g yoghurt (plain or flavored) • ½ cup evaporated milk • 1 cup soy milk (with added calcium) • 1 cup custard • 1 cup almonds • ½ cup salmon or sardines, including bones.
Lean meat, fish, poultry, eggs, legumes.	1½ serves, where a serve is: • ½ cup lean mince • piece of lean meat or chicken the size of the palm of your hand • 2 small chops • 1 small fish fillet • ½ cup salmon • 2 small eggs • 1/3 cup nuts • ¼ cup seeds • ½ cup cooked lentils, beans or chick peas.

Common food concerns during pregnancy

There are a few nutrients that your midwife or doctor may say are particularly important that you eat while you are pregnant.

Folate

It's important to get enough folate, especially in the first few months of pregnancy, as this can prevent birth defects.

Eat some of these foods every day:

- **Excellent folate foods** Asparagus, avocado, wholegrain breakfast cereal fortified with folate, yeast spreads eg Marmite, Vegemite, brussels sprouts, dried beans, chick peas and lentils, spinach.
- **Very good folate foods** Wholegrain bread, wheatgerm, broccoli, steamed cauliflower or green beans, raw cabbage, leeks, orange juice, porridge, peas, parsnips, potato.
- **Good folate foods** Bananas, beetroot, steamed cabbage, nuts, almonds, cashews, hazelnuts, tomatoes, canned salmon.

Breastfeeding and food

When you start breastfeeding, you may feel hungrier and thirstier than usual. This is normal. It means you can enjoy more of the healthy foods you need. Keep planning your food based on the table opposite, and add one or two extra serves of each of these food groups:

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

FAQ
Q: What about fats and oils?

A: You only need small amounts – a little butter or margarine spread thinly on bread, and a little oil for cooking and salad dressing. Canola, olive, sunflower, safflower, corn and soya bean oils are healthier choices.

Helpful hint

Easy and delicious ways to get more folate include:

- wholegrain breakfast cereal with added folate, sliced banana and a glass of orange juice
- big helpings of steamed or stir-fried vegetables
- snack on bananas, raw unsalted nuts or wholegrain toast with yeast spreads (eg Marmite or Vegemite)
- spread mashed avocado on bread instead of margarine or butter.

Iron

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

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

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

Calcium

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

Remember that low-fat or reduced fat dairy products usually have as much if not more calcium than full-cream dairy foods (but cottage cheese doesn't contain much calcium). If you don't eat any of the dairy products or alternatives listed in the table on page 74, you may need a calcium supplement. Check with your midwife or doctor.

Smart snacking

During pregnancy, many women have the desire to eat between meals. While this is a normal urge, frequent snacking on carbohydrate-containing foods can increase the risk of tooth decay. Try to resist the urge to snack constantly. When you need a snack, choose foods that are nutritious for you and your baby such as fruit, vegetables, dairy products, fresh or dried fruit, yoghurt, unsalted nuts, wholegrain fruit bread, cheese and tomato on toast, or pitta bread and fresh hommus.

These are better for you and your baby than cakes, biscuits or salty snack foods – though it's okay to treat yourself sometimes.

FAQ
Q: What about takeaway foods?

A: Many takeaway foods have too much saturated fat and salt and are too high in kilojoules.

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

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

FAQ
Q: Does a woman lose calcium from her teeth during pregnancy?

A: It is a myth that calcium is lost from the mother's teeth during pregnancy. If calcium intake in inadequate, however, your body will provide this mineral from stores in your bones.

There are many ways to eat healthily. If you're stuck for ideas, here are some options to try.

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

Eating fish when you're pregnant

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

Raw fish and seafood such as oysters, sashimi, smoked salmon or smoked oysters should be avoided all together by pregnant women.

Pregnant & breastfeeding women & women planning pregnancy*	**1 serve = 150 grams**
Children (up to 6 years)	**1 serve = 75 grams**
2-3 serves per week of any cooked fish and cooked seafood not listed below OR	
1 serve per week of Orange Roughy (Sea Perch) or Catfish and no other fish that week OR	
1 serve per fortnight of Shark (Flake), or Billfish (Swordfish/ Broadbill and Marlin) and no other fish that fortnight	

*Food Standards Australia New Zealand 2005

Special situations

What if I'm a vegetarian?

A balanced vegetarian diet can be very healthy. Use the table at the beginning of this section to check that you are getting enough servings of all the food groups.

Sometimes, vegetarian diets can be low in the following nutrients. These tips will help you get everything you need:

- **Iron and zinc** Eat plenty of the plant foods (legumes and nuts) which have iron and zinc. Have a vitamin C food at the same meal.
- **Vitamin B12** If you don't eat dairy foods or eggs, you may need a supplement. Fortified breakfast cereals are an excellent source of vitamin B12 for vegetarians.
- **Calcium** See the table on page 74 for a list of non-dairy calcium foods. If you are not eating plenty of these, you may need a calcium supplement.
- **Protein** Make sure you get enough plant protein from legumes, nuts and seeds.

If you need help planning your diet, talk to your midwife or doctor.

What if I'm a teenager?

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

FAQ

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

A: Experts recommend no changes are needed in pregnancy. Research has found that when women avoid foods like egg, peanut, soy, fish or cows milk (foods that may cause allergies in some people), it doesn't affect the baby's risk of allergy. But if your baby has a high risk of developing an allergy (because there's a family history), you may want to avoid these foods when you breastfeed. Studies show that avoiding these foods while breastfeeding (or in the first three months of breastfeeding) may reduce the risk of allergies in the first 18 months.

For more information, talk to your doctor or lactation consultant. For information on allergies, including food allergies, go to www.allergy.org.au and click on Consumer Information.

Keeping food safe

Common sense in the kitchen – rules to prevent foodborne infections

- Thoroughly cook raw food from animal sources, eg beef, lamb, pork, and poultry.
- Wash raw vegetables and fruit carefully before eating.
- Keep raw meat separate from vegetables, cooked foods, and ready to eat foods (don't let blood from raw meat contact other food).
- Use one cutting board for raw meat and another for cooked foods and vegetables.
- Wash hands carefully before and after preparing food.
- Wash knives and cutting boards with hot soapy water.
- Store perishable foods in a cold (less than 5ºC) fridge. Wash and eat them as soon as possible.
- Don't leave cooked food sitting on the kitchen bench – put it in the fridge as soon as the steam has gone.
- Don't thaw frozen food on the kitchen bench – only thaw in the fridge or in the microwave.

While you're pregnant avoid eating:

- pre-prepared salads (eg from salad bars) and pre-cut fruit
- cold delicatessen meats and pate
- cooked, diced chicken (but you can eat chicken that you have cooked thoroughly yourself, and kept in the fridge)
- raw seafood, including sushi and sashimi
- smoked fish
- soft cheeses like brie, camembert, ricotta or blue vein
- sprouted seeds
- raw mushrooms (cooked is okay)
- soft serve ice cream
- dips and salad dressings which may have been in contact with raw vegetables
- food that's been pre-prepared and kept in the fridge for more than 12 hours
- refrigerated food past its use by date
- raw eggs (it's best to eat eggs cooked, not raw, at all times – not just during pregnancy).

Don't eat lukewarm food

- Make sure food reheated at home, including in the microwave, is hot all the way through.
- If you eat food from a takeaway or a restaurant, it must be served hot, and eaten hot. Don't eat lukewarm food. It's safest to avoid buffet-style meals. If that's not possible, eat only hot food from the buffet.

Will the baby be healthy?

Genetic counselling and prenatal testing

How genetic counselling can help

Most babies in Australia (about 97 per cent) are born without serious problems. But some couples have a higher risk of having a baby with a physical or intellectual disorder caused by a problem with the baby's genes. These genetic problems are also called inherited disorders. Sometimes these problems don't show up until later in childhood, adolescence or as adults.

What causes genetic disorders?

Genetic problems can happen in two ways:

1. Faulty genes can be passed down to the baby from one or both parents. Some faulty genes are more common in some population groups than others. This means that the disorders they cause, such as thalassaemia, can be more common in these groups (see following pages).
2. Problems can occur when the baby is conceived.

What are faulty genes?

We inherit our genes from our parents. Genes are the instructions that tell our bodies how to work and develop. Each of the thousands of genes in our bodies has two copies – one from our mother and one from our father. We all have the same genes, but small variations in the information in these genes make us different to each other. But sometimes these changes can make the gene faulty, so the gene doesn't work as well as it should.

We all have some faulty genes. But as each gene has two copies, we can carry a faulty gene copy and not have a disorder. This is because our other correct gene copy sends the right instructions to the body. But sometimes the instructions from the faulty gene override the instructions from the correct copy. The baby can then be affected by the disorder.

How can genetic counselling help?

A genetic counsellor can estimate the risk of having a child with a particular disorder. This is done by:

- asking questions about any illnesses or disabilities in your own family or your partner's
- in some cases, having tests before pregnancy to check if either partner carries the faulty gene copy for a particular disorder, such as cystic fibrosis or thalassaemia (see following pages)
- tests done in early pregnancy (prenatal tests) to check the health of the baby.

Who might need genetic counselling?

It's a good idea to sit down with your partner and discuss your families' medical history. Sharing this information with your GP or midwife may highlight any areas that need further investigation, either by them or by referring you to a genetic counsellor.

Genetic counselling (available at most large hospitals and in some community centres) is particularly helpful if:

- you already have a child with a serious disorder
- you or your partner have a serious disorder which may be passed onto the baby, or you have a relative with a serious disorder or an affected child
- you have a family history of a disorder which only affects boys. Women in the family may be carriers of a faulty gene for the disorder. This means that although they don't have the condition themselves, they may pass it on to their children. If their sons inherit the faulty gene, they will be affected by the disorder. Their daughters who inherit the faulty gene will be carriers like their mother and usually unaffected. One example is haemophilia, a blood-clotting disorder
- your partner is a close relative, and so you may have some faulty genes in common
- you're having (or planning) a baby and are in your mid-30s, or older.

What disorders or conditions may be inherited?

There are many genetic disorders where faulty genes directly cause the condition or make you more vulnerable to the condition. Some of the more common ones include:

- cystic fibrosis
- thalassaemia
- sickle cell disease
- some forms of heart disease
- diabetes
- some forms of cancer
- muscular dystrophy
- some visual disorders
- Down syndrome
- haemophilia
- osteoporosis
- short stature syndromes
- some hearing disorders
- some allergies
- asthma
- eczema.

Most people with a vulnerability won't develop a problem unless there is also an environmental trigger which activates the condition (eg you may be at risk of developing asthma, but won't unless you are exposed to certain irritants in the air).

Cystic fibrosis, thalassaemia and sickle cell disease are three of the most common genetic disorders. These appear in children more frequently from certain cultures and are life-threatening.

Cystic fibrosis (CF)
About one in every 2,000 children is born with this disorder, which affects the lungs and digestive system.

One in 25 people from a European or Anglo-Saxon background carry the faulty gene that causes CF but don't have CF themselves. If two people who are carriers of this faulty gene have a child together, there's a one in four chance their child will have CF. It's now possible to test a person to see if they carry the faulty gene for CF. Genetic counselling is recommended if you have a family history of CF.

For more information, contact the Cystic Fibrosis Foundation (NSW), PO Box 149, North Ryde, NSW 2113, Tel. (02) 9878 2075, or the Centre for Genetics Education (see details under Sickle cell disease on this page).

Thalassaemia
There are two kinds of this blood disorder:

- *Thalassaemia trait* (also called *thalassaemia minor*) This is the most common kind and doesn't usually cause serious health problems, just mild anaemia. People who carry a faulty gene for thalassaemia have thalassaemia minor. There are two kinds of thalassaemia minor: alpha thalassaemia minor and beta thalassaemia minor.
- *Thalassaemia major* This happens when a child inherits a faulty gene for thalassaemia from *both* parents who have the same form of thalassaemia minor. Thalassaemia major is a lifelong condition, which often causes a serious form of anaemia.

Thalassaemia minor is more common in families originally from Southern Europe, India, the Middle East, South East Asia, Africa or the Pacific.

As many people may not be fully aware of their background, it's best to discuss with your doctor the need for testing for thalassaemia minor before having children. These tests are available, free, at most major hospitals in NSW. If both parents have thalassaemia minor, genetic counselling is recommended.

If one parent has thalassaemia minor, there's a one in two chance the baby will inherit thalassaemia minor. However, two parents with the same form of thalassaemia minor face a one in four risk of having a baby with thalassaemia major.

If you have tested positive for thalassaemia minor in pregnancy, your partner should have a test as soon as possible. The unborn baby can be tested for thalassaemia major early in pregnancy (before 18 weeks).

For more information about thalassaemia, contact the Thalassaemia Centre of NSW, Royal Prince Alfred Hospital, Level 5, Queen Mary Building, Grose St, Camperdown NSW 2050, Tel. (02) 9550 4844, or the Centre for Genetics Education (details below).

Sickle cell disease
This disease causes the red blood cells to be folded and abnormally shaped like a sickle and means they are not able to carry oxygen around the body very efficiently.

Sickle cell disease is more common in families originally from Southern Europe, Middle East and Africa.

For more information about genetic conditions and counselling and prenatal testing, contact The Centre for Genetics Education, PO Box 317, St Leonards, NSW 1590. Tel. (02) 9926 7324, or visit www.genetics.com.au

Prenatal testing – special tests for your baby in pregnancy

There are some tests for a baby's health that can be done before a baby is born. They are called prenatal tests. It's up to you to decide whether you want them.

Some reasons why you might consider them include:

- The same reasons listed under *Who might need genetic counselling?* on page 82.
- Exposure to something that may seriously affect the baby – radiation x-rays or prescription drugs taken before you knew you were pregnant).

There are two types of tests:

- Screening tests can only show if the baby has an increased risk of a problem – they can't say for sure if there is a problem.
- Diagnostic tests can show if a baby actually has a problem such as a problem with the baby's chromosomes (Down syndrome). Diagnostic tests are often done when a screening test suggests that a baby has an increased risk of a problem with the chromosomes. Some diagnostic tests may carry a risk to the pregnancy.

Things to think about before you and your partner decide if any of these tests are appropriate for you:

- Prenatal tests can't find all problems a baby may be born with or develop later on.
- No test can guarantee a perfect baby.
- Like any medical test, no prenatal test is 100 per cent accurate – this means there's always a very small chance that a test result will be wrong, or unclear.
- If a screening test suggests your baby has an increased risk of a particular problem, you'll need to decide whether to have diagnostic tests to find out more. Genetic counselling is available to help you make this decision.
- If a diagnostic test shows the baby has a problem, genetic counselling is available to talk about your options. These may include deciding whether or not to continue the pregnancy.
- Some couples don't have these tests in pregnancy – they feel that they could never end the pregnancy even if the baby did have a serious problem. Other couples who also feel they would never end a pregnancy, still choose to have the test as they would like to know the result and be prepared if there is a problem. Again, it's up to you.

What if I get a 'high risk' result after a screening test?

- Discuss the result with your doctor, midwife or genetic counsellor.
- It doesn't mean your baby definitely has a problem.
- Most babies with an increased risk result for a disorder will be found not to have the disorder.
- You may decide to have further tests to get a definite answer. Talk about the advantages and disadvantages of this with your midwife, doctor or genetic counsellor.

What if a diagnostic test shows the baby has a problem?

You will have support and counselling to help you decide what your options are.

What's a chromosomal abnormality?

Chromosomes are in every cell of your body. There are 23 paired chromosomes in the cells, one from the mother and one from the father. The chromosomes are numbered from one to 22 and there are two sex chromosomes: X and Y. A girl baby has two X chromosome copies (XX) and a boy baby has an X chromosome and a Y chromosome (XY). Each chromosome contains thousands of genes. Genes are the instructions that decide things like how each person looks, develops and works.

When there are either too many or too few chromosomes in the cells, there may be a birth abnormality. This is caused by too few or too many genes providing instructions to the developing baby. The most well-known chromosomal disorder is Down syndrome. This happens when a baby has an extra copy of a chromosome (#21) in its cells.

For more information about genetic conditions and counselling and prenatal testing, contact The Centre for Genetics Education, PO Box 317, St Leonards, NSW 1590. Tel. (02) 9926 7324, or visit www.genetics.com.au

Prenatal tests

Prenatal tests are described on the next page.

Test	Type	Timing	Purpose	Method	Risk to baby?	Results
Ultrasound	Screening and diagnostic	8-10 weeks	Determine date of pregnancy and/or check for physical problems such as heart or kidney disorders.	An instrument is pressed against your skin. This passes sound waves through the amniotic fluid, which create a picture of the baby on a computer screen.	Not known.	Available immediately.
Nuchal translucency ultrasound	Screening	11.5-13.5 weeks	Estimates baby's risk of Down syndrome or other chromosomal disorders.	Ultrasound is used to measure the depth of a fluid inside the back of the baby's neck. A blood test may also be done, which improves the likelihood of detecting a baby with a risk of Down syndrome.	Not known.	Available immediately or within a few days.
Chorionic villus sampling (CVS)	Diagnostic	11-12 weeks	Checks for Down syndrome, other chromosomal disorders, or some disorders due to faulty genes.	Tests cells in the placenta by inserting a fine tube into the uterus to remove a tiny amount of tissue.	Risk of miscarriage is less than one in 100 pregnancies ie less than 1%.	Available in one to three weeks.
Maternal serum (mother's blood)	Screening	15-17 weeks	Estimates baby's risk of neural tube defects (eg spina bifida) and Down syndrome.	Blood test checks levels of proteins in mother's blood.	No.	Available in one week.
Amniocentesis	Diagnostic	15-19 weeks	Checks for Down syndrome, other chromosomal problems, spina bifida, other neural tube defects or some disorders due to faulty genes.	A hollow needle draws a sample of amniotic fluid around the developing baby in the uterus.	Risk of miscarriage is less than one in 100 pregnancies.	Available in two to four weeks.
Fetal anomaly ultrasound	Screening and diagnostic	18 weeks	Checks for many physical problems, eg with baby's growth, spine, heart, kidney or other organs.	Ultrasound.	Not known.	Available immediately.

Common concerns in pregnancy

Abdominal ache

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

Backache

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

Some things that may help include:

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

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

For more ways to care for your back, see the section *Give me strength – pre and postnatal exercises*, on page 96.

Bleeding gums

During pregnancy, hormonal changes can make your gums become more easily irritated and inflamed. Red, puffy or tender gums that bleed when you brush is an exaggerated response to plaque that builds up on your teeth. Careful and gentle brushing (not over-vigorous) and flossing will help prevent this. Have a dental check-up before you get pregnant or early in pregnancy to make sure your teeth and gums are in good shape. See your dentist if bleeding gums persist.

Breathlessness

It's normal to feel short of breath when you exert yourself in the last few weeks of pregnancy – it's your growing uterus pressing against your diaphragm. Breathlessness can also happen when you're lying down – sleeping propped up on a couple of pillows should help. With your first baby you may notice that breathlessness stops towards the end of pregnancy. That's because the pressure lessens as the uterus drops as the baby's head moves down into the pelvis. This is called lightening – it takes the pressure off the diaphragm (and often eases any heartburn too).

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

Constipation

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

Cramps

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

- Try rubbing the muscle firmly, or stretching it by walking around for a while.
- Relieve a foot cramp by bending your foot upwards with your hand.
- Try not to stretch with your toes pointed.
- Taking a supplement of magnesium lactate might help – talk to your doctor. Calcium is often suggested as a remedy, but there's no evidence that it really works.

Feeling faint

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

Frequent dizziness or fainting early in pregnancy (especially if there is vaginal bleeding or abdominal pain) could mean an ectopic pregnancy – see your doctor straight away.

Food cravings

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

Frequently passing urine

In early pregnancy, this is possibly caused by hormonal changes, but in later pregnancy, it's more likely to be the weight of the uterus pressing on the bladder. If you're having twins, this may be even more of a problem. In later pregnancy, you may find it harder to empty your bladder, and may also 'leak' a little urine when you sneeze, cough or lift something. Doing your pelvic floor exercise each day will help prevent this. See *Give me strength – pre and postnatal exercises*, on page 96. If passing urine causes stinging or burning, let your midwife or doctor know, as it may be an infection.

Headaches

Headaches are more likely in the early months. Rest and relaxation are the best solutions. Make sure you're drinking enough water, as headaches can be caused by dehydration, especially in warm weather. If headaches are frequent and severe, tell your doctor or midwife – in later pregnancy, this could be a sign of high blood pressure.

Heartburn

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

Ways to prevent heartburn include:

- eating slowly, and eating frequent, small meals instead of one large one
- avoiding large amounts of food close to bedtime
- sleeping in a semi-upright position, supported by pillows – this makes it harder for the fluid to spill into the food passage.

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

Itching

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

Nose bleeds

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

Piles (haemorrhoids)

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

Saliva

You may produce extra saliva (and even dribble in your sleep!). This is normal.

Skin

Sometimes acne can develop for the first time or be worse than usual. You might get patches of darker skin on your face. These are called chloasma and will fade after the baby is born. Oral contraceptives (the pill) can cause the same thing. If it bothers you, you can disguise it with make up.

Sleeping problems

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

Things that may help include:

- relaxing music or relaxation techniques (see *Getting ready for labour and birth – self-help techniques* starting on page 106) to help you go to sleep
- sleeping with one pillow under your tummy and another under your legs
- reading for a while with a drink of warm milk.

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

Stretch marks

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

Swollen ankles

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

Things that may help include:

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

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

Vaginal discharge

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

Varicose veins

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

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

Varicose veins can also appear in the vulva (external genitals), making it sore and swollen. Tell your doctor or midwife – they may suggest wearing a sanitary pad firmly against the swollen part as a support. You can also try the suggestions above for varicose veins. Sleeping with your bottom on a pillow may help too.

Having a baby at 35+

More women now have their first baby between the ages of 30 and 40. It's true that the risks increase with age, especially after 35 – and you need to know about them. But the important thing to remember is that most women over 35 have healthy babies.

Many of the risks and complications have less to do with your age and more to do with having problems like high blood pressure or diabetes (health problems that are more common as we get older). Being in good health, having good antenatal care, healthy eating and regular exercise will reduce your risk of complications.

What are the extra risks?

- **Miscarriage** The risk of a miscarriage is generally about one in seven. This rises to about one in four (25 per cent) by the age of 40. But this still means that most pregnancies will continue on.
- **Risk of having a baby with a disorder** The risk of having a baby with a chromosomal disorder such as Down syndrome rises with age. It's also important to remember that there is a risk at all ages. This extra risk of chromosomal disorders is the main reason for increased miscarriages in older women. If you're over 35, the risk of having a child with a chromosomal disorder is about one in 200. By age 40, it's much higher – about one in 66. At 45, it's about one in 20. For information about prenatal testing to check for some disorders, see *Will the baby be healthy? Genetic counselling and prenatal testing*, which starts on page 80.

There's also a higher risk of:

- premature birth
- low birthweight (not smoking will reduce the risk of this)
- placenta praevia
- high blood pressure
- bleeding in pregnancy
- pre-eclampsia
- gestational diabetes.

For more about these risks see *Complications in pregnancy*, which starts on page 102.

But again this is nothing to get too gloomy about – most women over 35 won't have these problems (especially if they're in good health to begin with). Again, these are all complications that can be minimised by good antenatal care and healthy habits.

When it's twins or more

– multiple pregnancy

Twins happen about once in every 100 births. You're more likely to have them if:

- you or your partner have identical twins in your family
- you're over 35 years of age
- you're having fertility treatment.

Identical twins happen when one fertilised egg splits into two separate cells. Each cell then develops into a baby. Because they have come from the same egg, the babies have the same genes. They are the same sex and they look very alike. Identical twins are likely to share one placenta but have separate cords.

Non-identical (fraternal) twins happen when two separate eggs are fertilised by two sperm. They look like each other in the same way that any brothers and sisters do. Each twin has its own placenta. Non-identical twins can be different sexes.

Triplets are rare and quads (four babies) rarer still, although the use of fertility drugs means multiple births are more common.

What are the signs that I may be carrying more than one baby?

These include fast weight gain or a uterus that is larger than usual for your particular stage of pregnancy. An extra baby can also mean that the normal discomforts of pregnancy, like nausea or more frequent trips to the loo, are more severe. There is a small risk of miscarriage of one twin early in pregnancy.

An ultrasound at about 10 or 18 weeks can confirm a multiple pregnancy.

What's different about a multiple pregnancy?

The prospect of twins can be exciting, but it also carries an increased risk of complications. These include:

- anaemia
- premature birth
- one or both babies not growing well.

This means that regular antenatal visits are really important – good care will help reduce the risk of problems. It is particularly important to identify twins that share a single placenta. This type of multiple pregnancy carries the highest risk to the babies and needs careful monitoring.

Think carefully about where you have your babies – more than 50 per cent of women with multiple pregnancies go into labour early. It's best to be in a hospital that has the facilities you need. Talk to your midwife or doctor.

Most women with multiple pregnancies can give birth normally, but you may need a caesarean or labour induction if there are complications. It's recommended that the babies be carefully monitored in pregnancy and labour. This may include using electronic fetal monitoring.

You may also be in hospital a little longer after giving birth – the babies may be premature, or you may need more time to get used to feeding and caring for more than one baby.

Knowing that you're having more than one baby may also make you more anxious. You may worry about complications, and how you'll cope with two or more babies. The extra fatigue and discomfort of carrying more than one baby can make things harder if you're feeling anxious or down.

Don't keep these feelings to yourself. Talk to your doctor, midwife, hospital social worker or a counsellor. There may also be local support groups for parents of twins in your area – to find out, contact the Australian Multiple Birth Association, PO Box 105, Coogee 2034. Email secretary@amba.org.au or visit www.amba.org.au

Give me strength

– pre and postnatal exercises

Exercises for pregnancy and afterwards

As well as keeping fit with walking, swimming or other activities, you need to take special care of muscles in your tummy, back and pelvic floor.

These muscles are under more stress than usual in pregnancy and are easily weakened. Exercise will help to:

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

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

Remember:

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

The tummy tuck

Strong abdominal muscles do more than flatten your tummy – they also help to protect your back.

Tummy tucks are better than sit-ups during pregnancy because they target the deeper layers of muscles. Avoid sit-ups until six weeks after the baby is born. You can do a tummy tuck either standing or on your hands and knees.

Do tummy tucks often during the day while you're at work or around the house. Try to tummy tuck whenever you start a new movement like getting out of a chair, lifting or bending. This will help support your back.

Standing

- Stand with feet apart and knees slightly bent.
- Put your fingers on the widest part of your tummy, below your navel.
- Pull your tummy in away from your fingers.
- Hold for a few seconds.
- Let go.

Repeat 5-10 times.

On your hands and knees

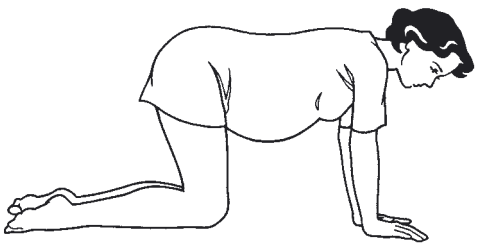
- Get down on the floor on your hands and knees.
- Pull your tummy in without holding your breath – hold for a few seconds and then let go.

Repeat 5-10 times.

If you want to make this exercise a little harder:

- Do a tummy tuck.
- Hold your body as still as possible.
- Lift one arm up level with your shoulder.
- Hold for a few seconds, then lower your arm.
- Relax the tummy muscles.
- Repeat with the other arm.

Repeat 5-10 times on each side.



Check your tummy muscles after the baby is born

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

- Lie on your back with your knees bent and your feet flat on the floor.
- Press the fingers of one hand gently into the area around your navel.
- Breathe out and raise your head and shoulders a little.
- If there is a separation, you'll feel a 'gap' and the two separate edges of the muscle.

Keeping up the tummy tuck exercises (either standing up or on all fours) will help to close the gap (though sometimes the gap may not close completely).

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

Mind your back

These exercises will help keep your spine flexible.

Pelvic rotation

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

Repeat 5-10 times.

Pelvic tilt (helps relieve back pain, too)

- Stand with your feet comfortably apart.
- Bend your knees slightly.
- Place one hand on your abdomen and the other on your lower back.
- Imagine your pelvis is a basin and tip it slowly backwards and forwards.

Repeat 5-10 times.

Repeat this exercise on your hands and knees.

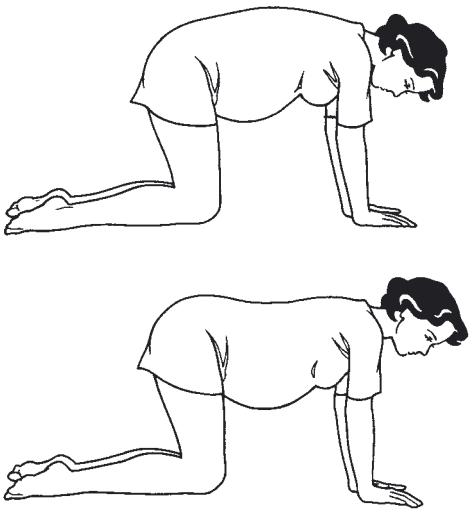
That's better! Stretches to ease aches and pains

For low backache

- Go down on your hands and knees.
- Do a tummy tuck.
- Round your back upwards (keep your tailbone tucked in and your head lowered between your arms).
- Hold.
- Gently lower the back down as far as feels comfortable.

For pain in shoulder blades or middle back

- Go down on your hands and knees.
- Do a tummy tuck.
- Stretch one arm up to the ceiling, then sweep it down and under the other arm.
- Follow the arm with your eyes.
- Relax and repeat with the other arm.



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

- Avoid standing on one leg or heavy lifting.
- Work at benches or tables that are at waist height.
- Keep nappy buckets and washing baskets at waist height.
- Carry the baby in a sling rather than a capsule.
- Kneel down rather than bending to clean the bath or make beds.
- Go for a swim (after birthing, wait until the lochia – discharge – has stopped before you start swimming again).
- If walking causes pain in one buttock (or if you notice the pain the day after a walk), try shortening your stride, avoid stairs, and avoid any activity (eg vacuuming) where you might put more weight on one leg.
- If back pain is severe or persistent, see a doctor and a physiotherapist.

Caring for your pelvic floor

One in three women who have had a baby wet themselves … you don't have to be one of them. Having a baby means you're almost three times more likely to leak urine and wet yourself than women who haven't had a baby. The more babies you have, the more likely you are to have these problems.

Why do you leak after having a baby? Giving birth stretches the muscles of your pelvic floor – the muscles that keep your bladder shut. Weakened muscles can't stop your bladder from leaking. This leaking happens mostly when you cough, sneeze, lift or exercise. You may also find that you can't wait when you want to pass urine.

Will leaking go away by itself? Not unless you help your pelvic floor muscles get strong again. If you don't strengthen them after each baby, you're likely to wet yourself when you reach middle age. Pelvic floor muscles tend to weaken with age. Menopause can make incontinence worse.

How can I prevent this?

- Drink at least l.5 litres (6-8 cups) of fluid every day.
- Don't go to the loo just in case – this trains your bladder to want to empty more often.
- Empty your bladder completely when you go to the toilet.
- Know how to protect your pelvic floor when you use your bowels (straining can also weaken the pelvic floor). Avoid constipation. Try sitting on the toilet with your elbows on your knees, and with your feet close to the toilet, raise your heels. Relax your pelvic floor and gently push.
- Do pelvic floor squeezes every day. Here's what you do:
  - Squeeze, lift and hold your pelvic floor as if you're trying not to pass wind.
  - Feel the pelvic floor lift.
  - At the same time, feel the muscles of the lower part of your tummy pull in as you squeeze and lift your pelvic floor muscles.

Once you can do this, practice the following routine:

- Squeeze and lift the pelvic floor three times quickly, without rests. Aim to hold each squeeze for up to three seconds.
- Squeeze, lift and hold for three seconds three times, but *slowly.*

Congratulations – you've done one set. Try to do three sets every day, gradually holding your squeeze for longer. As your pelvic muscles get stronger, you can aim for six seconds.

If you like, you can gradually increase the number of squeezes to 10 times, holding the squeeze for up to eight or 10 seconds.

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

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

- Going to the toilet.
- Washing your hands.
- Having a drink.
- Feeding the baby.
- Standing in line at the shopping checkout.

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

Weaker pelvic floor muscles can make you break wind more

Just in case you need another reason to get serious about strengthening your pelvic floor muscles – these muscles also help close off the back passage (anus). With less control, you may find it harder to control your wind, or to hold when you need to open your bowels.

Complications in pregnancy

Most pregnancies go smoothly. But get to know the warning signs of complications so you can act quickly – just in case.

Contact your doctor, midwife or hospital immediately if you have any of the following symptoms:

- vaginal bleeding (even if it's slight)
- very severe nausea or vomiting several times during a short period
- severe abdominal pain
- constant clear 'watery' vaginal discharge
- a severe headache that won't go away (especially in the second half of pregnancy)
- sudden swelling of the ankles, fingers and face
- sudden blurring of vision
- a temperature of more than 37.8°C
- the baby stops moving or has a marked decrease in movement for any 24-hour period from the 30th week of pregnancy onwards
- regular painful contractions any time before the 37th week.

Ectopic pregnancy

When an egg is fertilised, it normally moves down to the uterus. But sometimes it gets stuck in the fallopian tube and starts to grow there. This is called an ectopic or tubal pregnancy. The cause is often a narrowing in the fallopian tube that stops the egg from reaching the uterus. A baby cannot survive an ectopic pregnancy. An ectopic pregnancy can also cause serious problems for the woman.

Symptoms include:

- severe pain low down on one side of the abdomen a week or two after a missed period
- bleeding
- feeling faint or vomiting.

The bleeding may be mistaken for a period, especially if you don't know you are pregnant. If you suspect an ectopic pregnancy, it's important to see a doctor as soon as possible to stop the bleeding which may involve an operation.

After an ectopic pregnancy, you should discuss getting pregnant again with your doctor.

Bleeding and miscarriage

Bleeding in early pregnancy (before 20 weeks) is called a threatened miscarriage. Usually the bleeding stops and the pregnancy continues. But if there's bleeding *and* pain or discomfort in the lower back or abdomen (perhaps like period pains), it's more likely to be a miscarriage.

Miscarriages are common. One in seven pregnancies that have been confirmed end in miscarriage, usually in the first 14 weeks.

After a miscarriage, some women may need a procedure called a curettage or D&C (short for dilation and curettage). It's usually done under a general anaesthetic, and involves gently removing all the remaining pregnancy tissue from inside the uterus. This prevents any heavy bleeding and infection. But if an ultrasound scan shows the uterus is empty, a D&C isn't necessary.

While some women are not distressed by an early miscarriage, many find it devastating. One of the worst problems can be that other people don't always understand how much grief you can feel when you lose a baby this way. Although you can expect sympathy if your baby is stillborn or dies after birth, many people don't realise you can still feel real grief for a baby that is not fully formed.

For more information about coping with the grief of a miscarriage, see *When a baby dies*, which starts on page 122.

Bleeding after week 20

Bleeding after week 20 is called antepartum haemorrhage. It's uncommon, but needs immediate treatment. Always contact your doctor, midwife or hospital at the first sign of bleeding at any stage in pregnancy.

The cause may be a problem with the placenta called 'placenta praevia'. This means that instead of being attached to the top part of the uterus, some or all of the placenta is attached to the lower part of the uterus. When the uterus stretches in late pregnancy, it can dislodge part of the placenta, causing bleeding.

Sometimes, the placenta can separate slightly from the uterus, even though it's in the correct place. This can cause slight or heavy bleeding and, occasionally, abdominal pain. If a lot of the placenta comes away, there's a major risk to you and the baby. Prompt treatment usually saves the baby, although she or he may be born by caesarean and/or be preterm.

Diabetes and other problems with blood sugar

When someone has diabetes it means their body can't control the levels of glucose (blood sugar) in their blood. Uncontrolled blood sugar levels can cause serious health problems. There are two kinds of diabetes:

- insulin-dependent or type 1 diabetes means the body doesn't produce enough insulin to control blood sugar. People with type 1 diabetes need to inject insulin to keep blood sugar levels under control.
- with type 2 diabetes, the problem is a little different. People with this disease have enough insulin, but the body doesn't use it properly. As a result, blood sugar levels can become too high. Type 2 diabetes is usually controlled by diet and exercise, and sometimes tablets.

It is important to see your doctor or diabetes specialist early in pregnancy or even before you get pregnant, so that you get good care and control of sugar levels. With good care and treatment for their condition, most women with diabetes will have successful pregnancies. They will need to take extra care with diet, and self-test their blood glucose levels more often. Pregnant women with diabetes will need to see their doctor/specialist frequently for care and for adjustments to insulin doses (diabetes tablets cannot be used in pregnancy).

Gestational diabetes

This is a condition of abnormally raised blood sugar levels (also called glucose intolerance or hyperglycaemia) that may occur in the second part of the pregnancy. Some women with gestational diabetes may need no treatment, some need a strict diet and others may need insulin injections.

Some women with gestational diabetes (about 30 per cent) have larger than average babies. As a result, they are more likely to have intervention in labour such as a caesarean birth. Studies have suggested that women who develop gestational diabetes have an increased risk of developing type 2 diabetes later in life.

It's common for pregnant women to be offered a glucose test around 26-28 weeks of pregnancy.

However this condition is controversial because:

- there's a lack of evidence that women with only mildly raised blood sugar levels are more likely to have problems in pregnancy.
- there are concerns that women with only slightly raised blood sugar levels are being 'overdiagnosed' as having gestational diabetes. This diagnosis may mean they're more likely to have a medical intervention such as an induction or caesarean when there's no real need.

Some experts suggest that instead of screening all pregnant women for blood sugar problems, it would be better to just screen women with risk factors such as:

- sugar in the urine
- obesity
- over the age of 35 years
- a family history of diabetes.

According to the Australian Diabetes in Pregnancy Society, more good research is needed to find out the best way to diagnose gestational diabetes and how to treat it. If you're offered a test for gestational diabetes in pregnancy, you may want to ask some of the questions suggested in the section *It's okay to ask questions* on page 18).

For more information on diabetes, contact Diabetes Australia, GPO Box 9824, Sydney, NSW 2001.
Tel. (02) 9552 9900 or visit www.diabetesnsw.com.au

High blood pressure

The reason why doctors and midwives carefully check blood pressure in pregnancy is because untreated high blood pressure (called hypertension) can:

- reduce the blood supply to the baby
- have serious effects on the mother's kidneys, liver and brain.

With regular checking, high blood pressure can be found early and treated – another good reason for seeing a doctor or midwife as soon as you think you're pregnant, and for having regular antenatal care.

Raised blood pressure in later pregnancy can be an early sign of a condition called pre-eclampsia. Other signs of pre-eclampsia are protein in the urine and rapid swelling, especially in the hands, feet and face. This needs prompt treatment. Pre-eclampsia can develop into a more serious, but rare condition called eclampsia, which causes fitting.

Some women with high blood pressure that doesn't respond to anti-hypertensive medication may need to spend time in hospital during the pregnancy so that their blood pressure can be monitored and stabilised. This stay may be days, weeks or months, depending on how severe the problem is. Some large hospitals now have special day assessment units where you can stay during the day and go home at night.

Asthma

You will still need to take your asthma medication when pregnant. See your doctor regularly during pregnancy, as well-managed asthma is less likely to cause problems during the pregnancy. Asthma may improve or worsen during the pregnancy. You can improve your asthma if you don't smoke. If you experience breathing difficulties it is important that you consult your doctor. Uncontrolled asthma has been linked with premature births and low birthweight babies.

Epilepsy

If you have epilepsy it is important that you check with your doctor prior to getting pregnant as the medication and dose that you take to control epilepsy may change. Do not change the dose without discussing this with your doctor.

Depression

If you are planning a pregnancy and are on medications for depression, check with your doctor as your medication may change. Being pregnant may make your depression worse so it is important that you tell your midwife, doctor, or counsellor how you are feeling so they can provide or organise extra support for you. If you don't normally feel depressed and depression and/or anxiety develops during the pregnancy, please let your midwife or doctor know so they can provide or organise appropriate support for you.

Getting ready for labour and birth – self-help techniques

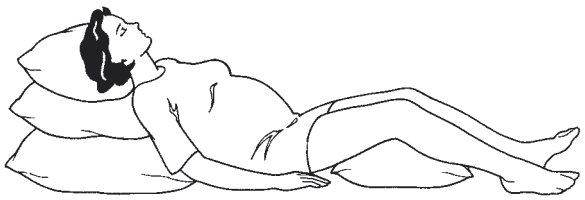
Relaxation and breath awareness

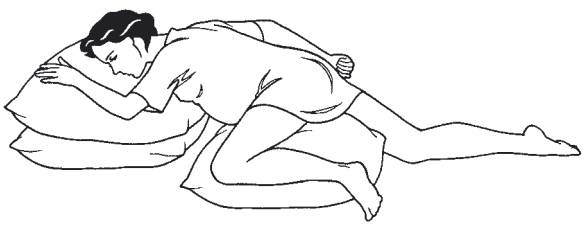
Being as relaxed as possible during labour will:

- help to relieve pain by relieving tension
- help your uterus to work better
- help you save energy (feeling stressed uses up energy!).

You can learn to relax in labour by using two simple techniques.

The first step in learning to relax is to find a position in which you feel totally comfortable





Basic relaxation technique

You don't need to be pregnant to benefit from this. It can help you cope with stress (and help you sleep) at any time in your life.

Practise this technique at home once or twice a day for at least 10 minutes if you can. It's good if your partner or other support person understands the technique as well.

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

1. Clench your right hand. Tense the arm muscles up to your shoulder. Now let go of the tension. Give a long, sighing, outward breath as you let go and relax. Feel your arm go loose. Be aware of how breathing out helps you relax. Relax more with each outward breath.
2. Repeat this with your:
   - left hand and arm
   - right foot and leg
   - left foot and left leg.
3. Bunch your shoulders up towards your ears. Feel how tense it makes you – now relax your shoulders as you breathe out.
4. Tighten the muscles around your genitals and anus (these muscles are part of your pelvic floor). Squeeze your buttocks together. Then let go as you breathe out.
5. Clench your jaw and frown, tightening your face and scalp muscles. Now breathe out and relax.

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

Breath awareness

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

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

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

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

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

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

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

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

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

Practising positions for labour

Changing positions in labour can really help (see *Labour and birth*, which starts on page 33). But if you're not used to some of these positions – eg squatting, rocking on your hands and knees – it's good to practise them during the pregnancy.

Stretches
Stretches can:

- help you hold different positions in labour without getting too uncomfortable
- relax tired muscles
- keep you supple.

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

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

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

Japanese sitting
Kneel on the floor with your knees apart and your toes pointing towards each other. Slowly move forward from the hips, keeping your buttocks down at your heels, and your back straight until your hands reach the floor. You should feel a stretch in your groin. If you can't feel a stretch, go down further onto your elbows.

Choices for pregnancy care and birth

Options for pregnancy care and place of birth

Pregnancy and birth are big events in your life. Make them as satisfying as possible by:

- being well informed about pregnancy and birth and what to expect
- being involved in decisions about your care
- having good support from your partner, family and caregivers.

There are many options available to you. The information in this section and in *Labour and birth*, which starts on page 33, can help you decide about your care. You should phone and visit the hospital/s or services where you are thinking of having your baby.

Health alert!!!

Babies benefit from both labour and vaginal birth for the preparation of their lungs for breathing.

Pregnancy and childbirth are a natural life event and in most cases you will have a natural birth. While all women hope for a normal pregnancy and birth there is always a chance of complications in pregnancy – to the mother, the baby or both of you. Some complications are found early in pregnancy and other problems may develop later in pregnancy or in the birthing stage. The purpose of your care is to identify any risks and manage them in the best possible way for you and your baby.

The following information describes most of the choices for pregnancy and birth care for public and private care options. For further information you can contact your Area Health Service, local Community Health Centre, the NSW Midwives Association or ask your midwife or doctor.

1. Public care options

Pregnancy care options

If you decide on a public care option your pregnancy care choices may include doctors clinic, midwives clinic, shared care, team midwifery, group practice and caseload.

Doctors antenatal clinic This clinic provides care in a team structure for women who are considered to have a high risk or complicated pregnancy. The team may consist of an obstetrician, a hospital doctor and a midwife.

Midwives clinic This clinic provides care by midwives for women who are considered to have normal or uncomplicated pregnancies.

Midwifery continuity of care models There are a variety of models available: team midwifery, group practice, and caseload (one-to-one care).

A midwife or small team of midwives may provide care throughout your pregnancy, during birth and after the baby is born. Check with your hospital on what models are available.

GP shared care Shared care means that you are able to have a combination of care between your General Practitioner (GP) and the midwives or doctors clinics. Please note that your GP must be approved by the Area Health Service to provide pregnancy care.

Place of birth options

Hospital care Hospital care is when you use a public hospital to have your baby. Midwives and/or doctors will provide care and support you through the birth. Your baby's birth would normally take place in the hospital's delivery/birthing suite.

After the birth you are cared for in a postnatal ward by midwives, doctors and other support workers, eg physiotherapists and social workers, depending on your needs.

Please see the section *After the baby is born – what happens in hospital,* on page 46 for more information regarding care in hospital.

Birth centre Birth centres look and feel more like a home than a hospital. Your care will be provided by midwives. There's a big demand for places in birth centres, so book in as early as possible.

This is an option for women with normal or low risk pregnancies. Birth centres aren't suitable for women with a higher risk of complications. This includes women who have heart or kidney disease, diabetes, high blood pressure or who have had complications in previous labours. The guidelines can vary from centre to centre. Check this with the birth centre.

During labour, you can do what feels comfortable - walk around, sit, squat or kneel. You can have people of your choice to be at the birth. You may be allowed to have children with you too. If a problem arises during your labour that requires medical attention you may be moved to the hospital delivery suite.

In a birth centre, you're likely to go home 24 hours after the birth and have follow-up care by midwives at home.

2. Private care options

If you have private health insurance, then you may be able to choose your own caregiver – such as an obstetrician, GP or independent midwife – and choose a private hospital or a public hospital with private wards for the birth.

You will need to check with your health insurance fund to find out what areas of care, including accommodation, are covered during your pregnancy, birth and postnatal period.

Some health insurance funds will give rebates for services by independent midwives. Please note that services by independent midwives are not covered by Medicare.

You can also pay for private care yourself if you are not a member of a health insurance fund.

Private obstetrician and General Practitioner (GP) With this option you receive care from a private obstetrician (Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists) and/or a GP (Diploma of Royal Australian and New Zealand College of Obstetricians and Gynaecologists or equivalent post graduate training in obstetrics) in their own private rooms. Some obstetricians may employ a midwife who may be involved in your antenatal care.

You may be admitted to a private hospital or public hospital (as a private patient) of your choice. You will be cared for in labour by midwives employed by the hospital but your doctor will be closely involved in your management and will normally be present at the birth of your baby. Some obstetricians or GPs may also provide care during pregnancy and for birthing at home.

Postnatal care will be provided by the hospital midwives and your doctor.

Independent midwives Some women choose to have a home birth with an independent midwife (registered with the NSW Nurses & Midwives Board). The midwife will care for you through your pregnancy, birth and after the baby is born. This is an option for women with normal or low risk pregnancies. Home births are not recommended for women with a higher risk of complications. This includes women who have heart or kidney disease, diabetes, high blood pressure or who have had complications in previous labours. You will need to discuss this with your midwife.

If complications do arise, you may need to transfer to hospital. You should prepare a Plan B – a back-up plan to go to hospital as part of your birth plan. Some hospitals like you to make an advance booking just in case, and your midwife will be able to advise you about local needs. In hospital your care will be provided by a midwife employed by the hospital.

Thinking of having a homebirth ...

It's important to:

- have a midwife (registered with the NSW Nurses and Midwives Board), GP or obstetrician care for you in labour and birth
- check with your local hospital if they provide homebirth as an option
- have regular antenatal care by a midwife or doctor in pregnancy
- have care after pregnancy (postnatal care) by a midwife or doctor
- have your newborn baby checked by a doctor in the first week after birth
- be sure your midwife or doctor offers tests for the baby after the birth (see *After the baby is born – what happens in hospital,* which starts on page 46), or refers you to a service that does them
- be sure your baby is offered vitamin K and other treatments as required after birth.

Some public hospitals provide homebirth services. Ask your midwife or doctor about the availability of this option.

To find out more about homebirth, contact the Independent Midwives' Association on (02) 9888 7829 (Sydney), the NSW Midwives Association on (02) 9281 9522, or Homebirth Australia on (02) 6545 3612. A leaflet, *Homebirth guidelines for parents*, is available from the National Health and Medical Research Council. Visit www.health.gov.au/nhmrc/publications

Complications in labour and birthing

Even if you're healthy and well prepared for labour and giving birth, there's always a chance of unexpected difficulties.

Slow progress of labour

Your midwife or doctor can tell how labour is progressing by checking how much the cervix has opened and how far the baby has dropped. If your cervix is opening slowly, or the contractions have slowed down or stopped your midwife or doctor may say that your labour isn't progressing.

It's good if you can relax and stay calm – anxiety can slow things down more. Ask what you and your partner or support person can do to get things going. The midwife or doctor may suggest some of the following:

- change to a position you're comfortable in
- walk around – movement can help the baby to move further down, and encourage contractions
- a warm shower or bath
- a back rub
- have a nap to regain your energy
- have something to eat or drink.

If progress continues to be slow your midwife or doctor may suggest inserting a IV drip with syntocinon to make your contractions more effective. If you're tired or uncomfortable, you may want to ask about options for pain relief.

When the baby is in an unusual position

Most babies are born head first, but some are in positions that may complicate labour and the birth.

Posterior position
This means the baby's head enters the pelvis facing your front instead of your back. This can mean a longer labour with more backache. Most babies will turn around during labour, but some don't. If a baby doesn't turn, you may be able to push it out yourself or the doctor may need to turn the baby's head and/or help it out with either forceps or a vacuum pump (see section *Labour and birth* on page 33. You can help by getting down on your hands and knees and rotating or rocking your pelvis - this may also help ease the backache.

Breech birth
This is when a baby presents bottom or feet first. In Australia about two per cent of babies are in the breech position by the time labour starts. Sometimes a procedure called 'external cephalic version' will be discussed – this is where a doctor gently turns the baby in late pregnancy by placing his or her hands on your abdomen and gently coaxing the baby around so it can be born head first. This turning is done at around 36 weeks, using ultrasound to help see the baby, cord and placenta. The baby and the mother are monitored during the procedure to make sure everything is okay. There's a small risk that turning the baby may tangle the cord or separate the placenta from the uterus. This is why the procedure is done in hospital, in case an emergency caesarean is needed.

Your midwife or doctor will discuss with you the best way of managing a breech labour and birth. If the baby is still in the breech position at the end of pregnancy, a caesarean may be recommended.

Multiple pregnancy

When there is more than one baby, labour may be preterm. When the last baby has been born, the placenta (or placentas) is expelled in the usual way. If the babies are premature, they are likely to need extra care at birth and for a few days or weeks afterwards.

At term, you may be induced if your babies are in the correct position. Often the obstetrician will suggest that you have an epidural. This is because after the first twin is born the second twin can get in an unusual position and the obstetrician may need to manoeuvre the second twin into position for birth.

"You've got to have a plan. But you can't expect to be too much in control of what happens. The main thing is to be as informed as possible." Katrina

Making your birth plan (see also page 27)

Things to think about:

- Where do I want to have my baby?
- Who do I want with me in labour eg my partner, my children, another family member or a friend? Support in labour is important.
- What do I want to bring into the delivery room, eg music?
- What birthing aids am I likely to need in labour – eg a beanbag, squatting bar or birth stool?
- Do I want pain relief – if so, what kind?
- How will the type of pain relief I choose affect the labour or the baby?
- What position do I want to try and give birth in?
- What is the usual practice for an episotomy?
- What if I need a caesarean? Would I prefer to have a caesarean with an epidural anaesthetic so I can stay awake? Do I want my partner to be with me – and will my partner be able to cope?
- What is the usual practice for an induction?
- What procedures may be recommended and why?
- What equipment may be used in my pregnancy care and for the birth of my baby and why?
- Do I have any cultural or religious needs around giving birth?

When you decide about any kind of treatment it's important to:

Make decisions based on good information. Talk to your midwife or doctor about the pros and cons of different treatments before you're likely to need them. Think of your own safety and well-being and that of your baby when you make these decisions.

Concern about the baby's condition

Sometimes there may be concerns that the baby is distressed during labour. Signs include:

- a faster, slower or unusual pattern to the baby's heartbeat
- a bowel movement by the baby (seen as a greenish-black fluid called meconium in the fluid around the baby).

If a baby is not coping well, its heart rate will usually be monitored. If necessary, the baby will be delivered as soon as possible with vacuum or forceps (or perhaps by caesarean).

Postpartum haemorrhage (heavier than normal bleeding)

It's normal to bleed a little after the birth. Your midwife or doctor will talk to you about this beforehand and discuss the best way to keep the bleeding within normal limits.

Heavier than normal bleeding after birth is called postpartum haemorrhage. This is when you lose 500ml of blood or more. The most common cause is the muscles of the uterus relaxing instead of contracting to prevent bleeding. An injection (oxytocin) given after the birth of the baby helps the uterus push the placenta out and reduces the risk of heavy bleeding. Your midwife will check your uterus regularly after the birth to make sure that it is firm and contracting.

Postpartum haemorrhage can cause a number of complications and may mean a longer stay in hospital. Some complications are severe but they rarely result in death.

Retained placenta

Occasionally the placenta doesn't come away after the baby is born, so the doctor needs to remove it promptly. This is usually done with an epidural or a general anaesthetic in theatre.

Early arrival
– when a baby comes too soon

While most pregnancies last between 37 and 41 weeks, it's not unusual for babies to arrive earlier. If a baby is born before the end of the 37th week, it's considered premature or preterm. About six per cent of babies born in Australia are premature.

Reasons can include:

- problems with the placenta or cervix
- a multiple pregnancy
- the waters have broken
- the mother has high blood pressure or diabetes
- an infection, particularly in the urinary tract.

There's also a higher risk of premature labour in women who haven't had regular antenatal care, but often the cause is unknown. If you have any symptoms of labour before 37 weeks, contact your midwife, doctor or hospital immediately.

It's safer for premature babies to be born in large, well-equipped hospitals with staff specially trained to care for small babies (especially those born before 33 weeks). If you live in a country area, it is important to go to the hospital as soon as possible so that you can be transferred to a larger hospital better equipped to handle a premature baby.

The chances of survival depend on how early the baby arrives and how quickly expert care is available. The chance of survival at 24 weeks is about 58 per cent. This rises to about 98 per cent by 28 to 30 weeks.

The risk of a disability depends on how premature the baby is. About 40 per cent of babies born at 24 weeks have a risk of a moderate or severe disability such as cerebral palsy, blindness, deafness or an intellectual disability. Babies born close to the end of pregnancy usually have no long-term problems.

Because their organs aren't fully developed, premature babies may have complications such as:

Lung problems Premature babies often need help to breathe because their lungs aren't fully developed.

Apnoea This means the baby stops breathing. It happens because the part of the brain that controls breathing isn't fully developed. Premature babies are monitored closely so they can be helped to restart breathing if it stops.

Difficulty feeding If babies can't suck, they need feeding through a tube into the stomach until they're ready to suck and swallow.

They get cold quickly Their natural thermostat hasn't developed properly so they can't control their own body temperature. That's why premature babies may need to be cared for in a humidicrib or under special overhead heaters until they are mature enough.

Jaundice The baby's skin may be yellow because the liver is still not working properly. For more information about jaundice, see *After the baby is born – what happens in hospital*, which starts on page 46.

"I was having twins and went into labour at 28 weeks. Looking back, I can remember lying in the ambulance going to the nearest hospital which had specialised care, and I was calm. I didn't panic. Somehow I think nature programs you to cope in these difficult situations. You just do what you have to do. Of course, after it was all over, I cried for a whole day. The twins were very sick at first, and they were monitored carefully for the first three years, but they're fine now."
Carol

Will my baby survive?

Normally, each extra week spent growing in the womb increases a baby's chance of survival dramatically. Babies born before 33 weeks of pregnancy are more likely to survive if they have specialised medical and nursing care in a neonatal intensive care unit.

Before 24 weeks, the chance of normal survival is very small and intensive care is not routinely given to these babies. If it looks as though your baby might be born this early in your pregnancy (before 24 weeks) your doctor will discuss this with you. It's important to be involved in the decision about whether or not to try to save your baby. To help you decide what is best for you and your family, your doctor will give you as much information as possible.

At 24 weeks, the survival rates are still low, but they improve dramatically after that time, so that by 28 weeks, more than 90 per cent will survive with highly specialised care in a neonatal intensive care unit.

For more information about premature birth, read:

- *Outcomes for premature babies: An information booklet for parents*, also known as the Green Book. This is available from your doctor, or from www.usyd.edu.au/cphsr
- *Care around preterm birth: a guide for parents.* (Cat no. 9702784) by the National Health and Medical Research Council (NH&MRC). Available by calling 1800 020 103 extension 9520, or from www.nhmrc.gov.au/publications

If your baby is premature or likely to be born prematurely, you may want to ask:

- Where is the best place for my preterm baby to be born?
- What can be done before birth to improve my baby's chances?
- What happens after my baby is born?
- What if my baby is born in a hospital without a neonatal intensive care unit (NICU)?
- Can I breastfeed my baby?
- How long will my baby be in hospital?
- How will my preterm baby develop in the long-term?
- Where can we find more information about preterm birth?

Babies with special needs

Some babies are premature, others are born with a condition that may make their life different in some ways, at least for a time. They may have an illness or other condition that affects the way their body or brain works.

These babies need special care in hospital. Their care will be supervised by a paediatrician (a doctor who specialises in caring for babies and children). If your hospital doesn't have the facilities to care for your baby, he or she may go to a different hospital by road or by air. NSW Health has a Newborn and Paediatric Emergency Transport Service (NETS), which will arrange this. It's often possible for you or your partner to travel with your baby to the new hospital.

If your baby has a problem, you'll have a lot of questions you want to ask. What is the cause of the condition and what can be done about it? How will it affect the child? Is there a chance any other babies you have in the future will be affected in the same way? Don't hesitate to ask questions – it's a good idea to write your questions down to make sure they all get answered.

Babies with health problems usually need to stay in hospital for special attention after the mother has gone home. It's important for you and your baby to get to know each other. You'll be encouraged to do this as soon as possible after the birth, even if the baby is in a humidicrib.

Some parents know in advance that their baby will have a problem, but whether the news comes before or after the birth, you may have feelings that are hard to cope with. Grief, anger and disbelief are natural at this time. Many parents, especially mothers, are worried that they are somehow to blame for the problem – but this is very unlikely.

You may hesitate to touch and handle your baby at first. The hospital staff will understand your feelings and try to help you cope with them.

You need as much support and information as you can get. Talking to your midwife, doctor, hospital staff, social worker or counsellor may help. So will talking to parents of babies with the same condition. Ask your midwife, doctor, hospital or Community Health Centre to put you in touch with appropriate community organisations or support groups. These organisations can provide information and support for you and your family.

When a baby dies

Sometimes, a pregnancy may have a sad rather than a happy ending when a baby is lost through miscarriage, is stillborn or dies soon after birth.

Miscarriage

Miscarriages are common, with one in seven confirmed pregnancies ending in miscarriage. Most happen in the first 14 weeks, but any loss before the 20th week is known as a miscarriage. For more information about what happens in a miscarriage, see *Complications in pregnancy*, which starts on page 102.

While many women do not have ongoing distress from an early miscarriage, others find it devastating. One of the worst problems can be that other people don't always understand how much grief you can feel when you lose a baby this way. Although you can expect sympathy if your baby is stillborn or dies after birth, many people don't realise you can still feel real grief for a baby that is not fully formed.

It's common to feel guilty after a miscarriage – you may think the miscarriage was caused by something you did (or didn't) do. It helps to talk to someone who understands what you're going through. This could be another woman who has miscarried, a hospital social worker, counsellor, doctor or midwife.

For more information and support contact SIDS and Kids NSW on (02) 9818 8400, on the 24hr Bereavement line 1800 651 186, or web address: http://www.sidsandkids.org/nsw/about_newsouthwales.html You can also contact Stillbirth and Neonatal Deaths support on (03) 9899 0217.

Stillbirth and the death of a newborn

When a baby dies in the uterus and is born after the 20th week of pregnancy, it's known as a stillbirth rather than a miscarriage.

Of all babies born in Australia, almost one in 100 is stillborn or dies soon after birth. This is more likely with a low birthweight baby or a baby with a developmental problem.

But whatever the reason, the grief you and your partner feel can be overwhelming. Most hospitals now have specially trained staff to help bereaved parents. As well as counselling, you will have the opportunity to spend time with and hold your baby, if you wish. You may also be able to go home and then come back and spend more time with the baby. Some people find this helps them understand the reality of the baby's death and allows them to express their grief.

You may want to have keepsakes of your baby – photographs, a hair clipping or a handprint, for example. It may be possible to bath your baby and video your time together. Again, for some people, these things help them cope better with their grief.

Mourning the loss of a baby is a very individual thing. It varies from person to person and culture to culture. The important thing is that your needs and choices are treated with respect. If there are cultural or religious practices you need to follow, let the hospital staff know.

"Losing Rebecca was the most emotionally shattering experience of my life. Holding her and having a funeral allowed me to have a sense of closure." David

It's normal for you and your partner to feel angry and even wonder if you or other people were to blame for your baby's death. You may worry that other pregnancies will end the same way. It will help to talk about these things with a doctor, midwife, grief counsellor or social worker at the hospital.

When a baby dies, the hospital will give you as much information as possible about what caused your baby's death. To find out more about this, you will be asked to consent to a post mortem, and possibly to tests on you and your baby. This can be very distressing. You don't have to agree to a post mortem or tests, but remember that finding out more about the cause of death may prevent similar problems in future pregnancies and help other people. Again, talking to a midwife, doctor, hospital social worker and your partner can help you cope with these decisions.

When you lose a baby through either miscarriage or stillbirth, you may find it helpful to spend time with other parents who have had a similar experience. To find a support group near you, contact SIDS and Kids NSW on (02) 9818 8400.

"My greatest sorrow was that I was never able to see Rebecca's eyes open, and the casts we made of her hand and footprints are more precious than any money in the world. When I fell pregnant again, I kept changing doctors until I found one who truly understood my absolute terror that I might also lose this new baby." Lindy

Feeding your baby

Breastfeeding – great for babies and mothers

For about the first six months of your baby's life, he or she will only need to drink breastmilk or a formula made for newborns.

"In the beginning, breastfeeding hurt so much and was so exhausting that I had to set myself goals – six weeks, three months, etc. By the time I reached that first goal, it had become so much more comfortable and easy that I was happy to keep going to the next marker. In the end, I breastfed for 16 months. In those first few tough weeks, I wouldn't have believed I'd do that." Chloe

It's really good to feed your baby only breastmilk for around the first six months. This gives the baby the best possible start. Even if you only breastfeed for a few months or weeks, this will be good for your baby. Breastfeeding is especially important for preterm babies.

Breastfeeding is good for babies because:

- It helps protect them from illnesses including diarrhoea.
- It may help prevent asthma, eczema and other allergies.
- It may improve their IQ.
- It helps their jaws develop properly.
- It is easier for them to digest.
- It gives them all the nutrients they need for the first six months.

Breastfeeding is good for mothers because:

- It helps you get back into shape faster – your uterus goes back to its normal size more quickly. You may also get back to your pre-pregnancy weight more quickly.
- It may help reduce the risk of developing breast cancer and weak bones.
- It's free.
- It's so convenient – no bottles, no equipment to keep clean (easier for night feeds and getting out and about).
- You don't have to worry about breastmilk being too strong or too weak – it's always just right.

Getting started

If you have any questions during pregnancy about breastfeeding, your midwife and the hospital where you have your baby can provide support and information.

After your baby is born, the midwives will show you how to breastfeed. Don't be surprised if you don't get it right straight away – breastfeeding doesn't come as naturally as many women expect. But once you get the knack, it's easy and convenient. Many women who have a bumpy start go on to breastfeed happily and successfully.

Putting your baby to the breast

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

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

Breastfeeding lying down can be very comfortable – it helps you to rest while your baby feeds.

- Try to lie fairly flat with a pillow under your head and your shoulder on the bed.
- Lie well over on your side – a pillow supporting your back and another between your legs can help.

Once you are feeding well, you will be able to feed your baby comfortably anywhere, without needing pillows.

FAQ
Q: How do I know if my baby is getting enough milk?

A: If your baby:

- is feeding at least six to eight times in 24 hours
- has six to eight pale, wet nappies in 24 hours
- poos occasionally
- is looking bright and alert
- is sleeping in the 24-hour period.

Healthy babies will take as much as they need. One of the major pluses for breastfeeding is that the baby can take as little or as much as he needs without anyone trying to make him finish the bottle.

Your baby's position
There are various ways that you can hold your baby for breastfeeding. Whichever way you choose, here are a few tips to help make sure that your baby is able to feed well:

- Your baby should be held close to you.
- He/she should be facing the breast with head, shoulders and body in a straight line.
- His/her nose or top lip should be opposite the nipple.
- He/she should be able to reach the breast easily, without having to stretch or twist.
- Always remember to move your baby towards the breast rather than your breast towards the baby.

Attaching your baby to the breast
It is important to make sure your baby latches onto the breast properly, otherwise he/she may not get enough milk during the feed and your nipples could become sore.

- Position your baby with their nose or top lip opposite your nipple.
- Wait until the baby opens his/her mouth really wide (you can gently brush his/her lips with your nipple to encourage this).
- Quickly move him/her onto your breast, so that the bottom lip touches the breast as far away as possible from the base of the nipple. This way, your nipple will be pointing towards the roof of his/her mouth.

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

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

FAQ
Q: Can I breastfeed if I have HIV?

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

FAQ
Q: Can I breastfeed if I have hepatitis C?

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

What to expect when breastfeeding

First feed
Babies show that they're ready to feed when they start searching for the breast and trying to bring their hands to their mouths. This happens soon after birth – usually within the first hour. Your midwife will help by making sure you and the baby are comfortable and well supported during the feed.

First week
Don't expect the baby to have a routine for feeding. At first your milk will be thick and creamy – this 'first' milk is called colostrum and is really good for the baby. This gradually changes to lighter and more abundant milk over a few days. After a slow start, most babies will feed at least eight times in every 24 hours. Some babies will feed more than this (however, they will not feed 12-15 times a day for all of their breastfeeding life!). Most women feel overwhelmed at some time during the first few days.

First six weeks
Some babies develop a pattern of sleeping and waking during the first six weeks. Others like to keep their parents guessing. At about 10 days, three weeks and six weeks, most babies have a growth spurt. They want to feed more frequently and may be more fussy. This is characteristic of baby-led feeding and is not an indication of a low milk supply.

Your breasts are settling and becoming more comfortable between feeds.

The next six months
Gradually babies become more predictable and it's easier to know what they need. As they become more sociable, they may be less interested in the breast unless they are really hungry. Many babies at this age are very efficient feeders and can get as much as they need in a few minutes.

At about four months, many women say their breasts feel different and are less full. This usually means that breastfeeding is well established, not that your supply has decreased. The changes are due to the breasts adjusting to supplying just as much as your baby needs.

FAQ
Q: Can I combine breastfeeding with formula feeding?

A: It is best for your baby if he or she only has breastmilk for around the first six months. If you need to leave him or her for an hour or two, the best option is to express milk and leave it with the babysitter. Do this in advance, so you are not rushing at the last minute. If you don't want to express, ask the babysitter to use an infant formula while you are away. Once your milk supply has been established, this won't affect breastfeeding. However, if your baby shows any signs of allergies, it is better to avoid using formula.

You may also need to combine breastfeeding and expressing or formula feeding if you are returning to work. For more information, contact your Child and Family Health Centre.

Health alert!!!
Medications

If you need to take any prescribed or over-the-counter medications, tell your doctor or pharmacist that you are breastfeeding. They will help you choose a safe medication. If in doubt, contact Mothersafe – Drugs in Pregnancy and Lactation Service. Tel. (02) 9382 6539 (Sydney metropolitan area) or 1800 647 848 (regional NSW).

Breastfeeding involves your partner too

Your partner will also bond in a unique way with your baby. They play a special role in breastfeeding by supporting both of you while you are learning. Research shows those mothers who have encouragement and support from their partner and family for breastfeeding find parenting more enjoyable.

Partners can be involved by:

- making sure you are comfortable and have enough to eat and drink while you are breastfeeding
- giving you some 'time out' by helping to settle the baby after the breastfeed
- providing practical support such as bathing and changing baby before/after the breastfeed
- monitoring the visitors while in hospital so well-wishers do not overwhelm you and your newborn.

Breastfeeding, formula feeding and allergies

Breastfeeding may help prevent children from developing allergies or eczema. There are also special formulas that reduce this risk, so if your family has a history of allergies, talk to your midwife, doctor or paediatrician during your pregnancy.

You can start to introduce solid foods at six months. See your Child and Family Health Centre for advice. You can get help and support with breastfeeding from:

- your hospital's lactation consultant (a health professional specially trained to help women breastfeed)
- your Child and Family Health Centre
- Australian Breastfeeding Association – a voluntary mother-to-mother support group that offers a phone helpline as well as discussion groups, coffee mornings and information. Tel. (02) 9639 8686 or (02) 6258 8928
- your local GP or paediatrician
- Tresillian Family Care Centres. Tel. (02) 9787 0800
- Karitane. Tel. (02) 9794 1800.

Expressing your breastmilk

Why you may want to express your milk:

- If you need to help your baby attach to a full breast.
- If your breasts feel full and uncomfortable.
- If your baby is too small or sick to breastfeed.
- If you need to be away from your baby for more than an hour or two.
- If you are going back to work.

There are a number of ways you can express your milk:

- hand expressing
- hand pumps
- electric pumps.

The method you choose may depend on why you want to express, how often you express and how much milk you want to express. You can ask your midwife or hospital lactation consultant to show you how to express and how to use a pump. There are lots of different types of pumps available, so before you buy or hire one, it's best to talk to a lactation consultant or the Australian Breastfeeding Association for advice about which type would suit you.

Common problems

Tender nipples
Let your nipples air dry after each feed. If any of the following problems continue after the first week, contact your local early childhood health centre:

- persistent tender nipples
- skin damage to nipples
- distorted pinched nipples.

Mastitis
There is a small risk of developing breast inflammation or infection (mastitis) in the first few weeks of breastfeeding. Prompt treatment will bring it under control quickly. Watch out for:

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

Things that may cause mastitis are:

- nipple damage (grazes or cracks caused by poor attachment) of the baby to the breast
- oversupply in the early weeks while your milk supply is adjusting to the baby's needs
- sudden changes in feeding pattern
- being overtired and skipping meals.

If you develop symptoms of mastitis, treat the affected breast by:

- applying moist heat, such as a shower, bath or warm pack
- massaging the area towards the nipple
- emptying the breast by feeding your baby or expressing some milk
- resting, increasing fluids and accepting any offers of help.

If you feel very ill or the problem does not get better quickly, it is important to contact your doctor as you may need antibiotics.

Alcohol and breastfeeding

Like other drugs, alcohol passes into breastmilk, so keep your intake to a minimum. The National Health and Medical Research Council recommends limiting intake to one standard drink just after a breastfeed. This will allow the alcohol to be broken down by the body before the next feed. For further information, contact ADIS, the Alcohol and Drug Information Service. Tel. (02) 9361 8000 (Sydney metropolitan area) or 1800 198 024 (regional NSW).

Smoking and breastfeeding

Chemicals such as nicotine from cigarettes pass into breastmilk. While it would be better to have no nicotine in your body at all, using nicotine replacement therapy (NRT), eg gum or inhaler, is better for you and your baby than continuing to smoke.

It is very important that babies live in a completely smoke-free environment. Babies exposed to cigarette smoke have a much greater risk of respiratory problems and SIDS (sudden infant death syndrome). If they are asthmatic, their symptoms will be worse.

For help with quitting smoking, phone the Quit information line on 13 18 48.

Tips for bottle feeding babies

Before giving the baby the bottle, always check the temperature of the feed. Shake a little from the teat onto the inside of your wrist. It should feel warm not hot. Allow it to cool if it is too hot. Don't use a microwave oven to heat baby formula, as it tends to heat unevenly and your baby could be burned.

Tilt the bottle at an angle to keep the teat full of milk, so the baby doesn't swallow air.

Adjust the tightness of the cap so the flow suits the baby. The tighter the cap the slower the flow. Sometimes the teat is too fast and one with fewer holes or a smaller hole may be needed.

The baby will need burping through the feed – usually when the faster sucking gives way to a slower, calmer suck. However, some babies become upset if their feed is interrupted and might need the bottle back.

Feeds usually take between 20-40 minutes.

It is dangerous for parents to 'prop' a bottle and walk away, leaving the baby to manage on his own. The milk could flow too quickly and cause the baby to splutter or even choke. Also, babies who feed a lot on their own are at greater risk of ear infections and tooth decay.

Babies need to be cuddled and talked to while they feed.

Putting your baby to bed with a bottle can cause tooth decay.

Encourage your baby to drink from a training cup from 6 months of age.

Formula feeding your baby

Whilst breastmilk is the best for babies, you may decide to feed your baby with formula, rather than breastmilk. This is your choice – what matters is that you and your baby are happy with whatever decision you make.

All infant formulas in Australia meet food and safety standards. Most are based on cow's milk.

Many hospitals will ask you to choose a formula during your pregnancy and bring it and your equipment into hospital with you when you have the baby. This means you can take time to choose which brand of formula or equipment you use and you'll be ready when your baby first wants to feed.

What you will need:

- Two to six large bottles – glass or plastic, with teats, caps and teat covers. Decorations and odd shapes make bottles hard to clean and there is no evidence that a particular shape of bottle or teat prevents wind or colic.
- Knife – plastic or metal for levelling the powder.
- Bottle brush to clean the bottles.
- Sterilising equipment.

How to prepare a bottle:

- Always wash hands and work surfaces before preparing formula.
- Boil fresh tap water and switch off within 30 seconds.
- Cool the water then measure the amount of water required into individual bottles.
- Using the scoop from the formula tin, measure the required number of scoops into the bottles, using a knife to level off each scoop. Do not pack down the formula in the scoop.
- Seal the bottle with a cap and disc and shake it gently to mix it.
- Put all made-up formula immediately in the centre back of the fridge where it is coldest.

Taking care of your baby's bottles

Everything that comes into contact with baby's feeds needs thorough cleaning and sterilising. This includes bottles, teats, caps, knives and dummies.

All equipment should be rinsed in cold water after use, washed in detergent and hot water using a bottle brush to thoroughly clean everything, then rinsed again, before sterilising.

You can choose which way you want to sterilise bottles and other equipment including:

- boiling – put utensils in a large saucepan of water and boil for five minutes
- chemicals – add a sterilising liquid or tablet to the container of water where you soak clean equipment
- steam sterilisers – an automatic unit which holds clean equipment
- microwave steam sterilisers – put bottles and other equipment into the steriliser, which is then heated in the microwave.

For more information about bottle feeding and sterilising equipment, talk to your Child and Family Health Nurse or a pharmacist.

Smoking and formula feeding

It is very important that babies live in a completely smoke-free environment. Babies exposed to cigarette smoke have a much greater risk of respiratory problems and SIDS (sudden infant death syndrome). If they are asthmatic, their symptoms will be worse. For help with quitting smoking, phone the Quit information line on 13 18 48.

For the sake of your baby's health, it is important to throw out any made-up unused formula after 24 hours.

Do not keep formula left in a bottle after a feed to give to your baby later – dispose of it at the end of the feed.

Your feelings
in pregnancy and early parenthood – what both partners need to know

Flip through a magazine or flick on TV, and you'd be forgiven for thinking that:

- all pregnant women glow with happiness
- no mother of a newborn baby ever felt worn out or overwhelmed
- every newborn baby has two devoted parents who share the workload and never fight about anything
- parenting comes naturally.

When you're pregnant or coping with early parenthood, life can seem very different to the rosy images in magazines and on TV. That doesn't mean there's something wrong with you – just that popular images of pregnancy and babyhood don't prepare you for the real thing.

The reality is that pregnancy and early parenthood can have a lot of ups and downs.

Any big event in your life (even good ones) can cause a lot of stress. That goes for weddings, new jobs, moving house, winning Lotto or having babies. Stress can make you feel down. Feeling tired – normal in pregnancy for women, and for both partners in early parenthood – adds to the load. For some parents, the fatigue in the first weeks can be overwhelming.

On top of this, women are dealing with the changes in their bodies and changing hormone levels that come after childbirth. They're also learning to breastfeed – and while it's best for mother and baby where possible, breastfeeding can be difficult at first. As for babies, it's not easy for them to adjust to their new world either – and if your baby has trouble feeding and settling, this will affect you too.

Don't be surprised if you feel down sometimes in both pregnancy and after the birth. Things that can help include:

- talking to someone – your partner, a friend, your midwife
- making more time for yourself – do something you enjoy
- trying not to get overtired when you're pregnant
- going for walks
- arranging for someone you trust to care for the baby for a few hours to give you some uninterrupted sleep.

Depression in pregnancy

While almost everyone feels down sometimes in pregnancy, some women feel down a lot of the time. If you're depressed it can be hard for you to tell how serious your feelings are. The best thing is to get help early. Tell your midwife or doctor about your feelings – they can help decide if you're just feeling down, or if it's something more serious.

Always tell your midwife or doctor if you are:

- feeling low a lot of the time
- feeling guilty
- not enjoying things you normally enjoy
- crying a lot
- blaming yourself for things that go wrong in your life
- being irritable most of the time
- having difficulty concentrating and making decisions
- feeling hopeless or helpless
- cutting yourself off from other people
- wanting to harm yourself.

If you have many of these feelings a lot of the time, get help. Depression can be treated very successfully. It's better to do something now than risk postnatal depression (PND) later – depression in pregnancy can increase the risk of PND. Some women may need anti-depressant medication (some anti-depressants can be safely prescribed in pregnancy).

Some things can make you vulnerable to feeling down or overwhelmed during pregnancy or the first few weeks at home with your baby. These include:

- you didn't plan to get pregnant
- past experiences of trauma or loss of a child
- feeling very alone and without support
- financial problems
- relationship problems
- having had depression or other mental health problems in the past
- using alcohol or other drugs, or coping with an addiction
- having high expectations of yourself and feeling you're not meeting them – perhaps you feel you're not coping, not getting enough done through the day, or you feel others are judging you.

"During pregnancy, I felt a lot of anxiety. What was happening didn't seem real and I was afraid of the unknown – I'd never had much to do with babies, so how was I going to look after this one?" Jay

Postnatal depression

It's normal to feel down for a few days or a couple of weeks after the birth (the baby blues). But for some women, the feeling doesn't stop. This may make the job of parenting seem overwhelming.

If you feel very low and lose interest or pleasure in things you normally enjoy, and have any four of the following symptoms for two weeks or more, you may have PND:

- feeling down
- feeling inadequate
- feeling you're not a good mother
- feeling hopeless about the future
- feeling helpless
- feeling guilty or ashamed
- anxiety or feelings of panic
- fears for the baby
- fears being alone or of going out
- feeling worn out, tearful, sad and 'empty'
- waking up early and having trouble getting back to sleep; being unable to sleep
- eating too little or eating too much
- difficulty concentrating, making decisions or remembering things
- thinking about harming yourself or wanting to die
- constantly thinking about running away from everything
- worrying about your partner leaving
- generally worrying about something bad happening to your baby or partner.

Don't be ashamed of these feelings – many women from all cultures and backgrounds feel like this. See your doctor or talk to your Child and Family Health Nurse as soon as possible.

What causes postnatal depression?

It's not certain what the real cause is. It's thought to be a mixture of physical and psychological things, as well as difficulties you may be having in your life.

Some things that increase your risk of postnatal depression include:

- if you've had depression before
- problems with your partner
- lack of support (practical help as well as emotional support)
- a number of stressful life events all piling up
- if others in your family have depression or other mental health problems
- being a single parent
- negative thinking – 'looking on the black side of things'
- complications with labour and birth
- problems with the baby's health (including a premature baby)
- having a 'difficult' baby (a baby that's easily upset, or is difficult to settle, or has problems with feeding and sleeping).

In the first few months of caring for a baby, it's normal to feel stressed, have disturbed sleep and changes to your routine. This can make it hard for you to know what's just part of the normal strain of early parenting, and what are signs of depression. Let other people know how you are coping and let them help. Talk to your doctor or Child and Family Health Nurse about how you feel. They can help monitor the situation.

How is PND treated?

Everyone has different needs. Treatment can include a number of things, including counselling, medication, self-help and services to give you support.

Did you know fathers can also be at risk of PND?

A partner can be struggling to cope and this can affect their emotions too. With all the attention on the baby and mother, the stress on fathers often goes unrecognised and they don't get the support they need.

"Many fathers feel the burden of responsibility that comes with a new baby. My partner asked me for a list of things so he could do the shopping. He was really trying to help. But all I could do was lie down on the bed and cry because I was too tired to think what I needed. But it doesn't last. Once you start getting more sleep, everything seems a lot easier." Mina

Postpartum psychosis

Postpartum psychosis isn't common. But it's very serious and needs immediate treatment. It can start anytime but usually starts within four to six weeks after birth. Symptoms include:

- severe mood swings
- very unusual beliefs, thoughts and ideas (delusions)
- hallucinations – seeing, hearing or smelling things that aren't there
- behaviour that is very odd and out of character for the person
- extreme despair
- withdrawing from people
- thinking or talking about morbid things; saying things like 'you'd be better off without me'.

Postpartum psychosis affects only one or two women in every 1,000 mothers. It's more likely to affect women who have been previously diagnosed with a mental illness, or who have family members with these illnesses.

Treatment usually includes admission to hospital, medication and help to look after the baby.

For more information about postnatal depression, see *Postnatal Depression: Not Just the Baby Blues*, available from the National Health & Medical Research Council, Tel. 1800 020 103, extension 9520, or by visiting www.nhmrc.gov.au/publications

If you want to talk to someone about feeling down or depressed in pregnancy, or when you're at home with your baby, you can call these 24-hour help lines:

- Tresillian Parent Helpline.
  Tel. (02) 9787 5255 (Sydney metropolitan area) or 1800 637 357 (regional NSW)
- Karitane Care Line.
  Tel. (02) 9794 1852 (Sydney metropolitan area) or 1800 677 961 (regional NSW).

How experiences of neglect and abuse can affect pregnancy and early parenthood

Being neglected or abused in childhood Some women who've experienced these things feel fine in pregnancy and parenthood. But for others, being pregnant or becoming a parent themselves can bring problems to the surface. It can be a painful reminder of things that happened to them in the past, or can make people feel more anxious about what kind of parent they will be.

Some people worry that they will be parents who neglect or abuse their children too. Some things you can do:

- Remember that just because you were abused yourself doesn't mean you'll be a bad parent.
- Talk to someone about how you feel. Many pregnant women feel what you feel and there are services to help. Your midwife can put you in touch with the hospital social worker, counsellor or other services.
- If you want to improve your parenting skills, there are people who can help. Your midwife can refer you to services. Or ask for support from a friend or relative whose parenting skills you respect (most people will be pleased – and flattered – to be asked).

Sexual abuse About one in three to four women experience some form of sexual abuse in their lifetime. Many of them have no problems in pregnancy or parenthood. But sometimes this experience can bring extra problems with pregnancy, childbirth and early parenting. Feelings from the past may come back. You may feel you're not coping. This is normal. If you feel anxious at this time, it's not surprising.

For some women, experiences of sexual abuse make it hard for them to let other people – even health professionals – touch their bodies. They may find it difficult to cope with some medical procedures, or even with the birth itself. If this is a problem for you, you can get help from a hospital social worker or counsellor. They can work with your midwife or doctor to make sure you feel as comfortable as possible.

You don't have to go into details about the sexual abuse either. A social worker or counsellor can help you plan for the birth, get ready for parenthood and help you with any worries about relationships with your partner or your own family without knowing the details.

Other things that may help include:

- taking a friend or other support person with you to examinations and other medical appointments
- talking to a friend
- ask to have medical tests and treatments explained to you first. If you think you may have difficulty with something, ask if there's another option.
- if you have a flashback or feel panicky, it may help to look around at where you are now, talk to someone and remind yourself that you're an adult now.

For support and information, contact a sexual assault service, community health centre or Dympna House, Tel. (02) 9797 6733 (Sydney metropolitan) or 1800 654 119 (regional NSW).

Relationships
in pregnancy and early parenthood

Becoming a parent – get ready for some changes …

Many people aren't prepared for the changes that being a parent brings to their relationship. The change from being a couple with time to spend on yourselves and each other to being parents with a small baby is a big one.

Pregnant partners

Because she's the one carrying the baby, it's often easier for a pregnant woman to bond with the baby and to get used to the idea of being a parent. But for her partner, it may not be so easy. Things that can help partners cope with pregnancy and prepare for early parenthood include:

- Be there for the ultrasound scan. Many partners find it a very powerful experience to see the baby for the first time.
- Talk to other friends who are parents and fathers. Talk to your own dad. Ask about their feelings and experiences.
- If you're apprehensive about being with your partner during labour and birth, talk to her about it. Ask other parents about their experiences in labour and talk to the midwife – this can give you an idea of what to expect.
- Go with your partner to childbirth education classes (partners are welcome too). Ask if you can go on a tour of the delivery/birthing suite at the hospital to see what it's like.
- Feel the baby kick.
- Get involved with caring for the baby as soon as possible after the birth. It does more than give your partner a break – it helps you feel more confident about parenting, and closer to the baby too.

Parents at last

Some people think having a baby won't change their relationship much. They think the baby will fit into their lifestyle. But your lifestyle *will* change – thinking about this before the baby arrives will help prepare you emotionally for these changes. Some things to think about:

All babies are different. Yours will arrive with a unique personality and temperament. As with any other person in your life, there will be things about your baby that you can't change. You'll need to spend time getting to know, understanding – and learning to live with – the way this little person is.

It's not just first babies that change things – the arrival of other children also affects relationships between parents, and relationships between parents and their children.

Babies have a habit of changing other relationships too, especially with a couple's own parents. Some women find that motherhood deepens the bond they have with their own mother, for instance. Some partners may find this change a bit threatening ('she's at her mum's *again* …'). But this doesn't mean that she's abandoning her partner. It's just natural for some women to feel closer to their mothers (or other mother figures) at this time.

The experience of changing from partner to parent can be different for each partner. If you're the one doing most of the nurturing of your baby in the early days, your experience will be different to your partner's. Yet at the same time, many concerns and experiences will be similar. See the examples below. Don't be put off by the list of losses some parents feel – most people find the gains of parenting more than make up for them.

"If you're a partner, talking about the baby helps you feel connected and involved. But the ultrasound really helped too – that's when the baby seemed to become real." Mark

Women may feel

- I've lost the identity I had before.
- I've gained a new identity as a mother.
- I've gained a different relationship with my partner as we learn to be parents together.
- I've gained a new relationship with my child.
- I have less time for myself.
- I have less time to spend with my partner and less time for just being together and talking.
- I wonder what will happen to our sex life?
- I've lost my work identity.
- I've lost my body shape.
- I've lost control over my body.
- I've lost control over my routine.
- I've gained a special relationship with my baby.

Partners may feel

- I've lost the identity I had before.
- I've gained a new identity as a father/parent.
- I've gained a different relationship with my partner as we learn to be parents together.
- I've gained a new relationship with my child.
- I have less time for myself.
- I have less time to spend with my partner and less time for just being together and talking.
- I wonder what will happen to our sex life?
- I wonder how much my life will change? What will happen to my time with friends? Will I have time for activities I enjoy?

"While I was euphoric about my new son, I wasn't prepared for the lack of closeness with my wife. It took many months to rebuild the loving, sexual relationship we'd previously enjoyed."
Lex

Emotional ups and downs – tips for coping

Remind yourself that some emotional ups and downs and arguments are normal for both of you. They're normal at any time – but especially in pregnancy and early parenthood when you're both coping with big changes.

Share your feelings with each other. This will help you understand and support each other. Although it's usually the pregnant woman who's the centre of attention and concern, she's not the only one who needs support. Her partner is often dealing with the same worries – will I be a good parent? Will the baby be okay? Will we cope on one wage? What will it be like to share you with the baby? What will our baby do to our relationship and our sex life? How will I feel about having less time for things like sport, social life or other interests? Will parenthood make me feel trapped?

Remember your partner isn't a mind reader. If one of you feels you're not getting the support and understanding you need, talk about it.

Talk about possible changes to your life that being a parent will bring. These may include financial changes, sharing household tasks, sharing the care of your baby, changes to your social life, less time to go out as a couple or changes to your working life. Think about how you'll cope with these changes.

Remember that parents still need their 'couple time' after the baby is born. This is a part of the glue that strengthens a relationship when you become parents. Try to find friends and relatives who'll mind your baby while you have time together as a couple, or just some time for one or both of you to get a few hours' sleep.

Domestic violence

Domestic violence has a big impact on the health of families, especially on women and their children. Research tells us that:

- pregnancy is the first time many women experience domestic violence
- for women already living with domestic violence, this violence tends to get worse in pregnancy.

Domestic violence can even impact on children before they are born. This can be because their mother is injured. But new research also shows that the stress of living with violence (physical or other kinds of violence) has a great effect on pregnant women. This can influence how their baby develops. Babies of women affected by domestic violence in pregnancy may:

- have a lower birthweight
- grow up with social and emotional problems, even if they don't experience the violence after they are born.

This is why all women are likely to be asked about domestic violence by their midwife or Child and Family Health Nurse.

You may be asked more than once – it's part of routine health care. You don't have to answer questions about violence if you don't want to, but it's important to know that violence is a health issue. If you tell a health worker you are experiencing domestic violence and that you are afraid, they will offer to help you get in touch with services that can help.

Domestic violence is also a crime – a crime that affects all kinds of women from all kinds of backgrounds.

Domestic violence isn't just being punched or hit. It can mean other things that are done to control and dominate another person, such as:

- making threats
- forcing you to do sexual things when you don't want to
- controlling your money
- stopping you from seeing family and friends.

If you're afraid or concerned for your safety or the safety of your children, you can:

- call the police or a local refuge
- tell someone you trust (friend, GP or health worker)
- go to a safe place
- use the law to protect you and your children – talk to the police or local court about how to get help
- make a safety plan in case you and your children have to leave quickly.

There is free counselling, information and medical help for anyone who has been assaulted or abused. These services are based in many hospitals.

You can also call the domestic violence helpline on 1800 656 463 or TTY 1800 671 442 (toll free, 24 hours a day, seven days a week). This service can give you details of the nearest refuge, court assistance scheme and other services.

If you are in danger, call the police on 000.

Resources and services

Can I believe what I read?

There are lots of places to find out more about being pregnant and having a baby, but how do you know you can trust the information? How can you decide whether the information is balanced? Is it just someone's opinion, for instance? Or is it trying to get you to make a certain decision or to buy something?

Here's a checklist of questions to help you decide how much you can trust the information you might read. Think about these questions when you read anything, even *Having a baby.*

1. **Is the purpose of the information clear?** Why are you being given this information? Is it to inform you about a subject or is it trying to persuade you to choose something or buy a product?
2. **Where does the information come from?** Can you tell who wrote it? What qualifications or experience do they have? Has it been scientifically tested? Does it come from a range of experts or from just one person?
3. **Is the information balanced and unbiased?** Does it give you all the options or does it push one point of view? Does it come from a range of sources?
4. **Is it relevant?** Does the information apply to your circumstances?
5. **Is it up to date?** Can you tell when it was first published? Has it been updated since? Does it agree with what other sources of information are saying?
6. **Does it let you know if the experts don't have all the answers on an issue?** Does it admit that not all the answers are known or that there is a debate about the subject?
7. **Does it encourage you to find out more elsewhere?** Does it refer you to other books, websites or organisations for more information about the subject?
8. **Does it encourage you to make your own choices?** Is it pushing you to do something or does it help you to make your own decision abut an issue, regardless of what that choice is?

Information about pregnancy, birth and babies

Australian Baby
Web. www.australianbaby.info

Australian Government
Web. www.healthinsite.gov.au

Birth International
PO Box 366, Camperdown NSW 1450
Tel. (02) 9564 2322
Email. ozinfo@birthinternational.com
Web. www.birthinternational.com

Birthnet
Web. www.birthnet.com.au

Cochrane Collaboration Consumer Network
Tel. (03) 9594 7530
Email. cochrane@med.monash.edu.au
Web. www.informedhealthonline.org

Enkin et al, (Oxford University Press, 2000). **A Guide to Effective Care in Pregnancy & Childbirth**. In full text PDF format on the American Maternity Center Association.
Web. www.maternitywise.org/guide/

Maternity Center Association
Web. www.maternitywise.org

MyDr
Web. www.mydr.com.au

National Health and Medical Research Council
Executive Secretary
Office of NHMRC (MDP 100)
GPO Box 9848, Canberra ACT 2601
Tel. (02) 6289 9184
Email. exec.sec@nhmrc.gov.au
Web. www.nhmrc.gov.au

NSW Health
Locked Mail Bag 961, North Sydney NSW 2059
Tel. (02) 9391 9000
Email. nswhealth@doh.health.nsw.gov.au
Web. www.health.nsw.gov.au/pubs

NSW Multicultural Health Communication Service
GPO Box 1614, Sydney NSW 2001
Tel. (02) 9382 7516
Email. mhcs@sesahs.nsw.gov.au
Web. www.mhcs.health.nsw.gov.au

Parents' Place
Web. www.parentsplace.com

Royal Australian New Zealand College Obstetricians and Gynaecologists
College House
254-260 Albert St, East Melbourne VIC 3002
Tel. (03) 9417 1699
Web. www.ranzcog.edu.au

Victorian Government
Web. www.betterhealth.vic.gov.au

Women's Health Victoria
Web. www.whv.org.au

Extra resources and services that may be helpful during pregnancy

Alcohol, tobacco and other drug use

Alcohol and Drug Information Service
Tel. (02) 9361 8000 or 1800 198 024

Australian Drug Foundation
PO Box 818, North Melbourne VIC 3051
Tel. (03) 9278 8100
Email. adf@adf.org.au
Web. www.adf.org.au/adp

MotherSafe
Tel. (02) 9382 6539 or 1800 647 848

Quit information line
Tel. 13 18 48

Diet and pregnancy

Food Standards Australia New Zealand
PO Box 7186, Canberra BC ACT 2610
Tel. (02) 6271 2222
Email. info@foodstandards.gov.au
Web. www.foodstandards.gov.au

Nutrition Australia
PO Box 71, Oakflats NSW 2529
Tel. (02) 4257 9011
Email. nsw@NutritionAustralia.org
Web. www.nutritionaustralia.org

Domestic violence and assault

Domestic Violence Line
Tel. 1800 656 463
TTY 1800 671 442

NSW Rape Crisis Centre
1800 424 017 (24 hour counselling)
www.nswrapecrisis.com.au

Infections, genetic disorders and conditions

Aids Council of Australia
Tel. (02) 9206 2000

Australian Action on Pre-eclampsia
PO Box 29, Carlton South VIC 3053
Tel. (03) 9330 0441
Email. info@aapec.com
Web. www.aapec.com

Australian Diabetes in Pregnancy Society
Web. www.adips.org

Centre for Genetics Education
PO Box 317, St Leonards NSW 1590
Tel. (02) 9926 7324
Web. www.genetics.com.au

Cystic Fibrosis Foundation (NSW)
PO Box 149, North Ryde NSW 2113
Tel. (02) 9878 2075

Diabetes Australia – NSW
GPO Box 9824, Sydney NSW 2001
Tel. (02) 9552 9900
Web. www.diabetesnsw.com.au

Hepatitis C helpline
Tel. (02) 9332 1599 or 1800 803 990
Email. info@hepatitisc.org.au
Web. www.hepatitisc.org.au

Pre-eclampsia Foundation
PO Box 52993. Bellevue, WA 98015-2993. USA
Email. info@preeclampsia.org
Web. www.preeclampsia.org

Thalassaemia Centre of NSW
Level 5, Queen Mary Building
Grose St, Camperdown NSW 2050
Tel. (02) 9550 4844

Multiple pregnancy

Multiple Birth Association of Australia
PO Box 105, Coogee NSW 2034
Web. www.amba.org.au

Sport and exercise

Australian Sports Commission
PO Box 176, Belconnen ACT 2616
Tel. (02) 6214 1111
Web. www.activeaustralia.org/women/pregnancy.htm

NSW Branch of the
Australian Physiotherapy Association
Tel. (02) 8748 1555

NSW Department of Sport and Recreation
Locked Bag 1422, Silverwater NSW 2128
Tel. 13 13 02
Email. info@dsr.nsw.gov.au
Web. www.dsr.nsw.gov.au/active/h_preg.asp

Sports Medicine Australia
PO Box 237, Dickson ACT 2602
Tel. (02) 6230 4650
Web. www.sma.org.au/information/policies.asp

Work and pregnancy

WorkCover Authority of NSW
92-100 Donnison St, Gosford NSW 2250
Tel. (02) 4321 5000
Web. www.workcover.nsw.gov.au

Extra resources that explore labour and birth

Homebirth Access Sydney
Web. www.homebirthsydney.org.au

Homebirth Australia
PO Box 625, Scone NSW 2337
Tel. (02) 6545 3612
Email. homebirth.australia@bigpond.com
Web. www.homebirthaustralia.org

Independent Midwives Association
Tel. (02) 9888 7829

Parents of Premature Babies Inc (Preemie-L)
Web. www.preemie-l.org

Vaginal Birth After Caesarean (VBAC)
Birthrites
Web. www.birthrites.org

Extra resources and services that may be helpful after the baby is born

Allergies

Australasian Society of
Clinical Immunology and Allergy
Web. www.allergy.org.au

Breastfeeding

Australian Breastfeeding Association
1818-1822 Malvern Rd, East Malvern VIC 3145.
Helplines:
ACT/Southern NSW (02) 6258 8928
NSW (02) 9639 8686
Web. www.breastfeeding.asn.au

Breastfeeding.com
Web. www.breastfeeding.com

La Leche League International
Web. www.lalecheleague.org

Car restraints

Children's Hospital at Westmead
Locked Bag 4001, Westmead NSW 2145
Tel. (02) 9845 0000
Web. www.chw.edu.au/parents/factsheets

Roads and Traffic Authority
Tel. 13 22 13
Web. www.rta.nsw.gov.au

Community Health Centres

For your local centre, check the phone book

Contraception

FPA Healthline
Tel. 1300 658 886
Web. www.fpahealth.org.au

Early Childhood Centres

For your local centre, check the phone book

Immunisation

Immunise Australia Program
Web. www.immunise.health.gov.au

Money matters

Centrelink
Tel. 13 10 21
Web. www.centrelink.gov.au

Family Assistance Office
Tel. 13 61 50
Web. www.centrelink.gov.au

Naming baby

Baby names
Web. www.babynames.com.au

Parenting

Attachment Parenting International
2906 Berry Hill Drive
Nashville, TN 37204. USA
Web. www.attachmentparenting.org

Infant Massage Information Service
Tel. (02) 6952 2351
Email. info@infantmassage.imis.com.au
Web. www.infantmassage-imis.com.au

Karitane Care Line
Tel. (02) 9794 1852 or 1800 677 961

Kidslife
PO Box 2300, Balgowlah DC NSW 2093
Email. enquiries@kidslife.com.au
Web. www.kidslife.com.au

NSW Parenting Centre
Locked Bag 28, Ashfield NSW 1800
Tel. (02) 9716 2644
Email. parenting@community.nsw.gov.au
Web. www.parenting.nsw.gov.au

Relationships Australia
5 Sera Street, Lane Cove NSW 2066
Tel. 1300 364 277
Web. www.relationships.com.au

Tresillian Parent Helpline
Tel. (02) 9787 0855 or 1800 637 357

Postnatal depression

Beyond Blue
PO Box 6100, Hawthorn VIC 3122
Tel. (03) 9810 6100
Info. 1300 224 636
Email. bb@beyondblue.org.au
Web. www.beyondblue.org.au

Depression after Delivery
91 East Somerset St, Raritan, NJ 08869,USA
Web. www.depressionafterdelivery.com

When a baby dies

SIDS and Kids
PO Box 431, Camperdown NSW 1450
Tel. (02) 9818 8400
Email. sydney@sidsandkids.org
Web. www.sidsandkids.org

Miscarriage Support Auckland
Email. support@miscarriagesupport.org.nz
Web. www.miscarriagesupport.org.nz

Resources and services that may be useful for health professionals

Australian Breastfeeding Association
1818-1822 Malvern Rd, East Malvern VIC 3145
Helplines:
ACT/Southern NSW (02) 6258 8928
NSW (02) 9639 8686
Web. www.breastfeeding.asn.au

Australian College of Midwives
GPO Box 666
Canberra ACT 2601
Tel. (02) 6230 7333
Free call 1300 360 480
Email. acmi@acmi.org.au
Web. www.acmi.org.au

Australian Government
Web. www.healthinsite.gov.au

Cochrane Collaboration Consumer Network
Tel. (03) 9594 7530
Email. cochrane@med.monash.edu.au
Web. www.informedhealthonline.org

Cochrane Collection
Tel. (03) 9594 7530
Email. cochrane@med.monash.edu.au
Web. www.cochrane.org

International Board of Lactation Consultant Examiners
PO Box 13, South Hobart TAS 7004 Australia
Tel. (03) 6223 8445
Regional administrator (07) 5529 8811
Email. admin@iblce.edu.au
Web. www.iblce.edu.au

La Leche League International
Web. www.lalecheleague.org

Maternity Center Association
Web. www.maternitywise.org

Maternity Coalition
PO Box 1190, Blackburn North VIC 3130, Australia
Email. inquiries@maternitycoalition.org.au
Web. www.maternitycoalition.org.au

National Health and Medical Research Council
Web. www.nhmrc.gov.au

National Perinatal Epidemiology Unit
Institute of Health Sciences
Old Road, Headington, Oxford OX3 7LF
Web. www.npeu.ox.ac.uk

National Perinatal Statistics Unit
2nd floor, McNevin Dickson Building
Randwick Hospitals Campus
Avoca Street, Randwick NSW 2031
Tel. (02) 9382 1014
Email. npsu@unsw.edu.au
Web. www.npsu.unsw.edu.au

NSW Health
Locked Mail Bag 961, North Sydney NSW 2059
Tel. (02) 9391 9000
Email. nswhealth@doh.health.nsw.gov.au
Web. www.health.nsw.gov.au

Pregnancy and Newborn Services Network
QE II Building, University of Sydney NSW 2006
Web. www.psn.org.au

Your comments matter

If you want to comment about the quality of your maternity care, consider talking or writing to the organisation that provided the service. If you have a complaint, it is particularly important to do this because it shows areas that may need improvement.

If you don't feel comfortable about making your comment, you can ring the complaints resolution service on the numbers below.

Penrith/Blue Mountains
Tel. (02) 4734 3870

Western Sydney
Tel. (02) 9881 1506

South Eastern Sydney
Tel. (02) 9382 8129

Wollongong
Tel (02) 4222 5556

Northern Sydney
Tel. (02) 9926 8184

South Western Sydney
Tel. (02) 9828 5710

Central Sydney
Tel. (02) 9395 2028

Newcastle/Hunter
Tel. (02) 4985 3143

If you live in a rural or remote area, you can call the Complaints Resolution Service on 1800 043 159 or TTY (02) 9219 7555. If you need more information, contact the Health Care Complaints Commission on (02) 9219 7444 or visit www.hccc.nsw.gov.au

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