



The Pregnancy Book 2026



Your complete guide to:

A healthy pregnancy

Labour and childbirth

The first weeks with your new baby



This book employs the terms 'woman' and 'mother'. These terms should be taken to include people who do not identify as women but who are pregnant. Similarly, where the term 'parents' is used, this should be taken to include anyone who has main responsibility for caring for a baby.

This book is given free to all expectant mothers. Because developments can be very rapid, significant changes will always be notified to doctors and other health professionals at once. They will then be incorporated into the text for the next reprint.

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Introduction



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

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

This book brings together everything you need to know to have a healthy and happy pregnancy, and to make sure you get the care that is right for you. The guidance about pregnancy and babies does change, so it's important to get up-to-date, trusted advice to help you make the right decisions and choices.

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



Your pregnancy at a glance

Before you get pregnant

- Think about the lifestyle factors that might affect your ability to get pregnant and have a healthy pregnancy (see Chapter 5). This applies to men too. You are more likely to get pregnant if you are both in good health.

- If you smoke, get advice about stopping. You are up to four times more likely to stop smoking successfully with support. Visit www.stopsmokingni.info for further information on the 650+ specialist stop smoking services that are available across Northern Ireland. These free stop smoking services provide nicotine replacement therapy (NRT) and are run by specially trained staff who can advise you on the best way to manage your cravings and become smoke free. Services are offered in many GP practices, community pharmacies, HSCT premises, and community and



voluntary organisations. They can be set up in workplaces.

- Eat a balanced diet.
- Maintain a healthy weight.
- You should avoid drinking alcohol if you are pregnant or trying to conceive.
- Take exercise.
- If you or your partner take any medication, talk to your doctor about whether it will affect your pregnancy.
- Take 400 micrograms of folic acid a day. This is available to buy from your pharmacy or supermarket. You should continue to take this until you are 12 weeks pregnant (see page 35).
- Take a 10 microgram supplement of vitamin D daily. During the summer months (late March/April to the end of September), most people will usually get enough vitamin D from sunlight, so you may choose not to take

a supplement over the summer.

- If you already have a baby with spina bifida, or if you have coeliac disease, sickle cell disease, diabetes, are living with overweight or obesity or take anti-epileptic medicines, ask your GP or midwife for more advice. You will need to take a bigger dose of folic acid that requires a prescription.
- If you have a health condition, for example mental health problems, diabetes or a family history of any inherited diseases, talk to your GP or a specialist before you try to get pregnant.

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

Further information is available at www.nidirect.gov.uk/information-and-services/living-well/pregnancy-and-trying-baby

PHDG youtube - Planning your pregnancy
www.youtube.com/watch?v=R2VmFqMm6Z8&t=6s

0–8 weeks

- As soon as you know you are pregnant, get in touch with a midwife or your GP to organise your antenatal care (see Antenatal care on page 57). Begin to think about where you want your baby to be born (see page 63).
- Some pregnant women start to feel sick or tired or have other minor physical problems for a few weeks (see page 77).
- Take 10 micrograms of vitamin D per day. This is available to buy from your pharmacy or supermarket. You should continue to take vitamin D throughout your pregnancy and while you are breastfeeding. If you qualify for Healthy Start (you are at least 10 weeks pregnant and in receipt of certain benefits) you will be entitled to Healthy Start vitamins which contain vitamin D and folic acid. If you do not qualify for Healthy Start your midwife may recommend other supplements.
- If you have type 1 or type 2 diabetes or a past history of gestational diabetes, telephone the antenatal clinic for an early appointment as soon as you realise you are pregnant.
- If you are not already taking folic acid supplements, you should start now. If you already have a baby with spina bifida, or if you have coeliac disease, sickle cell disease, diabetes, are living with overweight or obesity or take anti-epileptic medicines, ask your GP or midwife for more advice. You will need to take a bigger dose of folic acid that requires a prescription.

8–12 weeks

- You will usually attend your first booking appointment by 12 weeks.
- At the booking appointment, your weight, height and body mass index will be measured. You will be asked about your health and family history as well as about your baby's father's family history. This is to find out if you or your baby are at risk of certain conditions.
- Your maternity record and plan of care will be completed.
- You will be offered screening for infectious diseases including HIV, hepatitis B, syphilis and rubella. You will also have blood tests for anaemia and blood grouping and antibody check.
- Your midwife will discuss various tests you will be offered during your pregnancy, one of which is an ultrasound scan to check for certain conditions in your baby (see page 66). You will be offered information about what to expect during pregnancy and how to have a healthy pregnancy. Ask if you are unsure about anything.
- Your midwife will also discuss the whooping cough, RSV, flu and COVID-19 vaccines which are offered to all pregnant women.
- Your midwife or GP will be able to give you advice on where to get your flu vaccine at any stage of pregnancy during flu season.
- You can ask your midwife about your rights at work and the benefits available.
- You will usually be offered an ultrasound scan between eight and 14 weeks. This will check the baby's measurements and give an accurate due date. The scan can also detect some genetic conditions and check if you are carrying more than one baby. Your partner can come along to the scan (see Antenatal care on page 57).
- Make a dental appointment. HSC dental care is free during pregnancy and for a year after the birth of your baby.
- Just 12 weeks after conception, your baby is fully formed. It has all its organs, muscles, limbs and bones, and its sex organs are well developed. However, it takes several more weeks to easily identify the difference between boys and girls on ultrasound scan.
- Your baby is already moving about but you cannot feel the movements yet.



12–16 weeks

- Find out about antenatal education (see Antenatal care on page 57).
- Start to think about how you want to feed your baby (see Feeding your baby on page 121).
- Make sure you are wearing a supportive bra. Your breasts will probably increase in size during pregnancy so you need to make sure you are wearing the right sized bra.
- If you have been feeling sick and tired, you will probably start to feel better around this time.
- Your pregnancy may just be beginning to show. This varies a lot from woman to woman.



16–20 weeks

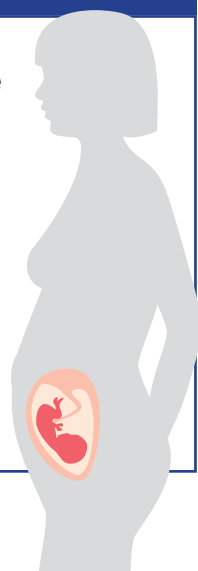
- You may start to feel your baby move (see How your baby develops on page 23).
- Your tummy will begin to get bigger and you will need looser clothes.
- You may feel a surge of energy.
- Try to do your pregnancy exercises regularly (see Keeping active on page 45).
- Your midwife or doctor should:
 - review, discuss and record the results of any screening tests;
 - measure your blood pressure and test your urine for protein;
 - consider an iron supplement if you are anaemic
 - offer and give you the whooping cough vaccine between 16–32 weeks.
- Your midwife or doctor should give you information about the anomaly scan you will be offered at 18–20 weeks and answer any questions you have.
- Your baby is now growing quickly. Their face becomes much more defined and their hair, eyebrows and eyelashes are beginning to grow.
- Ask your doctor or midwife to let you hear your baby's heartbeat.

20–25 weeks

- Your uterus will begin to get bigger more quickly and you will really begin to look pregnant.
- You may feel hungrier than before. Stick to a sensible balanced diet (see Your health in pregnancy on page 31).
- Ask your midwife about antenatal education (see Antenatal education/parentcraft on page 74).
- You will begin to feel your baby move.
- Get your maternity certificate (form MAT B1) from your doctor or midwife.

25 weeks

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

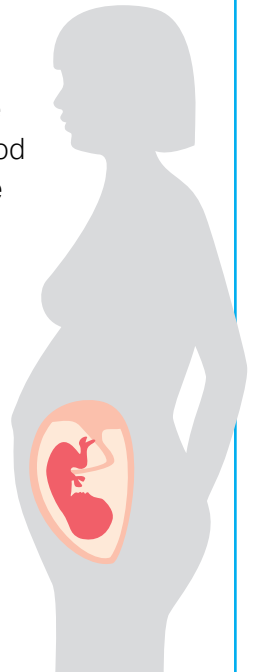


28 weeks

- Your baby will be quite small.
- You may find that you are getting more tired.
- Your midwife or doctor should:
 - use a tape or ultrasound scan to measure the size of your uterus;
 - measure your blood pressure and test your urine for protein;
 - repeat your blood tests to check for antibodies and anaemia. Your midwife or doctor should offer your anti-D treatment (see page 64) if you are rhesus negative.
 - offer and give you the whooping cough vaccine between 16–32 weeks
 - offer and give you the RSV vaccine from 28 weeks.
- If you are claiming Statutory Maternity Pay (SMP), you must inform your employer at least 28 days before you stop work.
- You can claim a lump sum Sure Start Maternity Grant to help buy things for your first baby if you get one of the following:
 - Income Support;
 - Income-based Jobseeker's Allowance;
 - Income-related Employment and Support Allowance;
 - Pension Credit;
 - Working Tax Credit where the disability or severe disability element is included in the award;
 - Child Tax Credit payable at a rate higher than the family element.
- Think about what you need for the baby (see What you need for your baby on page 153).
- If you have young children, it's good to talk to them about the new baby.
- Make sure your shoes are comfortable. If you get tired, try to rest with your feet up.

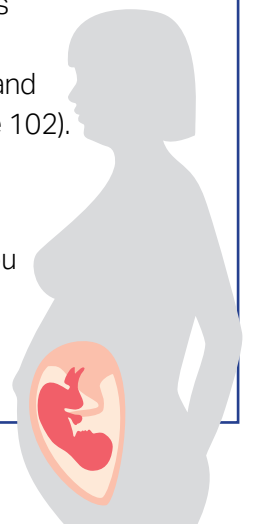
31 weeks

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



34 weeks

- Your midwife or doctor will give you information about preparing for labour and birth, including how to recognise active labour, ways of coping with pain in labour and developing your birth plan. They should also:
 - review, discuss and record the results of any screening tests from the last appointment;
 - measure the size of your uterus;
 - measure your blood pressure and test your urine for protein.
- Make arrangements for the birth. You can give birth at home, in a midwifery unit or in hospital. If you have children already, you may want to make childcare arrangements for when you go into labour.
- You may want to ask about whether tours of maternity facilities for birth are available.
- Think about who you would like to have with you during labour.
- Get your bag ready if you are planning to give birth in hospital or in a midwifery unit.
- You will probably be attending antenatal classes now (see Antenatal care on page 57).
- You may be more aware of your uterus tightening from time to time. These are mild contractions known as Braxton Hicks contractions (see Labour and birth on page 102).
- You may feel quite tired. Make sure you get plenty of rest.



36 weeks

- Make sure you have all your important telephone numbers handy in case labour starts (see Labour and birth on page 101).
- Your midwife or doctor should give you information about:
 - feeding your baby;
 - caring for your newborn baby;
 - vitamin K and screening tests for your newborn baby;
 - the 'baby blues' and postnatal depression.
- Your midwife or doctor should:
 - measure the size of your uterus;
 - check the position of your baby;
 - measure your blood pressure and test your urine for protein.
- Sleeping may be increasingly difficult.

38 weeks

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

40 weeks

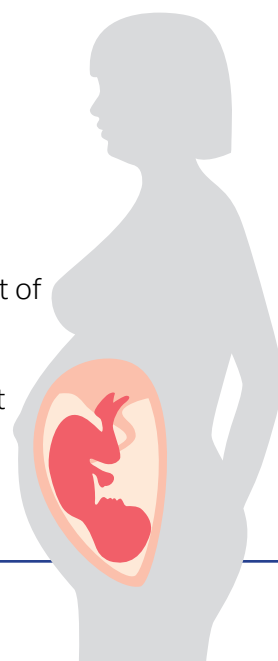
(if this is your first baby)

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



41 weeks

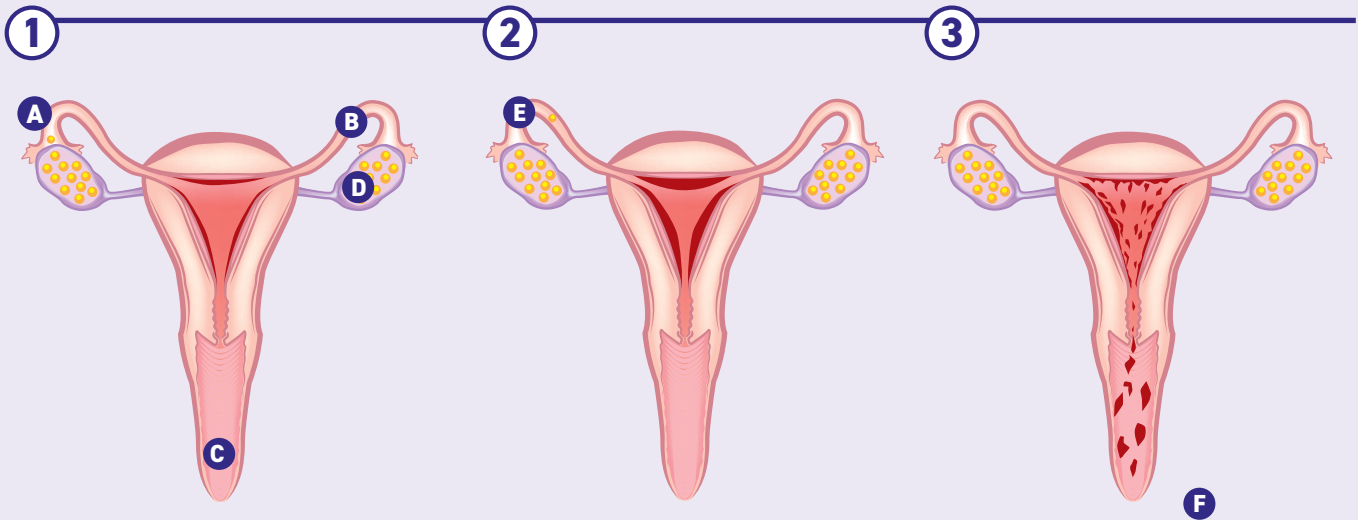
- If your pregnancy lasts longer than 41 weeks, you may be induced. Your midwife or doctor will explain what this means and what the risks are.
- Your midwife or doctor should:
 - measure the size of your uterus;
 - measure your blood pressure and test your urine for protein;
 - offer a membrane sweep (see page 112);
 - discuss your options and choices for induction of labour and provide leaflet of explanation.
- Call your hospital or midwife if you have any worries about your baby or about labour and birth.
- See www.nice.org.uk/guidance/ng207 for guidelines on induction of labour.



1

Becoming pregnant

Ovulation



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

- E** Egg progressing down the fallopian tube

- F** Uterus lining being shed

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

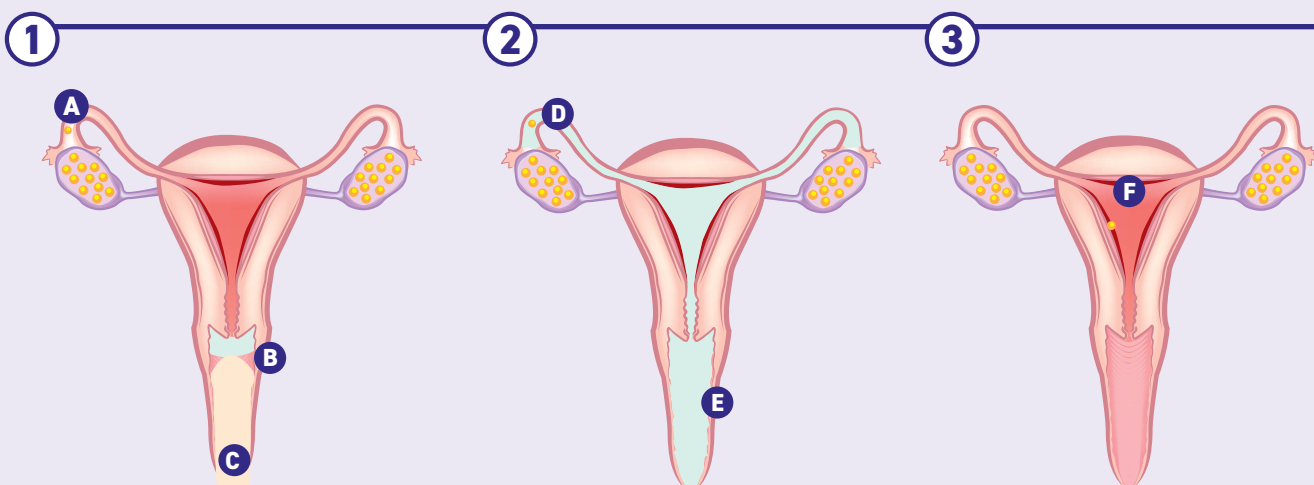
The egg begins to travel down the fallopian tube. If a man and woman have recently had sex, the egg might be fertilised here by the man's sperm. The lining of the uterus is now thick enough for the fertilised egg to be implanted.

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



Conception

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



A Egg

B Sperm being ejaculated

C Penis

D Egg being fertilised

E Sperm

F Attached embryo

Ovulation

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

Fertilisation

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

Implantation

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





Hormones

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

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

the muscles of your uterus to relax to make room for the growing baby.

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

Boy or girl?

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

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

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

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



Twins, triplets or more

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

Twins happen in about 1 in every 65 pregnancies. A



couple is more likely to have twins if there are twins in the woman's family. Triplets occur naturally in 1 in 10,000 pregnancies and quads are even rarer. Nowadays, the use of treatments such as in vitro fertilisation (IVF) has made multiple births more common.

Are you carrying twins?

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

- you are very sick in early pregnancy;
- you seem bigger than you should be for your 'dates';
- you have had fertility treatment.

It is usually possible to find out through your dating ultrasound scan, which happens between 6 and 12 weeks (see page 66).

You may need another scan after this to find out whether the babies share a placenta (are identical) or if they have two separate placentas, in which case they can be either identical or non-identical. It is important to know this because women with babies who share a placenta will need to have more appointments and scans. If this cannot be determined, you should be offered a further scan. A third of identical twins have

two separate placentas. This happens when the fertilised egg splits in the first 3–4 days after conception and before it implants in the uterus.

What is different about being pregnant with twins or more?

Multiple pregnancies have a higher risk of complications – particularly premature birth. If your babies share a placenta (identical twins) or if you are having more than two babies, you should be offered pregnancy care at a special clinic for multiple pregnancies. These clinics are not held in every hospital in Northern Ireland, and you might need to travel to another hospital. Your doctor might also refer you to the Regional Fetal Medicine Service in Belfast if you require more specialised

care. If your babies are triplets or if they share a placenta it is recommended that you are scanned every two weeks from 16 weeks onwards, and every four weeks if your babies have separate placentas. You are more likely to have a caesarean section but twins can sometimes be delivered vaginally. Your doctor should discuss this with you.

It is possible to breastfeed twins and triplets and there is more information about how you can do this in chapter 10. Advice on the care you might expect during pregnancy is available from the National Institute for Health and Care Excellence (NICE), www.nice.org.uk/guidance/ng137



2

Now you are pregnant

The time from when you find out you are pregnant until you have your baby is the antenatal period and during this time you will receive your care from the most appropriate person for your pregnancy.

As soon as you know you are pregnant, you should get in touch with your maternity service or GP to organise your antenatal care. It's best to see them as early as possible. You can complete a self referral form to maternity services online via your local Health and Social Care Trust website, or contact your GP surgery and they will refer you to maternity services where you will see a midwife.

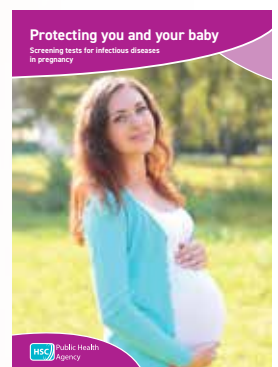
When you first make contact with your midwife or GP you will be given information about:

- folic acid and vitamin D supplements;
- nutrition and diet;
- food hygiene;
- lifestyle factors that may affect your health or the health of your baby, such as smoking, recreational drug use and alcohol consumption.

Your booking appointment

Most women have their 'booking appointment' with a midwife between the 8th and 12th week of pregnancy. This can take a couple of hours.

You will also be offered an ultrasound scan to confirm you are pregnant and





when your baby is due. You will be offered a number of tests from a single sampling of blood giving information about your general health and whether you have any infections which could effect the baby. This is known as antenatal screening. You will be given information on these tests and asked for your consent prior to testing. For more information see pha.site/antenatal-blood-tests

This appointment may take place either in hospital or community.

At this appointment you will be given information about:

- how the baby develops during pregnancy;
- nutrition and diet;
- exercise and pelvic floor exercises;
- your antenatal care including group-based care and education;

- Flu, whooping cough , RSV and COVID-19 vaccines to protect you and your baby;
- breastfeeding;
- antenatal education;
- your options for where to have your baby;
- any previous illnesses and operations;
- details of any previous pregnancies or miscarriages;
- your and your baby's father's origins. This is to find out if your baby is at risk of certain inherited conditions, or if there are other factors, such as a history of twins;
- how you are feeling and if you have been feeling depressed;
- family history of inherited disorders.

Questions at the booking appointment

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

You may be asked about:

- your health and any family health issues;

At the end of your booking appointment, you should understand the plan of care for your pregnancy.

Your booking appointment is an opportunity to tell your





Where to have your baby

You can have your baby at home, in a midwife-led unit (MLU) or in hospital. It is important that you make an informed decision about where you would like to give birth. It is up to you where you can have your baby. Even after you have decided, you can still change your mind.

Your midwife will discuss the options that are available to you locally, though you are free to choose any maternity services in Northern Ireland, if you are prepared to travel.

At the booking appointment, your midwife will discuss options with you, using evidence-based information.

Please ask for this information if it is not provided.

Further information on shared decision making and how risk is discussed is available from: www.nice.org.uk/guidance/ng197

midwife or doctor if you are in a vulnerable situation or if you need extra support. This could be because of issues such as domestic violence, sexual abuse or female genital mutilation.

Let your midwife know if you have a disability that means you have special requirements for your antenatal appointments or labour. If you don't speak English as your first language and need an interpreter, let your midwife know and arrangements will be made.

At this appointment the type of care you will have during your pregnancy will be discussed and decided.

If all is well with your pregnancy you will have the majority of

your appointments with your midwife in the community, usually close to where you live.

If there are complications with your pregnancy (either your health, your baby or with previous pregnancies) you will have the majority of your care in the maternity hospital where you are going to have your baby and be seen by an obstetrician throughout your pregnancy.

Sometimes the type of care may change during your pregnancy, for example if your obstetrician is happy for you to receive care in the community or your midwife discovers a problem which means you need to be seen by a doctor and continue your care in the hospital.

Midwife-led care: This is designed for women who are having a low-risk pregnancy. Care is delivered by midwives and birth commonly takes place in the midwife-led unit.

Consultant-led care: This is for women who have had medical complications with a previous pregnancy or who develop problems during their pregnancy.

Shared care: Your care is delivered by hospital and community based midwives together with your GP.

Continuity of midwifery care: Your care will be provided by the same midwife or team of midwives during your pregnancy, birth and postnatal period. See pha.site/MidwifeCare for more information.

Planning a hospital birth

Many women will be advised to give birth in a consultant-led hospital.

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

General questions about midwife-led units and consultant-led units

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



- Are partners, close relatives or friends welcome in the delivery room?
- Are birthing partners ever asked to leave the room? Why?
- Can I move around in labour and find my own position for the birth?
- What services are provided for sick babies?
- Who will help me breastfeed my baby?
- Who will help me if I choose to formula feed?
- How long am I likely to be in hospital?
- What are the visiting hours?
- Are tours of maternity facilities for birth available before the birth or does the unit provide an online option?
- When can I discuss my birth plan?
- Are TENS machines available (see page 106) or do I need to hire one?
- What equipment is available – for example mats, a birthing chair or beanbags?
- Are there birthing pools?

The main types of maternity care in Northern Ireland are:

a) Midwife-led

b) Consultant-led (In this case the consultant is a doctor known as an obstetrician, and the units are called obstetric units).

c) Continuity of Midwifery Carer

Your options are described in more detail below:

a) Midwife-led care

This includes birth at home or in a midwife-led unit.

Benefits of midwife-led care

- you are twice as likely to have a normal labour and birth;
- you can give birth in surroundings where you may feel more relaxed and able to cope with labour;
- you are more likely to be looked after by a midwife who you have got to know during your pregnancy;
- most MLU teams offer complementary therapies during pregnancy;





- you are less likely to experience unnecessary interventions including having your waters broken, or having a drip to speed up your labour;
- you are less likely to request morphine/ diamorphine or an epidural;
- you are less likely to have a caesarean section, or to need ventouse (vacuum) or forceps to assist with the birth of your baby;
- you are less likely to need a blood transfusion for your baby;
- your baby is less likely to need to go to a neonatal unit;
- you are more likely to breastfeed successfully (if this is your choice);
- most MLUs support partners to stay overnight.

For consideration

- you may need to transfer from home to an obstetric unit though emergency transfers are uncommon;

- epidurals are not available in midwifery-led units – however a birthing pool can be used during labour and birth, if available;
- you can access gas and air and medication such as morphine.

A planned birth at home

If your pregnancy is low risk and it's not the first time you're giving birth, research shows that planned home birth is just as safe for your baby as a planned birth in hospital. If your pregnancy is low risk and this is your first birth, there is a small increase in risk for your baby.

Transfers to hospital

Sometimes, a transfer from home, a freestanding midwife-led unit, or an alongside midwife-led unit to a hospital labour ward is needed after labour has started. Some transfers are made before the baby is born and some after. Transfers are more likely for first-time births.

At home and in freestanding or alongside birth centres, you won't have access to

immediate obstetric, neonatal or anaesthetic care. So when you're planning where to have your baby, a consideration might be your chances of being transferred to an obstetric unit during labour or after birth.

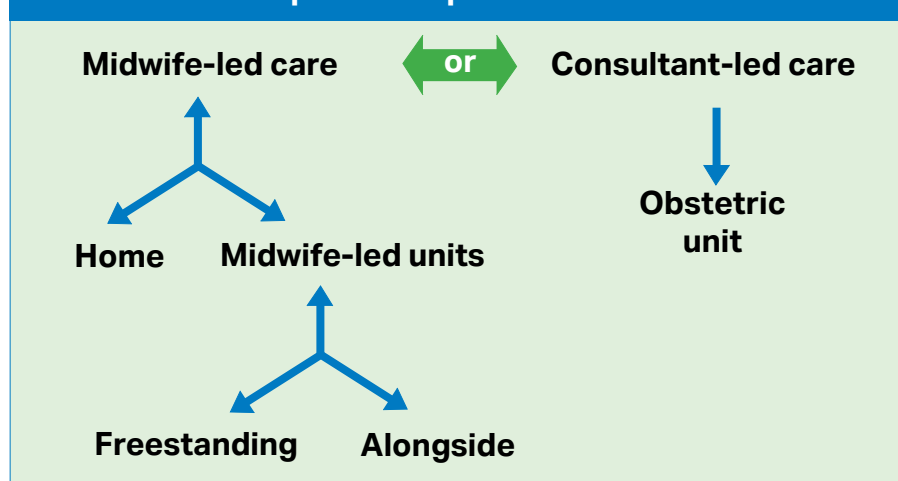
Most commonly, transfers are made because of slow or delayed progress in labour. Some transfers are made because a woman decides that she wants to move, for a reason such as wanting different pain relief. Other transfers may be for the midwife to feel more supported with additional care in case a problem emerges, while more rarely some transfers are due to an actual problem during labour.

For first-time births, 36 in 100 of those planned at freestanding units are transferred, compared with 40 in 100 births for planned births in alongside midwife-led units. Second time or subsequent births have a 9 in 100 chance of transfer from freestanding midwife-led units, with 13 in 100 transferring from an alongside unit.

Midwife-led unit

Midwife-led units are staffed by midwives and are particularly recommended for women with a straightforward pregnancy, because the rate of intervention is lower and the outcome for the baby is

Options for place of birth



no different compared with an obstetric unit. More details are available from your midwife.

Your care in labour will be provided by midwives and if a problem arises you will be transferred to the local consultant-led unit, via ambulance if needed. There are two types of midwife-led units - freestanding and alongside.

Freestanding midwife-led units

The option to deliver your baby in a free standing midwife-led unit is currently limited. Please speak to your midwife regarding available birthplace options.

Alongside midwife-led units

There are currently five alongside midwife-led units (AMU) in Northern Ireland: Altnagelvin, Craigavon, Daisy Hill, Royal Maternity (ABC - Active Birth Centre), South

Western Acute Hospital, Ulster Hospital (Home from Home); with further units in development - ask your midwife for details.

b) Consultant-led care

Obstetric unit – In hospital

There are currently seven obstetric units situated within hospitals in Northern Ireland: Antrim Area, Altnagelvin, Craigavon, Daisy Hill, Royal Maternity, South Western Acute Hospital, Ulster Hospital. Planning your birth in these units is recommended particularly for women who have additional health needs or have complications, or whose pregnancy has not been straightforward. You will be looked after by a midwife, but doctors will be available if you need their help.

What is a midwife?

The midwife is the main provider of care for most pregnant women. Midwives are highly skilled, qualified professionals who care for women during normal pregnancy, childbirth and after the birth. You will be introduced to your midwife, who will care for you during pregnancy and when you go home. You may meet different members of a team of midwives throughout your pregnancy.

Midwives are trained to make sure everything goes as well as possible and to recognise any potential problems for you and your baby. Midwives work both in maternity units and in the community, often in a team system. The style of care may depend on where you live. Community midwives may visit you at home before the birth and will continue to care for you after the birth.



Benefits of consultant-led care

- you can access specialised medical services, including doctors who support women with health complications such as diabetes, heart conditions, thyroid problems, neurological conditions, or cancer;
- you can access specialised medical services, including doctors who support babies with health complications;
- epidurals are normally available.

For consideration

- when you arrive in labour you may go to an antenatal ward, followed by delivery suite (where you will have your baby). Afterwards you may go home within a few hours or be transferred to a postnatal ward;
- there is a greater chance that you will have a caesarean section, a ventouse (vacuum) birth, or forceps birth;
- You may not need a blood transfusion;
- you may not see the consultant at your clinical appointment and are more likely to be seen by a wide range of health



professionals including doctors in training;

- your partner is unlikely to be able to stay overnight.

c) Continuity of Midwifery Carer

Continuity of Midwifery Carer is a model where you will have a named midwife, who with the support of a small team, will work together to provide all of your care during your pregnancy, birth and after your baby is born.

This means you are much more likely to have the same midwife during your pregnancy who you get to know and have a trusting relationship with.

Benefits of Continuity of Midwifery Carer

There is evidence that shows the safety and positive outcomes of this model of care.

- you are more likely to have a positive birth experience

- you are more likely to have a normal vaginal delivery
- you are less likely to require induction of labour
- you are less likely to require an epidural
- you are less likely to experience preterm birth
- you are less likely to require an assisted birth or caesarean section
- you are 7 times more likely to know the midwife who will be supporting you in labour

Help for young mums

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

If you are on your own

If you are pregnant and on your own, it is even more

important that there are people with whom you can share your feelings and who can offer you support. Sorting out problems, whether personal or medical, is often difficult when you are by yourself, and it is better to find someone to talk to rather than let things get you down.

Carrying on with your education

Becoming a mother certainly

does not have to mean the end of your education. If you are still of compulsory school age, your school should not exclude you on grounds of pregnancy or health and safety issues connected with your pregnancy.

However, they may talk to you about making alternative arrangements for your education. You will be allowed up to 16 calendar weeks off

school before and after the birth.

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

Help and support

Common Youth

If you are under 19, you can visit Common Youth for free, confidential advice. To find your nearest centre, go to www.commonyouth.com





Family Nurse Partnership Programme

If you are under 20 and expecting your first baby, a family nurse can visit you to help you have a healthy

pregnancy and enjoy being the best mum you can be. Your specially trained family nurse will help you understand all about your pregnancy and how to care for yourself

and your baby. Your nurse will visit you regularly during your pregnancy and then after the birth until your baby is two years old. You and your family nurse will decide together what you will cover in each visit. Your nurse will share lots of information with you about pregnancy, giving birth and looking after babies and toddlers, helping you to prepare well and decide what is right for you and your family. You and your family nurse will get to know each other well and you will be able to rely on her to help you out if things get difficult in any way.

Your nurse will help you plan for your future. You can talk about childcare, education, training and gaining new skills as well as about housing and finances. Together, you decide what you want and how to make it happen.

Somewhere to live

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



3

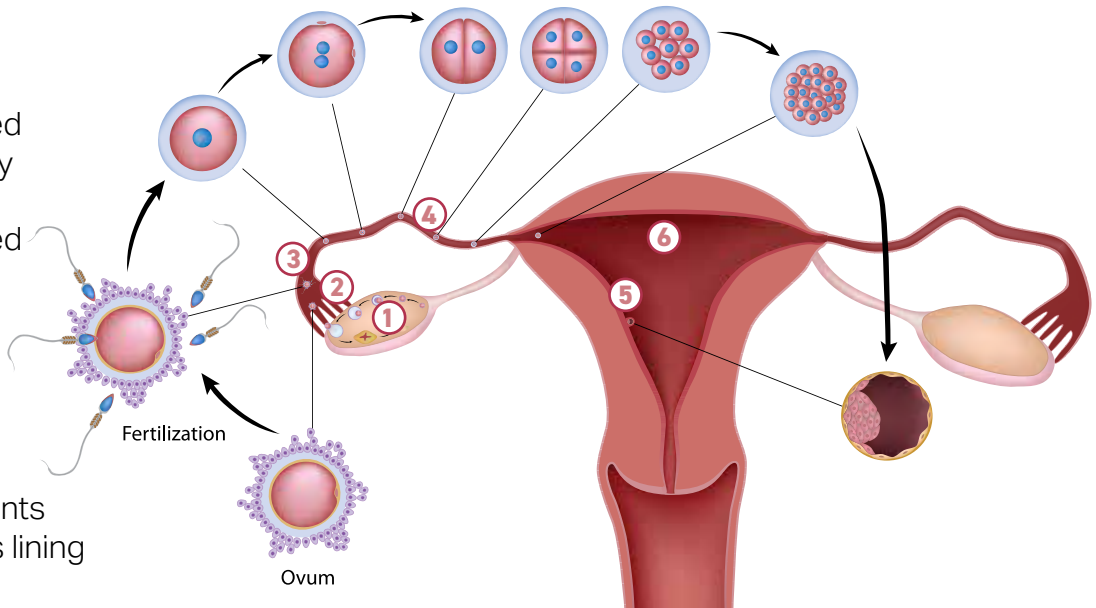
How your baby develops and grows

3

How your baby develops and grows

Week 3

- ① Ovary
- ② Egg is released from the ovary
- ③ Egg is fertilised
- ④ Fertilised egg divides and travels down fallopian tube
- ⑤ Embryo implants itself in uterus lining
- ⑥ Uterus



Measuring your pregnancy

Doctors and midwives in the UK measure the duration of pregnancy from the first day of your last menstrual period, not from the day you conceive. So when you are 'four weeks pregnant', it is actually about two weeks after you conceived. Pregnancy normally lasts for 37–42 weeks from the first day of your last period. The average is 40 weeks. If you are not sure about the date of your last period, then your early scan will give a good indication of when your baby will be due.

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



Week 3

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

Weeks 4–5

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

Week 4

The actual size of the embryo is about 5mm



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

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

Weeks 6–7

There is now a large bulge where your baby's heart is and a bump for the head because



① The umbilical cord

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

② The placenta

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

③ The amniotic sac

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



1 month



2 months

the brain is developing. The heart begins to beat and can be seen beating on an ultrasound

Week 6

The actual size from head to bottom is about 8mm



scan. Dimples on the side of the head will become the ears and there are thickenings where the eyes will be. On the body, bumps are forming that will become muscles and bones. Small swellings (called 'limb buds') show where the arms and legs are growing. At seven weeks, the embryo has grown to about 10mm long from head to bottom. This measurement is called the 'crown-rump length'.

Week 7

The actual size from head to bottom is about 10mm



Weeks 8-9

Your baby's face is slowly forming. The eyes are more obvious and have some colour in them. The fetus has a mouth

Week 9

The actual size from head to bottom is about 22mm



with a tongue. There are the beginnings of hands and feet, with ridges where the fingers and toes will be. The major internal organs – the heart, brain, lungs, kidneys, liver and gut – are all developing. At nine weeks, the baby has grown to about 22mm long from head to bottom.

Weeks 10-14

Just 12 weeks after conception, the fetus is fully formed. Your baby has all of their organs, muscles, limbs and bones, and their sex organs are developed. From now on your baby will grow and mature. Your baby is already moving about, but you will not be able to feel movements yet. By about 14 weeks, your baby's heartbeat is strong and can be heard by an ultrasound scanner.

The heartbeat is very fast – about twice as fast as a normal adult's heartbeat. At 14 weeks, the baby is about 85mm long



3 months



4 months



5 months

from head to bottom. Your pregnancy may start to show, but this varies a lot from woman to woman.

Week 14

The actual size from head to bottom is about 85mm



Weeks 15–22

Your baby is growing faster than at any other time in their life. Their body grows bigger so that their head and body are more in proportion, and they don't look so 'top heavy'. The face becomes much more defined and the hair, eyebrows and eyelashes are beginning to grow. Their eyelids stay closed over

their eyes. Your baby already has their own individual fingerprints, as the lines on the skin of their fingers are now formed. Their fingernails and toenails are growing and their hands can grip. Your baby starts to hear from 16 weeks inside of the womb. Talk and sing to your baby as they can hear your voice.

At about 22 weeks, your baby becomes covered in a very fine, soft hair called lanugo. We don't know what this hair is for, but it is thought that

it may keep the baby at the right temperature. The lanugo disappears before birth or soon after.

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

Week 22

The actual size from head to bottom is about 27cm



Sometimes you will see a bump that is clearly a hand or a foot.

Weeks 23–30

Your baby is now moving about vigorously, and responds to touch and sound. A very loud noise close by may make them jump and kick.



6 months



7 months



8 months

They are also swallowing small amounts of the amniotic fluid in which they are floating, and are passing tiny amounts of urine back into the fluid. Sometimes your baby may get hiccups, and you can feel the jerk of each hiccup. Your baby may also begin to follow a pattern for waking and sleeping. Very often this is a different pattern from yours. So when you go to bed at night, your baby may wake up and start kicking.

Your baby's heartbeat can be heard through a stethoscope. Later, your partner may be able to hear the heartbeat by putting their ear to your abdomen, but it can be difficult to find the right place. Your baby is now covered in a white, greasy substance called vernix. It is thought that this may be to protect its skin as it floats in the amniotic fluid. The vernix mostly disappears before the birth.

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

Week 30

The actual size from head to bottom is about 33cm



survive. Babies born at around this time have increased risks of disability. At around 26 weeks your baby's eyelids open for the first time.

A baby's eyes are almost

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

Weeks 31–40

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

By about 32 weeks, the baby is usually lying with its head pointing downwards, ready for birth. The baby's head can 'engage', or move down into the pelvis, before birth.

Sometimes the head doesn't engage until labour has started.



9 months

4

Getting to know your baby

You are about to become a mum, again or maybe for the first time. This is a time of great change, on the outside and inside!

This chapter will help you understand what your baby needs to feel safe and secure and will help you get off to a good start with caring for your baby. It will also explain where to get help if you need it.

Baby brain development

During the last three months of pregnancy and the first two years of life your baby's brain is developing at a rapid rate. Responding to your baby's needs can support emotional and mental development. Developing a close and loving relationship with your baby will lay the building blocks for growing into a secure and confident child and adult.

Saying 'hello' to your baby can start today

Pregnancy is a special time and you are probably already starting to connect with your baby. This will help you form a strong and loving bond with your baby after birth. You can start to build your relationship by taking time out every day to relax, stroke your bump, talk or sing to your growing baby and respond to your baby's movements. Check out some ideas for talking and

bonding with your baby during pregnancy as well as reasons why you should talk to your bump and things to do to help you prepare for baby's arrival at www.bbc.co.uk/tiny-happy-people/talking-to-bump

Scans and research show that even in the womb, babies yawn, suck their thumbs and respond to familiar voices and music, perhaps even the theme tune to your favourite TV soap!

Many partners like to get involved at this stage too. Have you thought about who your baby might look like?

Looking after yourself

It is not uncommon to feel a bit anxious or depressed during pregnancy. If you are feeling stressed, try to take some time out for you - have a nice relaxing bath or go for a gentle walk. If you

are feeling overwhelmed, talk to your GP or midwife. Your relationship with your partner may also be under pressure at this time. If you think you or your partner need further support, you can talk to your midwife in complete confidence.



Myth

Babies must get into a routine as this makes your life easier.

Reality

Young babies are not capable of learning a routine. Responding to their cues for feeding and comfort makes babies feel secure, so they cry less, which makes your life easier too.

Myth

Babies become spoilt and demanding if they are given too much attention.

Reality

Babies will be calmer and grow up to be more confident if their needs for love and comfort are met.

Giving a warm welcome after birth

Skin-to-skin contact

Even if you have a caesarean section or a difficult delivery, try to have skin-to-skin contact with your baby as soon as possible after the birth. This will:

- keep your baby warm and calm;
- help regulate breathing and heartbeat;
- release mothering hormones to help with bonding.

Try the following:

- place your baby on your tummy with their head near your breast;
- gently stroke and caress your baby;
- allow the baby to focus on your face;
- ask to be left undisturbed to get to know your baby.

What your newborn baby can do

Babies are born knowing how to suck. During the first few days they learn to coordinate their sucking and their breathing.

Newborn babies will automatically turn towards a nipple or teat if it is brushed against their cheek, and they will open their mouths if their upper lip is stroked.

They can also grasp things (like your finger) with either their hands or feet, and they will make stepping movements if they are held upright on a flat surface. Apart from sucking, these automatic responses will go,

and your baby will begin to make controlled movements instead.

Newborn babies can use all of their senses. They will look at people and things, especially if they are near, and particularly at people's faces. They will enjoy gentle touch and the sound of a soothing voice, and they will react to bright light and noise.

Having conversations with your baby from day one

Communicating

Babies can recognise their mother's voice from birth. From the moment your baby is born, they will want to



Myth

Babies need lots of toys to help them learn.

Reality

The best way for your baby to learn is by looking at your face. Talking, listening and smiling triggers hormones that help your baby's brain to grow.

communicate with you through eye contact, facial expressions and body movements. It is good to try to understand how your baby might be feeling.

Your baby will enjoy being talked and sung to and being held, touched and comforted. Your baby needs you to be interested in how they feel as well as their physical needs such as feeding and changing. Online resources, developed by speech and language therapists in Northern Ireland are available at www.publichealth.hscni.net/publications/helping-your-baby-learn-talk

Young babies are unable to cope with delays in having their needs met. Learn to understand your baby's needs and comfort your crying baby as soon as possible.

Keeping your baby close

It is good for both you and your baby to stay close together,

including sleeping in the same room (the hospital may call this 'rooming-in'). This helps your baby feel safe and secure and allows you to be more confident about caring for them. It is also reassuring to have your baby close by and means that feeding is established more quickly, especially if breastfeeding.

You can also keep the close relationship going by placing your baby's cot or Moses basket beside your bed at night and using a soft baby carrier (sling) during the day.

When choosing a pram or buggy, go for one that faces towards you as this allows your baby to see your face, and you will be able to respond and talk to your baby, which helps them feel safe and secure.

Responsiveness

During the first few months almost all of your time will be taken up with getting to know your baby and responding to their needs.

Caring for babies in a

responsive way helps build a strong and loving bond. This involves keeping your baby close, cuddling and stroking them, talking to them in a soothing voice, learning about their signs when they want to be fed or comforted, and comforting them as soon as possible when they cry.

Trust your instincts – responding quickly to your baby's cries will not 'spoil' them, but make them feel safe and loved and help them grow up to be confident and happy. Security comes from not having to wait too long to be comforted.

Partners

Partners should also spend time holding and being close to the baby. They may feel a little left out, especially if they have to leave you and the baby in hospital and return to an empty home. They may need support and encouragement to get involved. The more you can both hold and cuddle your baby, the more confident you will all feel.



5

Your health in pregnancy

5

Your health in pregnancy

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

What should you eat?

A healthy diet is very important if you are pregnant or trying to get pregnant. You don't need to go on a special diet, but make sure that you eat a variety of different foods every day in order to get the right balance of nutrients that you and your baby need. You should also avoid certain foods – see Foods to avoid on page 34.

You will probably find that you are more hungry than normal, but you don't need to 'eat for two' – even if you are expecting twins or triplets. Have breakfast every day – this will help you to avoid snacking on foods that are high in fat and sugar.

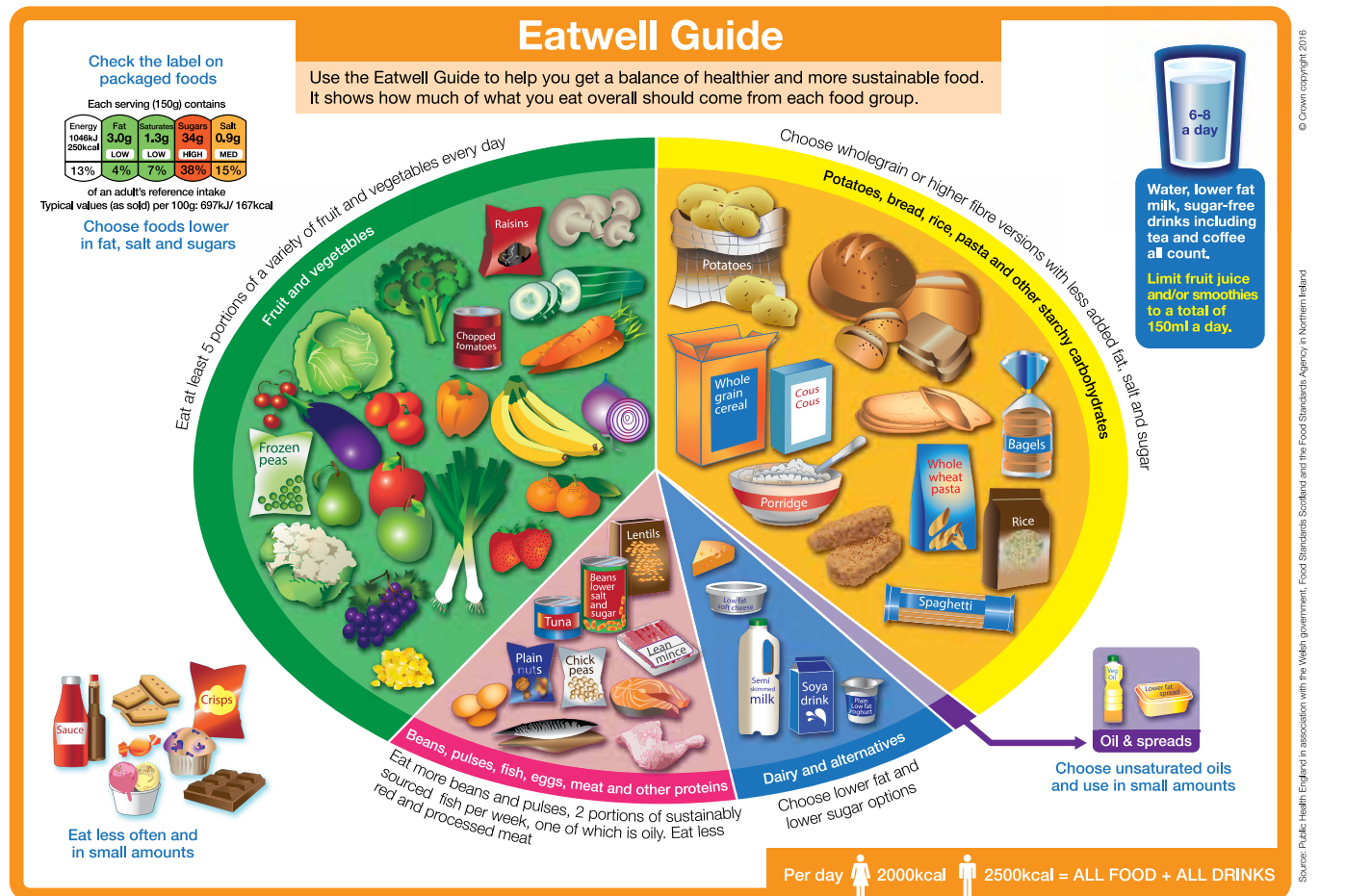
More information

For useful information on what you should eat when you are pregnant or trying for a baby, go to pha.site/healthy-pregnancy-diet



The Eatwell Guide

The guide below shows how much of each type of food you need to have for a healthy and well-balanced diet.



Fruit and vegetables

As well as vitamins and minerals, fruit and vegetables provide fibre, which helps digestion and prevents constipation. Eat at least five portions of fresh, frozen, canned, dried or juiced fruit and vegetables each day. Always wash them carefully. To get the most out of vegetables, don't over cook them. For more information and portion sizes, visit pha.site/5-a-day

Dried fruit should only be eaten at mealtimes to reduce the risk of tooth decay. Juices should be limited to no more than 150mls, once a day and at a mealtime, as juicing fruits releases sugars which can damage teeth.

Potatoes, bread, rice, pasta and other starchy carbohydrates

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

Foods high in fat, salt and sugars

This includes products such as chocolate, cakes, biscuits, full-sugar soft drinks, butter and ice-cream. These foods are not needed in the diet and so, if included, should only be done infrequently and in small amounts. If you consume these foods and drinks

often, try to limit their consumption so you have them less often and in smaller amounts. Food and drinks high in fat and sugar contain lots of energy, particularly when you have large servings. Check the label and avoid foods which are high in fat, salt and sugar!

Eating well during pregnancy

www.youtube.com/watch?v=aYIP4_VLfxI

Beans, pulses, fish, eggs, meat and other proteins

Good sources of protein include beans, pulses, fish, eggs and meat (for information on peanuts see page 35). These foods are also good sources of essential vitamins and minerals. Eat moderate amounts each day. Choose lean meat, remove the skin from poultry and cook using only a little fat. You should try to limit the amount of red meat or processed meat (for example sausages, bacon, cured meats) to no more than 90g per day. Make sure poultry, pork, burgers and sausages are cooked all the way through. Check that there is no pink meat and that juices have no pink or red in them.

Try to eat two portions of fish a week, one of which should be oily fish. There are some fish that you should avoid – see Foods to avoid on page 34 for more information.

Due to improved food safety controls in recent years you are unlikely to get food poisoning from raw or lightly cooked UK hen eggs from reputable suppliers which have been produced under the British Lion Code of Practice.

Oils and spreads

This food group includes all unsaturated oils including vegetable oil, rapeseed oil, olive oil sunflower oil and soft spreads made from unsaturated oils. Butters are not included in this section as these are high in saturated fat and should be eaten less often and in small amounts. Although some fat in the diet is essential, generally we are eating too much saturated fat and need to reduce our consumption.

Unsaturated fats are healthier fats that are usually from plant sources and in liquid form as oil, for example vegetable oil, rapeseed oil and olive oil. Swapping to unsaturated fats will help to reduce cholesterol in the blood, therefore it is important to get most of our fat from unsaturated oils.

Choosing lower fat spreads, as opposed to butter, is a good way to reduce your saturated fat intake. Remember that all types of fat are high in energy and should be limited in the diet.

Dairy and alternatives

Milk and dairy foods (or dairy alternatives) like cheese, fromage frais, soya drinks and yogurts (choose unsweetened calcium fortified milk alternatives) are important because they contain protein, calcium and other nutrients that your baby needs. Eat two or three portions a day, using low-fat varieties whenever you can – for example, semi-skimmed or skimmed milk, low-fat yogurt and half-fat hard cheese. However, there are some cheeses that you should avoid – see Foods to avoid on page 34 for more information.

Hydration

Aim to drink 6-8 glasses of fluid every day. Water, lower fat milk and sugar-free drinks including tea and coffee all count. Fruit juice and smoothies also count towards your fluid consumption, although they are a source of free sugars* and so you should limit consumption to no more than a combined total of 150ml

per day. Sugary drinks are one of the main contributors to excess sugar consumption in the UK. Swap sugary soft drinks for diet, sugar-free or no added sugar varieties to reduce your sugar intake in a simple step.

** free sugars are sugars added to foods by the manufacturer/cook or consumer or sugars naturally present in honey, syrups or fruit drinks.*

Foods to avoid

There are some foods that you should not eat when you are pregnant because they may make you ill or harm your baby. Use foods by their use-by date. You should avoid:

- **Some types of cheese.**

Don't eat mould-ripened soft cheese, like Brie, Camembert and others with a similar rind. You should also avoid soft blue-veined cheese, like Danish Blue. These are made with mould and they can contain listeria, a type of bacteria that can harm your unborn baby. Although listeriosis is a very rare infection, it is important to take special precautions during pregnancy because even the mild form of the illness in the mother can lead to miscarriage, stillbirth or severe illness in a newborn baby. You can eat hard cheeses such as cheddar and parmesan, and processed cheeses made from pasteurised milk such as cottage cheese, mozzarella and cheese spreads.

- **Raw or undercooked meat.**

Cook all meat and poultry thoroughly so that there is no trace of pink or blood. Take particular care with sausages and minced meat. It is fine to eat steaks and other whole cuts of beef and lamb rare, as long as the

outside has been properly cooked or sealed.

- **Liver products.**

Don't eat liver, or liver products like liver pâté

- **Cured meats** Cured meats are not cooked, so they may have parasites in them that cause toxoplasmosis. Cold, pre-packed meats such as ham and corned beef are not harmful, however you should be careful with cold cured meats, such as salami, pepperoni, chorizo and prosciutto (unless cooked thoroughly).

- **Pâté.** Avoid all types of pâté, including vegetable pâtés, as they can contain listeria and also be a source of vitamin A.

- **Supplements containing vitamin A.** Don't take high-dose multivitamin supplements, fish liver oil supplements or any supplements containing vitamin A.

- **Some types of fish.** Don't eat shark, marlin and swordfish, and limit the amount of tuna you eat to no more than two tuna steaks a week (about 140g cooked or 170g raw each) or four medium-sized cans of tuna a week (about 140g when drained). These types of fish contain high levels of mercury, which can damage your baby's developing

Foods to avoid in pregnancy

www.youtube.com/watch?v=bcj0PuAbbkA

nervous system. Don't eat more than two portions of oily fish per week. Oily fish includes salmon, mackerel, sardines and trout. Fresh tuna was classified as an oily fish until recently. Recent studies have shown the fish oil content of fresh tuna is similar to that of white fish. Smoked fish has been linked to an outbreak of listeria. Pregnant women or people who have a weakened immune system are more likely to suffer severe symptoms from listeria infection and are advised to avoid eating ready-to-eat cold-smoked or cured fish products, such as smoked salmon or gravlax.

- **Enoki mushrooms.** The Food Standards Agency are now advising pregnant women and those with a weakened immune system to thoroughly cook Enoki mushrooms before consuming them due to possible presence of listeria monocytogenes and the risk of severe disease.
- **Raw shellfish.** Eat cooked rather than raw shellfish as they can contain harmful bacteria and viruses that can cause food poisoning.

- **Peanuts.** If you would like to eat peanuts or foods containing peanuts (such as peanut butter) during pregnancy, you can choose to do so as part of a healthy balanced diet, unless you are allergic to them or your health professional advises you not to. This is different from previous advice on the consumption of peanuts during pregnancy.
- **Unpasteurised milk.** Drink only pasteurised or UHT milk which has been pasteurised. If only raw milk is available, boil it first. Don't drink unpasteurised goats' or sheep's milk or eat certain food that is made out of them, such as soft goats' cheese.

Preparing food

- Wash fruit, vegetables and salads to remove all traces of soil, which may contain toxoplasma. This can cause toxoplasmosis, which can harm your baby (see page 52).
- Heat ready-meals until they are piping hot all the way through. This is especially important for meals containing poultry.
- Keep leftovers covered in the fridge and use within two days.
- Wash all surfaces and utensils, and your hands, after preparing raw meat. This will help to avoid infection with toxoplasma.

Vitamins and minerals

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

- **Folic acid.** Folic acid is important as it can reduce the risk of neural tube defects such as spina bifida in your unborn child. Folic acid is available from your pharmacy or supermarket. If you are thinking about getting pregnant, you should take a 400 microgram folic acid tablet every day until you are 12 weeks pregnant. If you did not take folic acid before you conceived, you should start as soon as you find out that you

are pregnant. You should also eat foods that contain folic acid, such as green leafy vegetables, fortified breakfast cereals and brown rice. Some breakfast cereals, breads and margarines have folic acid added to them. From 2026 all flour will be fortified with folic acid, however it is still recommended that pregnant women take a 400 microgram supplement of folic acid every day for the first 12 weeks of pregnancy.

If you already have a baby with spina bifida, or if you have coeliac disease, or diabetes or take anti-epileptic medicines, ask your GP or midwife for more advice. You will need to take a bigger dose of

folic acid that requires a prescription. See the PHA leaflet Folic Acid - one of life's essentials at www.publichealth.hscni.net

Vitamins and pregnancy

www.youtube.com/watch?v=Ng9KLZpN7_0

- **Vitamin D.** Vitamin D is available to buy from your pharmacy or supermarket. All pregnant women should take a 10 microgram supplement of vitamin D daily. You need vitamin D to keep your bones healthy and to provide your baby with enough vitamin D for the first few months of their life. Vitamin D regulates the amount of calcium and phosphate in the body, and these are needed to help keep

Your weight and pregnancy

Pregnancy isn't the time to go on a diet, as it may harm the health of the unborn baby. It's important that you eat healthily during your pregnancy.

Living with obesity when you're pregnant increases the chance of some complications such as gestational diabetes. Make sure you go to all your antenatal appointments so your pregnancy team can monitor the health of you and your baby.

To find out if you are obese (very overweight), use the BMI healthy weight calculator.

If you are obese, usually defined as having a body mass index (BMI) of 30 or above, and pregnant, do not try to lose weight during your pregnancy. It will not reduce the chance of complications and may not be safe. The best way to protect you and your baby's health is to go to all your antenatal appointments. This is so your midwife, doctor and any other health professionals can help with any problems you might face and take steps to prevent or manage them.

It's important to eat a healthy, balanced diet and do some physical activity every day. You should be offered a referral to a dietitian or other health professional for advice on healthy eating and physical activity. Being physically active in pregnancy will not harm your baby.

Try eating healthily (including knowing what foods to avoid in

pregnancy) and doing activities such as walking or swimming.

If you were not active before pregnancy, it's a good idea to consult your midwife or doctor before starting a new exercise plan when you're pregnant.

If you are obese in pregnancy, you'll be offered a test for gestational diabetes.

If your BMI is 40 or above, you may also be referred to an anaesthetist to discuss issues such as pain relief in labour. You're more likely to have an instrumental delivery (ventouse or forceps or a caesarean section), and it can be difficult for an epidural to be given.

If your BMI is 38 or above, you will be offered access to a healthy pregnancy programme to support safe weight management during pregnancy.

Talk to your midwife or doctor about your birth options. Ask if there are any particular safety concerns for you around giving birth at home or in a birthing pool.

You may be advised to give birth in a hospital where there's easy access to medical care if you need it.

Being overweight increases the chance of complications for you and your baby. The higher your BMI, the higher the chance of complications.

The increasing chances are in relation to:

- miscarriage;

- gestational diabetes;
- high blood pressure and pre-eclampsia;
- blood clots;
- the baby's shoulder becoming "stuck" during labour;
- heavier bleeding than normal after the birth.

You are also more likely to need an instrumental delivery (forceps or ventouse), or an emergency caesarean section.

Problems for your baby can include being born early (before 37 weeks), and an increased chance of stillbirth. There is also a higher chance of your baby having a health condition, such as a neural tube defect like spina bifida.

Although the chances of these problems increase if you are obese, most pregnancies will result in a healthy baby.

If your BMI* is over 38, you will receive extra support throughout your pregnancy as part of the weigh to a healthy pregnancy programme to help ensure the best outcome for you and your baby.

Further information is available at www.rcog.org.uk/for-the-public/browse-our-patient-information/being-overweight-in-pregnancy-and-after-birth/

**BMI is a calculation that health professionals use to work out whether a person is a healthy weight. It is calculated by weight in kilograms divided by height in meters squared. Use an online calculator which can be found at pha.site/bmi-calculator*

bones and teeth healthy. The best source of vitamin D is summer sunlight. The amount of time you need in the sun to make enough vitamin D is different for every person and depends on things like skin type, time of day and time of the year but you don't need to sunbathe: the amount of sun you need to make enough vitamin D is less than the amount that causes tanning or burning. Deficiency of vitamin D can cause children's bones to soften and can lead to rickets.

Only a few foods contain vitamin D, including oily fish like sardines, fortified margarines, some breakfast cereals and eggs.

Breastfed babies from birth to one year of age, should be given a daily supplement of vitamin D throughout the year to make sure they get enough, as their bones are growing and developing very rapidly in these early years.

Babies fed infant formula will only need a vitamin D supplement if they are receiving less than 500ml (about a pint) of infant formula a day, because

infant formula has vitamin D added during processing.

Children aged 1 to 5 years require a daily supplement of 10 micrograms of vitamin D throughout the year.

Everyone aged five and over should consider taking a supplement of 10 micrograms of vitamin D every day.

If you have dark skin or always cover your skin, you may be at particular risk of vitamin D deficiency. Talk to your midwife or doctor if you are worried about this. (See also Vitamin supplements on page 134 and the PHA leaflet *Vitamin D and you* at www.publichealth.hscni.net)

- **Iron.** If you are low in iron, you will probably get very tired and you can become anaemic. Lean meat, green, leafy vegetables, dried fruit and nuts all contain iron. Many breakfast cereals have iron added. If the iron level in your blood becomes low, your GP or midwife will advise you to take iron supplements. These are available as tablets or a liquid.

Iodine supplements

There is growing concern that some women of child bearing age and women who are pregnant in the UK may not be getting the required 0.25mg of iodine from their diet. Pregnant women and breastfeeding mums who are vegan or avoid dairy products, eggs and or fish are at highest risk of iodine deficiency.

Iodine is essential for brain development in the fetus and young child. Adults who eat a healthy balanced diet that contains eggs, fish and dairy products should be able to meet their body's iodine requirement. If you avoid these food stuffs you should discuss this with your health professional.

- **Vitamin C.** Vitamin C helps your body absorb iron. Citrus fruits, tomatoes, broccoli, peppers, blackcurrants, potatoes and some pure fruit juices are good sources of vitamin C. If your iron levels are low, it may help to drink orange juice with an iron-rich meal.
- **Calcium.** Calcium is vital for making your baby's bones and teeth. Dairy products and fish with edible bones like sardines are rich in calcium.



Healthy Start

Healthy Start is a scheme that provides a prepaid card that can be used for milk, plain fresh or frozen fruit and vegetables and infant formula milk. You can also receive Healthy Start vitamins.

You qualify for Healthy Start if you are pregnant or have a child under four years old, and you or your family receive certain benefits.

For further information:

- ask your midwife or health visitor for more information or visit www.healthystart.nhs.uk.

Breakfast cereals, dried fruit such as figs and apricots, bread, almonds, tofu (a vegetable protein made from soya beans) and green leafy vegetables like watercress, broccoli and curly kale are other good sources of calcium.

Which supplements?

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

Healthy Start vitamins for women contain the correct amount of folic acid and vitamins C and D.

Vegetarian, vegan and special diets

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

You should also talk to your doctor or midwife if you have a special dietary requirement

(such as coeliac disease or for religious reasons). Ask to be referred to a dietitian who can give you advice on how to get the nutrients you need for you and your baby.

More information

For further information, visit:

- pha.site/vegetarian-diet
- pha.site/vegan-diet

Healthy snacks

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

- fresh fruit;
- sandwiches or pitta bread filled with grated cheese, lean ham, mashed tuna, salmon or sardines and salad;
- salad vegetables;
- low-fat yogurt or fromage frais;
- hummus and bread or vegetable sticks;
- ready-to-eat apricots, figs or prunes;
- vegetable and bean soups;
- unsweetened breakfast cereals or porridge and milk;
- milky drinks;



- baked beans on toast or a baked potato.

Caffeine

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

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

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

Don't worry if you occasionally have more than this, because the risks are quite small.



Caffeine content of food and drink

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

So if you eat...

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

Alcohol

Can I drink alcohol when I'm pregnant?

The safest approach in pregnancy is not to drink alcohol at all. Whether it is beer, wine or spirits, alcohol can cause harm to your baby at any stage of your pregnancy. A baby's brain and body grow and develop for the entire nine months of pregnancy. Drinking alcohol during pregnancy can affect how the baby's brain and body develop.

The Chief Medical Officers' guideline is that:

If you are pregnant or planning a pregnancy, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.

Drinking in pregnancy can lead to long-term harm to your baby, with the more you drink the greater the risk.

Therefore, it is important to be aware that:

- Drinking heavily or 'binge' drinking (over 6 units in one session) in early pregnancy can be harmful to your baby and there is an increased risk of early miscarriage.
- Some women may be unaware of their pregnancy for several weeks or months. If there is any chance you may be pregnant, avoid drinking alcohol until you are sure you are not pregnant.
- Pregnant mums should always consult with a health professional if they have any concerns about their alcohol intake.

How does alcohol affect the unborn baby?

Alcohol is a toxic substance. It takes a woman's liver 1½ hours (approx.) to break down 1 unit of alcohol.

However, in pregnancy, the alcohol passes from the mum's bloodstream through the placenta and into the baby's bloodstream. The placenta is not a filter. The unborn baby does not have a developed liver to process alcohol.

Drinking alcohol during pregnancy can affect:

- The way the baby develops in the womb.
- The baby's health at birth and increases the risks of Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Spectrum Disorder (FASD).
- The baby's long-term physical and mental health.
- The child's ability to learn (learning difficulties).



What does FAS/FASD mean?

Most women are aware of **Fetal Alcohol Syndrome (FAS)**. Children born with FAS can have growth problems, facial defects, and lifelong learning and behaviour problems. **Fetal Alcohol Spectrum Disorder (FASD)** describes the range of less obvious effects ('sleeping symptoms') that can be mild to severe. The majority of children with FASD may experience difficulties in many of the following areas:

- attention, learning and memory;
- understanding the world around them;
- poor social skills;
- hyperactivity;
- delayed language development;
- delay achieving milestones.

Children born with FASD may need medical care all their lives, and/or may need special educational support.

Remember that FAS and FASD are 100% preventable by not drinking alcohol during your pregnancy.

Getting help with drinking

If you have difficulty cutting down what you drink, talk to your doctor, midwife, pharmacist or other healthcare professional. Confidential help and support is available from local counselling services. Visit www.drugsandalcoholni.info for more information.

You should talk to your midwife if you have any concerns about your drinking around the time of conception and early pregnancy. You can get more advice from pha.site/alcohol-and-pregnancy

Smoking

- When you smoke, you breathe in nicotine, tar and carbon monoxide.
- You also breathe in around 4,000 other chemicals, many of them poisonous – like arsenic, ammonia and benzene.
- The tar and some chemicals build up inside your lungs, where they may eventually cause cancer.
- Nicotine, carbon monoxide and the other chemicals rush from your lungs into your bloodstream, reducing the amount of oxygen in your blood.
- All of these substances get into your baby's bloodstream from yours.

Every cigarette you smoke harms your baby. Cigarettes restrict the essential oxygen supply to your baby. So their tiny heart has to beat harder every time you smoke. Cigarettes contain over 4,000 chemicals. Protecting your baby from tobacco smoke is one of the best things you can do to give your child a healthy start in life. You will be offered carbon monoxide testing at your booking appointment to assess the level of carbon monoxide in your blood to assist with the decision to quit smoking. Carbon monoxide testing will be offered after your baby is

Examples of units in drinks

can of extra strong lager (440ml):	4 units
bottle of lager (330ml):	1.5 units
pint of standard lager (568ml):	2.5 units
pint of premium lager (568ml):	3 units
small pub bottle of wine (250ml):	2.25 units
70cl bottle of wine:	7–10 units
standard 275ml of alcopop:	1.5–1.75 units
70cl bottle of alcopop:	3.75–4.5 units
35ml measure of spirits:	1.4 units

born if you have a high level of carbon monoxide in your blood at booking.

It's never too late to stop.

Getting help with stopping smoking

Support and advice on stopping smoking is available at www.stopsmokingni.info. You can also

ask your midwife, health visitor, practice nurse or pharmacist for advice and for the details of your local stop smoking service.

These free stop smoking services offer one-to-one or group sessions, provide nicotine replacement therapy (NRT) and are run by specially trained staff who can advise

you on the best way to manage your cravings and become smoke free. They can offer advice about dealing with stress, weight gain and provide information on stop smoking medications such as NRT to help you manage your cravings.

If you smoke, get advice about stopping. You are up to four

Stopping smoking action plan

1 Think

Think about:

- What you and your baby will gain if you stop smoking (see above).
- How much smoking costs you.
- What else you could spend your money on.
- How you can treat yourself or your baby with the money you save.
- What is keeping you smoking.
- List your top five reasons for going smoke free; such as protecting your health or the health of your baby.

For more information on NRT, see the PHA website for a copy of the Pregnancy and NRT leaflet

2 Get help

Take advantage of the free support that is available to you. You are four times more likely to quit successfully using specialist support and licensed stop smoking medication.

Ask your friends and family to help and support you.

3 Prepare

If you understand why you smoke and what triggers your smoking, you will be able to prepare

yourself so that you can cope when you quit. It can help to:

- Give up with somebody else, so that you can support each other.
- Change the habits you associate with smoking.
- Plan how you will deal with difficult situations without the use of cigarettes.

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

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

4 Stop smoking

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

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

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

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

times more likely to stop smoking successfully with support and stop smoking medication.

If you stop smoking now

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

If you stop smoking:

- You will have fewer

complications in pregnancy.

- You are more likely to have a healthier pregnancy and a healthier baby.
- You will reduce the risk of stillbirth.
- Your baby will cope better with any birth complications.
- Your baby is less likely to be born too early and have to face the additional breathing, feeding and

health problems which often go with being premature (see chapter 15).

- Your baby is less likely to be born underweight and have a problem keeping warm. Babies of mothers who smoke are, on average, 200g (about 8oz) lighter than other babies. These babies may have problems during and after labour and are more prone to infection.

- Make sure the medicine is safe to take when pregnant.
- For further information, speak to your pharmacist.

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

- You will reduce the risk of sudden infant death, also known as 'cot death'. See page 154 for more information about how to reduce the risk of sudden infant death.

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

Secondhand smoke

If your partner or anyone else who lives with you smokes, it can affect you and your baby both before and after birth. You may also find it more difficult to quit. Secondhand smoke can cause low birth weight and sudden infant death.

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

From 1 February 2022, it is an offence to smoke in an enclosed private vehicle where a child or young person aged under 18 is present and there is more than one person in the vehicle. It is also an offence if the driver does not prevent smoking in a private vehicle.

Advice on e-cigarettes

E-cigarettes are designed to look and feel like cigarettes. Devices currently on the market may not meet appropriate standards of safety and quality. The level of risk associated with their use is not known.

The Public Health Agency recommends if you wish to stop smoking and are ready to do so you should use one of the free stop smoking services available across Northern Ireland, for information on these services visit www.stopsmokingni.info

Find out more on e-cigarettes at www.publichealth.hscni.net

Pills, medicines and other drugs

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

- **Keep taking your medication until you check with your doctor.**
- Always check with your doctor, midwife or pharmacist before taking any medicine.
- The use of antibiotics in pregnancy may be restricted and should only be used after a confirmed

diagnosis and on the advice of a health professional.

- Use as few over the counter medicines (such as from a pharmacist or supermarket) as possible.
- Seeking care for yourself for minor conditions is safe when pregnant after consulting a pharmacist or other health professional.



Be careful if you decide to purchase medicines or herbal supplements

online. There may be a risk of receiving medication that is not safe for you to use, only use a reputable website registered with competent authorities. Within the EU this is indicated by a common logo that appears on the websites operated by registered retailers.

- Make sure that your doctor, dentist or other health professional knows you are pregnant before they prescribe you anything or give you treatment.
- Talk to your doctor if you take regular medication – ideally before you start trying for a baby or as soon as you find out you are pregnant.

Medicines and treatments that are usually safe include paracetamol, most

antibiotics (seek advice from a health professional), dental treatments (including local anaesthetics), some immunisations (including tetanus, pertussis, RSV and flu injections) and nicotine replacement therapy. But you should always check with your GP, pharmacist or midwife first.

Illegal drugs

Using illegal or street drugs during pregnancy, including cannabis, ecstasy, cocaine and heroin, can have a potentially serious effect on your unborn baby; for example:

- marijuana may cause childhood brain development problems;
- cocaine may cause low birth weight, premature birth and stillbirth;
- heroin and other opiates may cause miscarriage, premature birth and stillbirth.

If you take any illegal drugs the best thing you can do for yourself and your baby is stop. Some people may be able to stop taking drugs without help. Others may find it more difficult due to a range of factors such as dependency, mental health issues or lack of family support. It is important that you get advice and support if you are finding it difficult to stop taking illegal drugs and you want to start

trying for a baby. It is best to keep using contraception until you have stopped using drugs. Your GP can give you advice about this if you need it.

Many parents and carers who use substances do so in moderation, however some parents and carers may develop a problematic substance use issue. This can lead to chaotic and unpredictable lifestyles with parents and carers struggling to recognise and meet their children's needs. This may result in their children being at risk of harm.

If you are worried about the impact of substance use on your family, information and local services can be accessed at drugsandalcoholni.info

Herbal and homeopathic remedies and aromatherapy

Not all 'natural' remedies are safe in pregnancy.

Tell your practitioner that you are pregnant, and tell your midwife or doctor and pharmacist which remedies you are using.

X-rays

X-rays should be avoided in

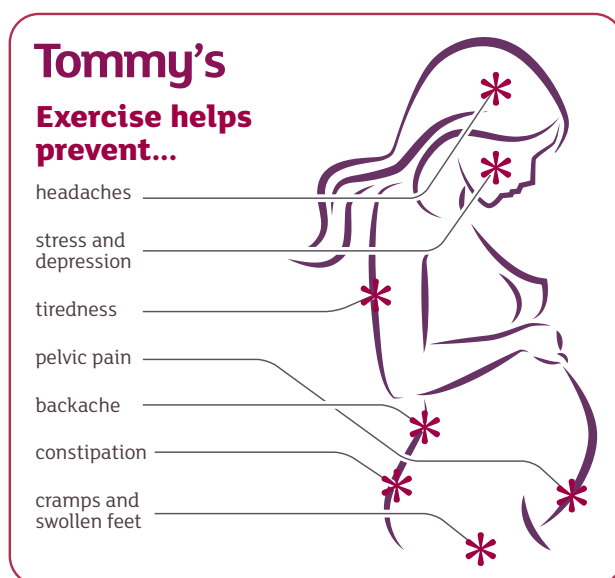
pregnancy if possible. Make sure that your dentist knows you are pregnant.

Keeping active

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

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

It is recommended you should do 150 minutes of physical



activity spread throughout the week in pregnancy. If you were inactive before you were pregnant, don't suddenly take up strenuous exercise. Begin exercising gradually with 10 minute bouts of moderate intensity continuous exercise building up to a total of 150 minutes across the week.

Exercise tips

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

Exercises to avoid

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

Exercises for a fitter pregnancy

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

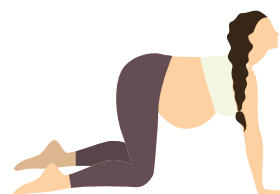
Stomach-strengthening exercises

These strengthen your stomach (abdominal) muscles and ease backache, which can

be a problem in pregnancy.

As your baby gets bigger you may find that the hollow in your lower back becomes more pronounced, which can lead to backache.

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



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



- Hold for a few seconds then slowly return to the box position.
- Take care not to hollow your back – it should always return to a straight or neutral position.
- Do this slowly and rhythmically 10 times,

making your muscles work hard and moving your back carefully. Only move your back as far as you can comfortably.

Pelvic tilt exercises

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

Pelvic floor exercises

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

The pelvic floor consists of layers of muscles which stretch like a supportive hammock from the pubic bone (in front) to the base of the backbone. During pregnancy you may find that you leak urine when you cough or strain. This is known as stress incontinence of urine and it can continue after pregnancy.

By performing pelvic floor exercises, you strengthen the pelvic floor muscles and this helps to reduce or avoid this problem after pregnancy. It is important to do them even if you are young and not suffering from stress incontinence now.

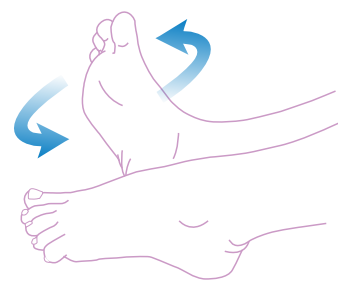
- Close up your back passage as if trying to prevent a bowel movement.
- At the same time, draw in your vagina as if you are gripping a tampon, and your urethra as if to stop the flow of urine.
- First do this exercise quickly – tightening and releasing the muscles straight away.
- Then do it slowly,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

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

Ask your midwife or doctor about these exercises. Your local maternity unit should run classes where a specialist physiotherapist attends. They can instruct you in groups or individually. Feel free to ask them for advice and help.

Foot exercises

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



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

To protect your back

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

For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/physical-activity-and-pregnancy

Infections

During pregnancy, changes take place in your immune system which may make you more susceptible to some infections. Vaccination can help prevent disease or make the illness less serious. Some vaccinations are recommended in pregnancy.

In Northern Ireland, the Health and Social Care (HSC) system provides vaccinations free of charge if you are registered with a General Practitioner (GP).

Influenza

While flu is a mild illness for most people, it can be very serious for pregnant women. Pregnant women are more likely to develop serious complications as a result of flu, and rarely even death, compared to women who are not pregnant. There are also risks for the baby, including miscarriage and premature labour.

Receiving the flu vaccine during pregnancy is the best way to protect you and your unborn baby from getting serious complications of flu, including death. The flu vaccine is licensed for use by the European Medicines Agency. It is regularly used for pregnant women across the United Kingdom, Ireland and other countries. Millions of pregnant women have received the flu vaccine and the safety of the vaccine has been carefully monitored. This has shown that it is extremely safe to give in pregnancy, both for the mother and the unborn baby.

The flu vaccine becomes available every year from late September onwards, at the

start of the winter flu season. If you are pregnant during flu season you will be offered the flu vaccine by your GP or midwife. You can have the vaccine at any stage in pregnancy. You should get it as early in the season as possible in order to receive the best protection for you and your baby. If you become pregnant later in the winter you should get the vaccine as soon as you know you are pregnant. Even if you received the flu vaccine in the past, you still need to get the vaccine as flu protection only lasts for one flu season.

Pregnant women can suffer the same minor side effects as anyone else, including soreness where the vaccine was injected and, less often, a slight temperature and aching muscles for a couple of days after being vaccinated. Other reactions are very rare. Flu vaccine does not contain a live virus and so it cannot give you flu. It will only protect you against flu. There are many other viruses around every winter which cause flu-like symptoms, but these are not usually as serious as flu. For more information about the flu vaccine talk to your GP, practice nurse, district nurse or pharmacist.

Whooping cough

Whooping cough (pertussis) is an infection which can

affect people of all ages but is particularly serious for babies. Most babies who get it will have to be admitted to hospital, some will end up in intensive care and it can even result in death. Very young babies (under three months) are at most risk of serious disease.

All babies are vaccinated against whooping cough at two, three and four months of age. This means they can be vulnerable to the infection in the first two to three months of life before they get their vaccines. The best way to protect babies during this time is to give the mother the vaccine during pregnancy, at any stage after 16 weeks. She will make antibodies that are passed onto the unborn baby, which then protect the baby after it is born until he or she gets their own vaccines. The vaccine needs to be repeated during each pregnancy.

All pregnant women are offered the whooping cough vaccine between 16 and 32 weeks of pregnancy. This is the recommended time to receive it so that the unborn baby receives the highest level of protection. Recent studies have shown that when the vaccine is given to pregnant women at this time, over 90% of newborn babies do not get whooping cough. Studies also show that giving the vaccine

to pregnant women is very safe for both the woman and unborn baby.

For more information about the whooping cough vaccine talk to your midwife, GP, practice nurse, district nurse or pharmacist.

Respiratory Syncytial Virus (RSV)

Respiratory syncytial virus or RSV is a common virus that can cause a lung infection called bronchiolitis. In young babies this condition can make it hard to breathe and to feed.

In most cases, it can be managed at home, but babies with severe bronchiolitis may need intensive care in hospital and the infection can be fatal. RSV is more likely to be serious in very young babies, those born prematurely, and those with conditions that affect their heart, breathing or immune system.

The best way to protect your baby against RSV infection is for you to have an RSV vaccine during pregnancy.

You should be offered the RSV vaccine around the time of your 28 week antenatal appointment. Having the vaccine in week 28 or within a few weeks of this will help you build up a good level of immunity to pass on to your baby before birth. This will give your baby the best

protection, including if they are born prematurely. Recent studies have shown that when the vaccine is given to pregnant women at this time, the risk of a baby being admitted to hospital with RSV is reduced by over 72%. Studies have also shown that giving the vaccine to pregnant women is very safe for both the woman and unborn baby.

For more information about the RSV vaccine visit www.nidirect.gov.uk/rsv-pregnancy or talk to your midwife.

COVID-19

COVID-19 vaccination is no longer routinely offered during pregnancy. However, you may still be eligible if you are immunosuppressed. The vaccine can be given safely at any stage of pregnancy and after you have had your baby. If you think you may be eligible, please speak to your midwife or GP for advice.

Rubella

Rubella (or German measles) generally causes a mild illness with a range of symptoms including slight temperature, coughing, sneezing, rash, swollen glands or sore throat. If you catch rubella in the first four months of pregnancy it can seriously affect your baby's sight and hearing and may cause brain and heart

defects. If you are more than four months pregnant, it is unlikely that rubella will affect your baby.

Rubella infection can be prevented by measles, mumps, rubella and varicella (MMRV) vaccine. All children are offered two MMRV vaccines, at 12 months and 18 months. Most adults in Northern Ireland will have developed immunity to rubella from having had the infection previously or having been vaccinated. Your antenatal rubella screening test will show if you are immune or not.

If you are not immune to rubella, you will be offered two vaccines to prevent mumps, measles and rubella (MMR), at least four weeks apart, **after the birth of your baby** (unless you can produce evidence from your GP of having had two MMR vaccines previously).

Vaccination with MMR is the best protection for future pregnancies, against rubella, as well as measles and mumps.

If you are not immune and you come into contact with someone who has rubella or if you develop a rash you should tell your midwife or GP at once. A blood test will then be carried out to show if you have been infected.

Sexually transmitted infections

Sexually transmitted infections (STIs) are on the increase. One of the most common is chlamydia. Up to 70% of women and 50% of men who have an STI show no symptoms, so you may not know if you have one. However, many STIs can affect your baby's health during pregnancy and after birth. If you have any reason to believe that you or your partner has an STI, you should go for a check-up as soon as you can. You can ask your GP or midwife, or go to a genitourinary medicine (GUM) or sexual health clinic. You will be guaranteed strict confidentiality. You can find your nearest GUM clinic or sexual health clinic online or at www.sexualhealthni.info. You can also order a free sexual health test online at <https://sh24.org.uk>

If you are under 19, you can visit Common Youth to get free, confidential advice. To find your nearest centre, visit www.commonyouth.com or email hello@commonyouth.com

HIV and screening

HIV: You will be offered screening for HIV as part of the Infectious Diseases in Pregnancy Screening Programme (IDPS). Should

you test positive for HIV you will be referred to genitourinary medicine (GUM) in Belfast where treatment will be organised and counselling services are available. Current evidence suggests that a mother who is HIV positive, in good health and without symptoms of the infection, is unlikely to be adversely affected by pregnancy. However the HIV virus can be passed on to the baby during pregnancy and through breastmilk, but with early treatment to reduce the amount of HIV virus in your system the risk of this happening is significantly reduced (see box on page 65).

For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/hiv-and-pregnancy

Hepatitis B screening

You will be offered hepatitis B screening as part of the Infectious Diseases in Pregnancy (IDPS) programme. Hepatitis B is an infection caused by the hepatitis B virus. The infection mainly affects the liver, but is present in blood and body fluids.

During childbirth, your baby is in contact with your blood so, there is a chance that the virus could be passed to your baby. If this happens, your baby could become infected, 9 out of 10 exposed babies will develop chronic (long-lasting) infection. This can lead to liver disease such as scarring of the liver (cirrhosis) and liver cancer, which stops the liver from working properly.

Risk factors for HIV, hepatitis B, or hepatitis C:

- having sex with someone who is infected without using a condom;
- injectable or snorting drugs and sharing equipment with an infected person.
- being born in or spent your childhood in a country where the infections are more common (You may have acquired the infection at birth or by household contacts in your early years of life.)
- received medical or dental treatment in countries where infection prevention is not regulated properly
- received a blood transfusion in the UK prior to September 1991, or blood products prior to 1986 (increased risk of hepatitis C)
- had tattoos or body piercing using non-sterile equipment
- if your partner has had sex with other men.

Hepatitis B infection can be prevented by vaccination.

You will be offered hepatitis B screening as part of your antenatal care. If your screening test shows that you have the infection, you will be referred for specialist assessment and follow-up with a hepatologist. Even if you know you have hepatitis B and already attend a specialist, it is still important that you are seen again, as early as possible during your pregnancy.

Your baby will also be offered a course of hepatitis B vaccines in the first year of life and be referred for specialist assessment and follow-up. The first vaccine is given within 24 hours of birth, along with another extra injection called hepatitis B immunoglobulin (HBIG) if you have high levels of the virus during your pregnancy. Subsequent hepatitis B vaccines are given at one month and 12 months of age, as well as in the routine vaccinations at two, three and four months of age. (6 hepatitis B vaccines in total). Your baby will then have a blood test done at 12 months old to determine whether your baby has been infected with hepatitis B or not.

Hepatitis C

Hepatitis C is a virus that infects the liver. Many people

will have no symptoms and be unaware that they are infected. If you have hepatitis C, there is a small risk that you could pass the infection to your baby. This cannot be prevented at present, as treatment for hepatitis C cannot be given in pregnancy, although there is very effective treatment which can be given after delivery. You will be referred to hepatology services for this treatment once delivered. Your baby will be tested for hepatitis C between 3-6 months of age.

Syphilis screening

You will be offered syphilis screening as part of the infectious diseases in pregnancy screening programme (IDPS). Syphilis is a bacterial infection carried in the blood. It often goes unnoticed as signs and symptoms are not always obvious. However, it is a serious condition which, if left untreated, can result in serious health problems for both you and your baby.

Syphilis can be passed to others: by bacteria entering your body if you have sexual contact with someone with syphilis (normally during unprotected vaginal, anal or oral sex), from a mother to her baby during pregnancy or at birth or from infected blood by sharing needles. Should you

screen positive for syphilis in pregnancy you will be referred to the GUM clinic for specialist review and treatment.

Syphilis can be cured with one or more doses of antibiotics. The earlier it is treated, the less chance you will have health complications. It is important to remember that even after treatment you can be re-infected with syphilis so the GUM team will recommend that your partner is also tested and treated if necessary. You will need to avoid all sexual contact with your partner until you have both finished treatments.

If you or your partner have other sexual partners, or if you have other children, they may also need to be tested. Your sexual health team will advise you and offer help in contacting partners. Syphilis can pass from a mother to her baby during pregnancy. If left untreated it can result in babies being born with symptoms or signs of syphilis infection, known as congenital syphilis. Treating syphilis as early as possible in pregnancy gives the best chance of preventing this.

Having syphilis will not affect the way you deliver your baby and you can still breastfeed your baby.

If you need treatment for syphilis in this pregnancy, your baby will need to be examined by a doctor following birth and have some follow-up blood tests. A very small number of babies also need antibiotic treatment.

Herpes

Genital herpes infection can be caught through genital contact with an infected person or from oral sex with someone who has oral herpes (cold sores) and can be dangerous for a newborn baby. Initial infection causes very painful blisters or ulcers on the genitals. Less severe attacks usually occur for some years afterwards. If you or your partner are infected, use condoms or avoid sex during an attack. Avoid oral sex if either of you have cold sores or active genital herpes. Tell your doctor or midwife if either you or your partner have recurring herpes or develop the symptoms described above. If your first infection occurs in pregnancy, there is treatment available. If your first infection occurs towards the end of your pregnancy or during labour, a caesarean section may be recommended to reduce the risk of transmission to your baby. Herpes can be very serious for a young baby whose immune system won't have fully developed to fight off the virus.

If you develop a cold sore or think you're coming down with a herpes infection:

- do not kiss any babies
- wash your hands before contact with a baby
- wash your hands and cover up any cold sores before breastfeeding.

For more on herpes in newborns, see www.nidirect.gov.uk/conditions/herpes-baby-neonatal-herpes

For further information see www.rcog.org.uk/guidance/browse-all-guidance/other-guidelines-and-reports/management-of-genital-herpes-in-pregnancy

Other infections

Chickenpox

Chickenpox (varicella) causes a blistering, itchy rash and mild temperature in most people, although it can be more serious in pregnant women and may adversely affect your baby.

Around 95% of women are immune to chickenpox from having had the infection as a child, although this may be lower in women who were born outside the UK and Ireland. Most women are therefore not at risk of catching chickenpox and passing it on to their unborn baby. If you have never

had chickenpox or received a varicella-containing vaccine, you may not be immune.

If you develop a rash or come into contact with someone who has chickenpox or shingles, you should speak to your GP, midwife or obstetrician at once. A blood test will be carried out to see if you are immune, and you may receive a course of antiviral medication.

For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/chickenpox-and-pregnancy

Toxoplasmosis

Toxoplasmosis is a common infection that you can catch from the following sources: Cat faeces, soil or litter in contact with cat faeces may contain the parasite; consuming raw or undercooked meat containing parasitic cysts; contaminated water; unpasteurised milk or its products, especially goat's milk; eating raw, unwashed fruits or vegetables which have been in contact with contaminated soil

Infection in pregnancy can cause infection in the baby, resulting in possible mental disability and blindness. The risk to the baby is related to the gestational age at the time of infection. The greatest risk

of transmission to the baby is during the third trimester, but disease is most severe when it is acquired during the first trimester

Most women have already had the infection before pregnancy and will be immune. If you feel you may have been at risk, talk to your GP, midwife or obstetrician

Parvovirus B19 (slapped cheek disease)

Parvovirus B19 infection is common in children aged 6–10. It causes a temperature and a characteristic red rash on the face, so it is often called 'slapped cheek disease'. Around 50–70% of women are immune to this infection. However, parvovirus B19 is very infectious and can be harmful to your baby. If you come into contact with someone who is infected you should talk to your midwife or doctor, who can check whether you are immune through a blood test. In most cases, the baby is not affected when a pregnant woman is infected with parvovirus. However, it will be necessary to perform extra scans to ensure the baby is not affected.

Listeriosis

Listeriosis is a rare infection that is usually caught from

eating food containing listeria bacteria. People such as those who are pregnant, babies, and those with a weakened immune system are at greater risk of serious problems from the infection. If you get listeriosis while you're pregnant, there is a risk it could cause miscarriage or stillbirth. See www.nidirect.gov.uk/conditions/listeriosis and page 34 for more details.

Cytomegalovirus

Cytomegalovirus (CMV) is a common virus that is usually harmless. Some people experience flu-like symptoms however CMV can often be present without showing any symptoms, so most people don't know if they have had the virus.

CMV is spread through prolonged close contact with someone who has an active infection. CMV can affect people of all ages, however infection is most common in young children, especially those who attend nursery. CMV is not generally harmful to children and most do not exhibit signs or symptoms of infection, however the infection can be easily spread to other children and to adults who are caring for the child, such as parents and childcare providers.

If you get infected with CMV when you are pregnant you can pass the virus on to your unborn baby. This can result in complications for the baby which include low birthweight, stillbirth, childhood hearing loss, speech and language difficulties and occasionally seizures and brain damage.

The infection can be prevented in pregnancy by following simple steps, these include; washing your hands after exposure to children's bodily fluids, for example when changing nappies or wiping the nose, not sharing cutlery, cups or food with children and avoiding kissing young children on the lips. Further information can be found www.nhs.uk/conditions/cytomegalovirus-cmv

Malaria in pregnancy

Malaria is an infection passed on through mosquito bites. It can make you very unwell during pregnancy and may affect your baby if it's not treated quickly. If you have travelled to or from an area where malaria is common and develop a fever, shivers, headache, or feel generally unwell, seek medical help straight away. Malaria can be safely treated in pregnancy, and early treatment helps keep you and your baby well. Always let your midwife or

doctor know about any recent travel.

For further information see:
www.rcog.org.uk/for-the-public/browse-our-patient-information/malaria-and-pregnancy

Rash in pregnancy

If you develop a rash or illness at any time in pregnancy you should contact your midwife, GP or obstetrician urgently for advice. You may need some investigations. You should avoid antenatal clinics or maternity settings until you have been assessed to avoid coming into contact with other pregnant women.

If you have been in contact with someone with a rash, or known infection such as chickenpox, shingles, slapped cheek syndrome or rubella, you should also contact your midwife, GP or obstetrician for advice.

Group B streptococcus

Group B streptococcus (also called GBS or strep B) is a bacterium carried by up to 30% of people without causing harm or symptoms. In women it is found in the intestine and vagina and causes no problem in most pregnancies. In a very small number it infects the baby, usually just before or during labour, and can lead to serious illness or death. If you have had GBS in a previous

pregnancy you will be offered either testing for GBS at 35-37 weeks or antibiotics in labour.

Your obstetrician or midwife will assess whether you need to be given antibiotics during labour. If you need antibiotics, they will be given through a vein (intravenously).

Treatment for GBS

In some circumstances antibiotics can reduce the risk of a baby developing GBS. You should be offered antibiotics during labour if:

- You have previously had a baby with invasive GBS infection.
- GBS has been found in your urine in your current pregnancy.
- GBS has been found on swabs from your vagina which have been taken for another reason during this pregnancy.
- You have a high temperature during labour.
- You have an infection of the membranes around the baby (Chorioamnionitis)

Screening for GBS

In Northern Ireland, as in the rest of the UK, routine testing for GBS in pregnancy is not currently recommended because there is insufficient evidence to support it. This

position is kept under regular review.

If you are concerned about GBS, discuss it with your doctor or midwife.

Useful links

Group B Strep Support (GBSS)
www.gbss.org.uk

Group B Streptococcus and pregnancy pha.site/group-b-strep

The Group B Strep Association (via Facebook)

Royal College of Obstetricians and Gynaecologists (RCOG)
www.rcog.org.uk

Infections transmitted by animals in pregnancy

If you are visiting farms or handling animals, it's important to protect yourself from infections that can harm you or your baby. Always wash your hands well after touching animals, their bedding, or equipment, and avoid handling newborn lambs, kid goats, or birthing materials.

Cats

Cats' faeces can contain an organism which causes toxoplasmosis. Avoid emptying



cat litter trays while you are pregnant. If no one else can do it, use disposable rubber gloves. Trays should be cleaned daily and filled with boiling water for five minutes. Avoid close contact with sick cats and wear gloves when gardening – even if you don't have a cat – in case the soil is contaminated with faeces. Wash your hands and gloves after gardening. If you do come into contact with cat faeces, make sure that you wash your hands thoroughly.



Sheep

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

Pigs

Research is going on to see if pigs can be a source of



hepatitis E infection. This infection is dangerous in pregnant women, so avoid contact with pigs and pig faeces. There is no risk of hepatitis E from eating cooked pork products.

For information on other animals see www.gov.uk/guidance/pregnancy-advice-on-contact-with-animals-that-are-giving-birth

Inherited conditions

Some diseases or conditions are inherited from one or both parents. These include medium chain acyl dehydrogenase deficiency (MCADD), cystic fibrosis, haemophilia, muscular dystrophy, sickle cell disorders and thalassaemia. If you, your baby's father or any of your relatives has an inherited condition or if you already have a baby with a disability, talk to your doctor. You may be able to have tests early in pregnancy to check whether your baby is at risk or affected (see page 68).

Ask your GP or midwife to refer you to a genetic counsellor (a specialist in inherited diseases) for advice.

Ideally, you should do this before you get pregnant or in the early weeks of pregnancy.

Work hazards

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

If it is a known and recognised risk, it may be illegal for you to continue in your current role, and your employer must offer you suitable alternative work on the same terms and conditions as your original job. If no safe alternative is available, your employer should suspend you on full pay (give you paid leave) for as long as necessary to avoid the risk. If your employer fails to pay you during your suspension, you can bring a claim in an employment tribunal (within three months). This will not affect your maternity pay and leave. See also page 190.

Computer screens

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

Coping at work

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

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

DIY

It is highly unlikely that painting or being around paint fumes while you're pregnant will harm your unborn baby, as the risk from most modern household paints is very low.

The risk of harm to your baby may be slightly greater from solvent-based paints and old paintwork, which may contain traces of lead.

For this reason, you should avoid using solvent-based paints and stripping old paintwork while you're pregnant.

Flying and travel

Flying is not harmful for you or your baby, but some airlines will not let you fly towards the end

of your pregnancy, and you should check conditions with them.

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

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

Before you travel, think about your destination. Could you get medical help if you needed it? Are any immunisations needed

which might be harmful in pregnancy?

For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/air-travel-and-pregnancy

Safety on the move

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



6

Antenatal care

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

As soon as you know you are pregnant, you should get in touch with a midwife or your GP (see chapter 2) to organise your antenatal care. It's best to see them as early as possible. Let your midwife know if you have a disability that means you have special requirements for your antenatal appointments or labour. If you don't speak English, let your midwife know and arrangements will be made for an interpreter.

If you have a long-term condition such as diabetes or epilepsy you should contact your hospital team as soon as possible.

Information

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

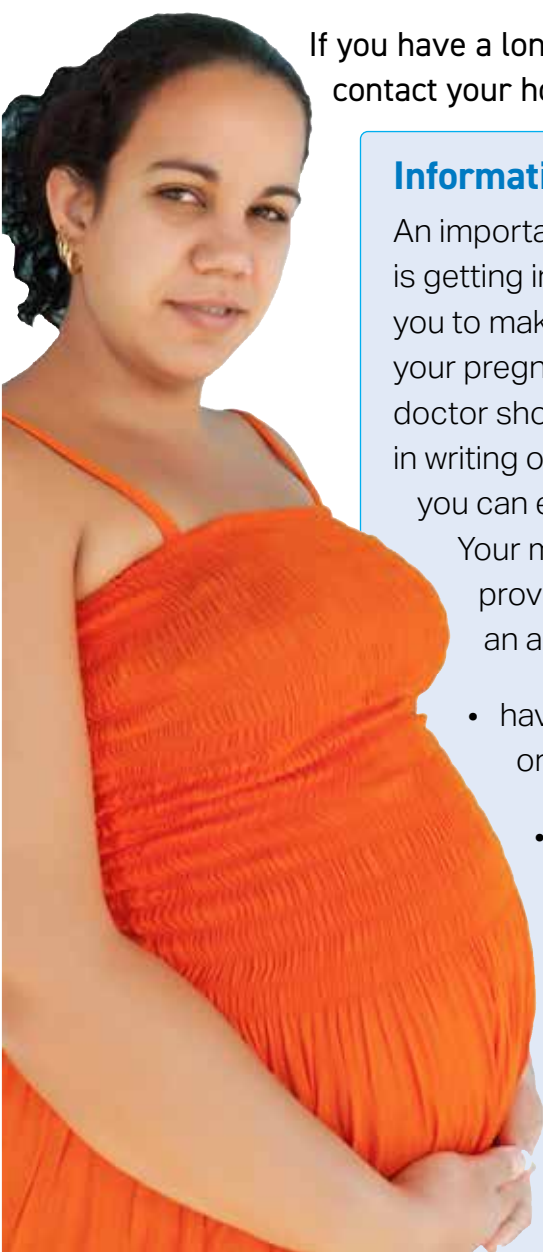
Your midwife or doctor should provide you with information in an appropriate format if you:

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

You may have lots of things you want to ask the midwife. It's a good idea to write your questions down, so you

don't forget. Tell the receptionist or your midwife if you require an interpreter or information in another language.

- If you have any questions or worries, talk to your midwife or doctor. Talking is as much a part of antenatal care as tests and examinations.
- Privacy – at your first appointment the midwife will ask you some very personal questions about your past history. To ensure your privacy the midwife will ask your partner or anyone else who accompanies you to remain in the waiting room until this part of your interview is completed. They can join you for the rest of your interview if you want them to. You will all have an opportunity to ask questions and discuss any concerns.



Antenatal appointments

If you are expecting your first child, you are likely to have up to 10 appointments. If you have had a baby before, you should have around seven appointments. In certain circumstances, for example if you have or develop a medical condition, you may have more appointments. Early in your pregnancy your midwife or doctor should give you information about how many appointments you are likely to have and when they will happen. You should have a chance to discuss the schedule with them. The table on page 68 gives a brief guide to what usually happens at each antenatal appointment.

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

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

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



What should happen at the appointments

The aim is to check on you and your baby's progress and to provide clear information and explanations about your care.

At each appointment you should have the chance to ask questions and discuss any concerns or issues with your midwife or doctor.

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

First booking appointments usually take up to two hours so it's best if you do not take other children as they will get restless or bored. If

your Trust has not moved to digital records remember to take a large bag for your green maternity hand-held records (MHHR) as it is easily recognisable by others (see page 70). Do not leave it in the car or anywhere other people could read it without permission.

Antenatal Care Core Pathway

As part of the implementation of the Northern Ireland Strategy for Maternity Care, an Antenatal Care Core Pathway has been developed which will identify the care all women should receive at their antenatal appointments throughout their pregnancy. Please discuss with your midwife or doctor if you do not feel that all aspects of this care is being provided.

For further information see www.nice.org.uk/guidance/ng201 and www.nice.org.uk/guidance/ng204

Antenatal appointments schedule

First contact with your midwife or doctor. Take a fresh urine sample to all your appointments

This is the appointment when you tell your midwife or doctor that you are pregnant. They should give you information about: • folic acid and vitamin D supplements, nutrition, diet and food hygiene; • lifestyle factors, such as smoking, drinking and recreational drug use; • antenatal screening tests; • flu, whooping cough, RSV and COVID-19 (if eligible) vaccines to protect you and your baby. It is important to tell your midwife or doctor if: • you smoke, take drugs or alcohol; • you are being treated for a long-term condition	• such as diabetes, high blood pressure, epilepsy or mental health problems; • you or anyone in your family has previously had a baby with a structural abnormality, for example spina bifida; • you are a victim of sexual abuse or domestic violence; • there were any complications or infections in a previous pregnancy or delivery, such as miscarriage, pre-eclampsia, premature birth, postnatal depression or Group B streptococcus; • there is a family history of an inherited disease, for example sickle cell, cystic fibrosis or MCADD; • you have other children in care.
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Booking

At your first booking appointment you should have a scan to confirm when your baby is due (in some areas the scan may be slightly after you have your booking visit). Your due date by ultrasound scan will be used rather than the date of your last period as it is a more accurate way of predicting your due date. You will be asked lots of questions about your medical history, your family history and details of any previous pregnancies you may have had. You will also be asked about your current pregnancy and given lots of information about your pregnancy. This appointment may last for up to two hours. Your midwife or doctor should give you information about: • how the baby develops during pregnancy; • nutrition and diet; • exercise and pelvic floor exercises; • antenatal screening tests; • your antenatal care; • breastfeeding, including workshops; • antenatal education;	• planning your labour; • your options for where to have your baby. Blood tests are normally offered and recommended at your first antenatal visit. These tests look for possible health problems that could affect your health and the health of your baby. Having the tests will help you make decisions about care, both before and after birth, to protect the health of you and your baby. Only one sampling of blood is needed to do all six tests. Before a blood sample is taken, you will be asked if you consent to the tests. You can decline to consent if you choose to. If a test is declined, it is standard practice to offer it again later in your pregnancy. Depending on any identified issues, further blood screening tests may be offered, such as Combined, Quadruple or Harmony tests. However, these tests are not funded by the NHS and must be funded privately. At time of printing these tests cost between £50-£250. You will be weighed at the booking appointment, but you probably will	not be weighed regularly during your pregnancy. Your height will be measured along with your weight so that your midwife can calculate your BMI (body mass index). Most women put on between 10 and 12.5kg (22–28lbs) in pregnancy, most of it after the 20th week. Much of the extra weight is due to the baby growing, but your body will also be storing fat ready to make breastmilk after the birth. Eating sensibly and taking regular exercise can help. See chapter 5 for what you should eat and for advice about exercise. Your height, weight and BMI are used to produce a personalised growth chart for your baby's development. You will receive a risk assessment for thromboembolism and gestational diabetes. At the end of your booking appointment, you should understand the plan of care for your pregnancy. Your booking appointment is an opportunity to tell your midwife or doctor if you are in a vulnerable situation or if you need extra support. This could be because of domestic violence, sexual abuse or female genital mutilation.
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8–12 weeks (dating scan)

Ultrasound scan to estimate when your baby is due and check the physical development of your baby.

16 weeks

Your midwife or doctor should:

- review, discuss and record the results of any screening tests;
- measure your blood pressure and test your urine for protein;
- consider an iron supplement if you are anaemic (see page 80);
- give you information about the ultrasound scan you will be offered at 18 to 20 weeks and help with any concerns or questions you have.



18–20 weeks (anomaly scan)

Ultrasound scan to check the physical development of your baby. (Remember, the main purpose of this scan is to check that there are no structural abnormalities.). More information is available on page 66.

25 weeks*

Your midwife or doctor should:

- use a tape or undertake an ultrasound scan to measure the size of your uterus and plot on your individual growth chart;
- measure your blood pressure and test your urine for protein;
- discuss flu, whooping cough and RSV.



Flu is more serious than you think

Get the flu vaccine to protect yourself and your baby



Whooping cough (Pertussis)

If you are pregnant you should get vaccinated to protect your baby



28 weeks

Your midwife or doctor should:

- offer more screening tests;
- use a tape or undertake an ultrasound scan to measure the size of your uterus and plot on your individual growth chart;
- discuss flu, whooping cough and RSV,;
- measure your blood pressure and test your urine for protein;
- discuss your baby's movements.

**Extra appointment if this is your first baby*

31 weeks*

Your midwife or doctor should:

- review, discuss and record the results of any screening tests from the last appointment;
- use a tape or undertake an ultrasound scan to measure the size of your uterus and plot on your individual growth chart;
- measure your blood pressure and test your urine for protein;
- discuss flu, whooping cough and RSV.
- discuss your baby's movements.

34 weeks

Your midwife or doctor should give you information about preparing for labour and birth, including how to recognise active labour, ways of coping with pain in labour and your birth plan. Your midwife or doctor should:

- review, discuss and record the results of any screening tests from the last appointment;
- use a tape or undertake an ultrasound scan to measure the size of your uterus and plot on your individual growth chart;
- measure your blood pressure and test your urine for protein;
- discuss flu, whooping cough and RSV.
- discuss your baby's movements.

36 weeks

Your midwife or doctor should give you information about:

- feeding your baby;
- caring for your newborn baby;
- vitamin K and screening tests for your newborn baby;
- your own health after your baby is born;
- the 'baby blues' and postnatal depression;
- discuss flu, whooping cough and RSV.
- discuss your baby's movements.

Your midwife or doctor should:

- use a tape or undertake an ultrasound scan to measure the size of your uterus and plot on your individual growth chart;
- check the position of your baby;
- measure your blood pressure and test your urine for protein;



38 weeks

Your midwife or doctor will discuss the options and choices about what happens if your pregnancy lasts longer than 41 weeks. Your midwife or doctor should:

- use a tape or undertake an ultrasound scan to measure the size of your uterus and plot on your individual growth chart;
- measure your blood pressure and test your urine for protein;
- discuss flu, whooping cough and RSV.
- discuss your baby's movements.

40 weeks*

Your midwife or doctor should give you more information about what happens if your pregnancy lasts longer than 41 weeks. Your midwife or doctor should:

- use a tape or undertake an ultrasound scan to measure the size of your uterus and plot on your individual growth chart;
- measure your blood pressure and test your urine for protein;
- discuss flu, whooping cough and RSV.
- discuss your baby's movements.



41 weeks

Your midwife or doctor should:

- use a tape or undertake an ultrasound scan to measure the size of your uterus and plot on your individual growth chart;
- measure your blood pressure and test your urine for protein;
- offer a membrane sweep (see page 112);
- discuss the options and choices for induction of labour;
- discuss flu, whooping cough and RSV.
- discuss your baby's movements.

**Extra appointment if this is your first baby*

Regular checks at every antenatal appointment

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

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

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

Urine

Your urine is checked for a number of things, including protein or 'albumin'. If this is in your urine, it may mean that you have an infection that needs to be treated. It may also be a sign of pre-eclampsia (see 'High blood pressure and pre-eclampsia' on page 86).

Blood pressure

A rise in blood pressure later in



pregnancy could be a sign of pre-eclampsia (see page 86). It is very common for your blood pressure to be lower in the middle of your pregnancy than at other times. This is not a problem, but may make you feel light-headed if you get up quickly. Talk to your midwife if you are concerned.

Checking your baby's development and wellbeing

At each antenatal appointment from 25 weeks, your midwife or doctor should check your baby's growth. To do this, they will measure the distance from the top of your uterus to your pubic bone, or measure the baby using an ultrasound scanner. The measurement will be recorded in your notes. If your baby's movements become different or less frequent, slow down or stop, contact your maternity unit immediately.

You will be offered an ultrasound scan if your midwife or doctor has any concerns about your baby's growth. See page 66 for more on fetal movement or visit www.rcog.org.uk

A risk assessment will be carried out to determine whether your baby's growth can be measured with a tape measure or whether you need to have an ultrasound scan every three weeks to monitor your baby's growth.

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

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

If you are going to have your baby in hospital

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



Blood tests

As part of your antenatal care, you will be offered a number of blood tests. Some are offered to all women and some are only offered if it is thought that you are at risk of a particular infection or inherited condition. All of the tests are done to ensure your own health and help protect the health of your baby. Only one sampling of blood is needed for the tests, and it is stored and can be checked for other infections throughout the pregnancy.

Talk to your midwife or doctor so that you understand why the blood tests are being offered and so that you can make an informed choice about whether or not you want them. Your midwife or doctor should also give you information about the tests. Below is an outline of all the tests that can be offered.

Your blood group and rhesus factor

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

People who are rhesus positive have a substance known as D antigen on the surface of their red blood cells. Rhesus negative people do not.

A woman who is rhesus negative can carry a baby who is rhesus positive if the baby's father is rhesus positive. During pregnancy or birth, small amounts of the baby's blood can enter the mother's bloodstream. This can cause the mother to produce antibodies. This usually doesn't affect the existing pregnancy, but the woman becomes 'sensitised'. The antibodies produced by the mother can cross the placenta and attach to the D antigen on her baby's red blood cells. This can be harmful to the baby as it may result in a condition called haemolytic disease of the fetus and newborn, which can lead to anaemia and jaundice.

Prevention of rhesus disease

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

Rhesus negative mothers who are not sensitised are offered an anti-D injection at around 28-30 weeks as well as after the birth of their baby. This will only be required if the baby has a rhesus positive blood group.

Anaemia

Anaemia makes you tired and less able to cope with any loss of blood when you give birth. If tests show you are anaemic, you will be offered iron tablets and an

iron rich diet is recommended.

Immunity to rubella (German measles)

Since rubella infection in early pregnancy can seriously damage your unborn baby, your screening test will check if you have immunity to rubella or not. If your result shows that you are susceptible to rubella (rubella non-immune) you should avoid contact with people who have a rash or have been diagnosed with rubella. After delivery you will be offered the measles, mumps, rubella (MMR) immunisation so that you will be protected against rubella in future pregnancies. If you can provide evidence from your GP that you have had two MMR vaccinations in the past you will not require immunisation. For more information about rubella, visit pha.site/immunisation-and-vaccinations

Syphilis screening

Syphilis infection in pregnancy if left untreated can lead to miscarriage, stillbirth or congenital syphilis in the baby. If you screen positive for syphilis you will be referred to genito-urinary medicine (GUM) who will organise antibiotic treatment for yourself and your partner if necessary. This treatment will cure your infection and reduce the risk of the baby developing congenital syphilis.

Hepatitis B screening

Hepatitis B is a virus that if left

unchecked can cause serious liver disease for yourself and in pregnancy can pass to the baby especially during the time of birth (see page 51). You will be referred to the hepatology clinic in Belfast and your baby will be offered a course of immunisations starting at birth to help prevent them becoming infected and reduce the chance of them developing long term liver disease.

HIV screening

HIV is a virus that attacks the immune system and can pass to the baby during pregnancy, at delivery, or after birth by breastfeeding (see page 50). If your screening tests is positive for HIV you will be referred to genito-urinary medicine (GUM) in Belfast who will organise treatment and care to reduce the risk of your baby becoming infected. The baby will also

require treatment for 4 weeks after delivery.

Other tests and checks

Screening for gestational diabetes

During your first antenatal appointment (also called a booking appointment) at around week 8 to 12 of your pregnancy, your midwife or doctor will ask you some questions to determine whether you're at an increased risk of gestational diabetes.

If you have 1 or more risk factors for gestational diabetes you should be offered a screening test. The screening test is called an oral glucose tolerance test (OGTT), which takes about 2 hours.

It involves having a blood test in the morning, when you have not had any food or drink for 8 to 10 hours (though you can

usually drink water, but check with the hospital if you're unsure). You're then given a glucose drink.

After resting for 2 hours, another blood sample is taken to see how your body is dealing with the glucose.

The OGTT is done when you're between 24 and 28 weeks pregnant. If you've had gestational diabetes before, you'll be offered an OGTT earlier in your pregnancy, soon after your booking appointment, then another OGTT at 24 to 28 weeks if the first test is normal.

For further information: www.nhs.uk/conditions/gestational-diabetes/

www.nice.org.uk/guidance/ng3 and www.rcog.org.uk/for-the-public/browse-our-patient-information/gestational-diabetes

If you are HIV positive

If you are HIV positive your management and delivery will depend on the effectiveness of your anti-retroviral (ARV) treatment. An elective caesarean birth (see page 117) may be necessary, but not always. Your doctor will discuss this with you. Not attending for, or not taking the treatment as prescribed will significantly increase the risk of transmitting the HIV infection to your baby, whereas

with adequate treatment the risk can be reduced to less than 1%.

Your baby will be tested for HIV at birth and at intervals for up to two years. If your baby is found to be infected with HIV, paediatricians will be able to anticipate certain illnesses that occur in infected babies, and treat them early.



You will be advised not to breastfeed because HIV can be transmitted to your baby through breastmilk.

If you think at any stage in pregnancy that you are at risk of getting HIV or know you are HIV positive, talk to your midwife or doctor about HIV testing and counselling. You can also get free confidential advice from the National AIDS Helpline on 0800 567 123.

Hepatitis C

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

Cervical cancer

Cervical screening (or a smear) tests cells from your cervix (the neck of the uterus) for high-risk strains of the human papillomavirus (HPV), which can cause cell changes. If this HPV is found, your sample will be checked for cell changes. Cervical screening is only offered to women over 25. If you are due to have a test (if you have not had one in the last three years), you will probably be told to wait until three months after your baby is born unless you have a history of abnormal results. This is based on guidance by the HSC cervical screening programme. For more information, go to www.cancerscreening.hscni.net

Herpes

If you, or your partner, have ever had genital herpes, or you get your first attack of genital blisters or ulcers during your

pregnancy, let your midwife or doctor know. Herpes can be dangerous for your newborn baby and it may need treatment (see page 52).

Other infections

There are other infections that are not routinely tested for – ask your GP or midwife about tests if you are concerned.

Breast lumps

If you note any unusual breast lumps or have been treated for breast cancer in the past ask your doctor to examine you. Lumps which are not harmful often appear in pregnancy but it is best to have them checked by a doctor.

Ultrasound scans

Most hospitals will offer women at least two ultrasound scans during their pregnancy. The first is usually around eight to 12 weeks and is sometimes called the dating scan because it can help to determine when the baby is due. The second scan usually takes place between 18 and 20 weeks and is called the anomaly scan because it checks for structural abnormalities.

Ultrasound scans use sound waves to build up a picture of your baby in your uterus. They are completely painless, have no known serious side effects on mothers or their babies, and may be carried out for medical need at any stage of pregnancy.

If you have any concerns about having a scan, talk it over with your midwife, GP or obstetrician. For women with a normal healthy uncomplicated pregnancy ultrasound scans are not recommended after 24 weeks (NICE NG210, 2021).

If you are carrying more than one baby, you will need more ultrasound scans.

What do scans tell us?

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

expected (this is particularly important if you are carrying twins or more) and does not have any of the 11 physical conditions screened for.

- There is always a chance that a baby may be born with a condition that could not be seen on the scan.
- You will always be told if anything unexpected is found during your scan. Sometimes it is difficult to get a clear view of your baby. This might be because your baby is lying in an awkward position, or you are above average weight. This does not mean there is anything to worry about. In this case you will be offered a second scan whereby the sonographer will try to complete the scan at the next appointment, but it is not always possible.

At the scan

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

The sound is reflected back and creates a picture that is shown on a screen. It can be very

exciting to see a picture of your own baby moving about inside you.

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

Fetal movement

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

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

Tests to detect structural and physiological differences or chromosomal conditions

You may be offered tests

that can detect structural abnormalities like spina bifida, which is a defect in the development of the spine, or some chromosomal conditions like Down's syndrome, which is caused by having an extra chromosome. Discuss the tests and what they mean with your midwife.

Screening tests can:

- reassure you that your baby has no detected structural abnormalities;
- provide you with an opportunity to see your baby during the scan;
- give you time to prepare for the individual needs of your baby.

Tests can also provide valuable information for your care during the pregnancy. However, no test can guarantee that your baby will be born without a condition or syndrome.

No test is 100% accurate and some conditions may remain undetected. See www.downsyndromeuk.co.uk

Not all these tests are currently funded by the Trusts and must be funded privately.

If you do have a screening test and it suggests an increased chance of a genetic condition, you will be offered diagnostic tests, which will give a more

definite diagnosis. These diagnostic tests carry a small risk of miscarriage, so you may decide not to have them. Discussing the issues with your partner, midwife, doctor and friends may help you in deciding what is right for you. You may also be offered tests for:

- sickle cell;
- thalassemia.

Further information is available at: www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/management-of-beta-thalassaemia-in-pregnancy-green-top-guideline-no-66 and www.rcog.org.uk/for-the-public/browse-our-patient-information/sickle-cell-disease-and-pregnancy

Haemophilia and muscular dystrophy

Some conditions, such as haemophilia and muscular dystrophy, are only found in boys (although girls may carry the condition in their chromosomes and pass it on to their sons).

Tell your midwife or doctor if these or other genetic conditions run in your family, as it may then be important to know your baby's sex.

Screening for Down's syndrome, Edwards' syndrome and Patau's syndrome

During the very early stages of development changes can occur leading to some babies having an extra chromosome causing Down's syndrome, Edwards' syndrome or Patau's syndrome.

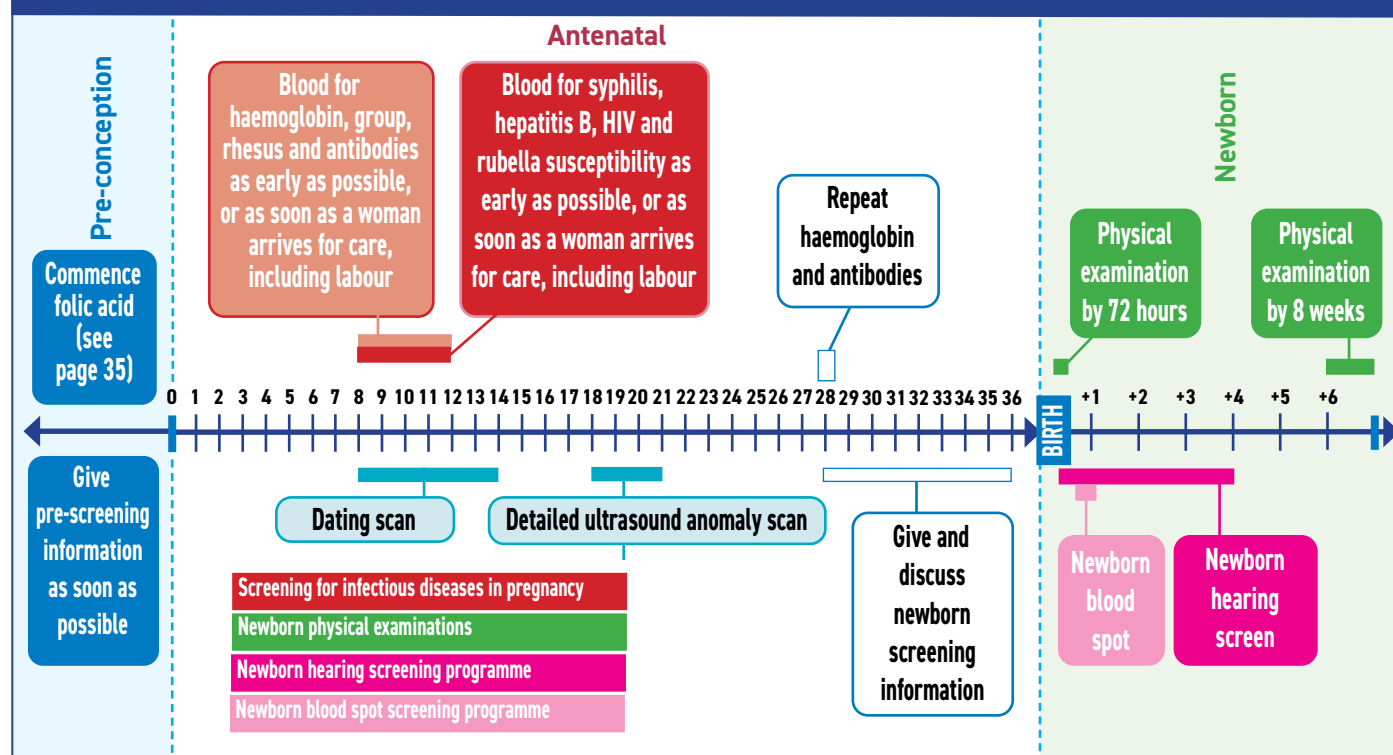
First trimester screening tests are not currently offered as part of routine antenatal care in Northern Ireland. If you would like these tests to be carried out you may have to pay privately. In some units in Northern Ireland, there is a test called the quadruple test that can be done in the second trimester. This test that is less accurate compared to the combined test or non-invasive prenatal testing (NIPT) done in the first trimester. If your unit offers the quadruple test and you want to avail of this, please speak to your midwife or doctor.

Test results

The screening test will not tell you whether your baby does or does not have Down's, Edwards' or Patau's syndromes. The test will tell you if you have a higher

Screening timetable – optimum times for testing

Women and families should understand the purpose of all tests before they are taken



or lower chance of having a baby with one of these conditions. If the results of the test show that you have a higher chance of having a baby with Down's syndrome, Edwards' syndrome or Patau's syndrome, you'll be offered further diagnostic tests such as amniocentesis to find out for certain if your baby has the condition. The diagnostic tests can provide valuable information for your care during pregnancy and for the care of your baby after delivery. However no test is 100% accurate and not all syndromes are tested for so some conditions or syndromes may remain undetected.

Amniocentesis

Amniocentesis can be offered from 15 weeks of pregnancy if:

- you have a positive or higher chance quadruple test screening result;
- an ultrasound scan detects a structural difference that is associated with a genetic condition;
- your past history or family history suggests that there may be an increased chance of your baby having a genetic or chromosomal condition such as Down's syndrome, sickle cell disease or thalassaemia.

What happens

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

Usually, the fluid will be tested for Down's syndrome, Edwards' syndrome and Patau's syndrome. The results should be available within three working days.

If all the chromosomes have to be looked at, it can take up to three weeks. This test will reveal your baby's sex, so tell your midwife or doctor whether, at this stage, you want to know if your baby is a boy or a girl.

The risks

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

Diagnostic tests for Down's syndrome and other genetic conditions

These tests will give you a definite diagnosis of Down's

Antenatal Results and Choices (ARC), Down's syndrome association Northern Ireland or Soft UK can help parents with all issues associated with antenatal testing and its implications. They can give you more information or put you in touch with parents with a pregnancy in which a genetic condition had been detected.

Go to www.arc-uk.org
www.downs-syndrome.org.uk/northern-ireland/ or
www.soft.org.uk/ for more information.

syndrome and other conditions.

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

If a test confirms that your baby has a genetic condition

Your midwife or doctor will make sure you see the appropriate health professionals to help you get all the information and support you need so you can make the choices that are right for you and your family.



Making the most of antenatal care

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

- In some clinics you can buy refreshments. If not, take a snack with you if you are likely to get hungry.

- Write a list of questions you want to ask and take it with you to remind you. Make sure you get answers to your questions or the opportunity to discuss any worries.
- If your partner is free, they may be able to go with you. This can help them feel more involved in the pregnancy.

Pregnancy and complex social factors

Some women may need extra because of their personal circumstances, such as problems with alcohol or drugs,

or because they have a violent partner or family member. A woman's age may also mean that extra support is needed – for example, young women might feel uncomfortable having check-ups in a clinic where most of the other women are older. Women who have moved here from another country may not know how to find a midwife or doctor, or may not understand English very well. Your maternity team will be there to provide you with extra support. For further information see www.nice.org.uk/guidance/cg110

Maternity hand-held record (MHHR) or ENCOMPASS digital record

ENCOMPASS is a new electronic patient record system for Northern Ireland with all Trusts moving to digital records in May 2025.

This means depending on what trust you book in you may have a digital health record or Maternity Hand Held Record

(Green notes) or a combination of both.

At your first antenatal visit, your midwife will enter your details in your digital record and add to them at each visit. You should be asked to keep your maternity hand-held record at home with you and to bring

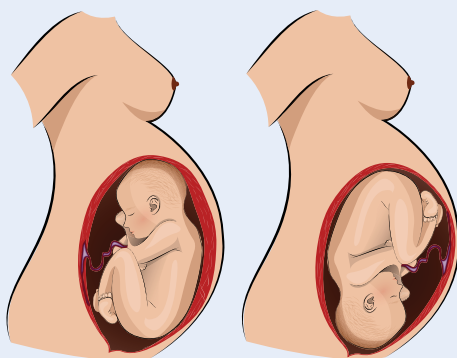
them along to all your antenatal appointments.

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

- 1 Date.** This is the date of your antenatal visit.
- 2 Gestation.** This refers to the length of your pregnancy in weeks from the date of your last menstrual period.
- 3 Blood pressure (BP).** This should stay at about the same level throughout your pregnancy. If it goes up a lot in the last half of your pregnancy, it may be a sign of pre-eclampsia (see page 86).
- 4 Urine.** These are the results of your urine tests for protein and sugar. '+' or 'Tr' means a quantity (or trace) has been found. 'glu' stands for 'glucose', 'Nil' or a tick or 'NAD' all mean the same: nothing abnormal has been discovered. 'Ketones' may be found if you have not eaten recently or have been vomiting. Mssu stands for "mid stream sample of urine" which will be sent away for testing if any protein is found in case an infection is present.

Date	Gestation Pressure (BP)	Blood	Urine
1	2	3	4
15/6/18	13	110/60	Nil
20/7/18	18	125/6	Nil
21/8/18	22	135/65	Nil
18/9/18	26+	125/75	Nil
28/10/18	30	125/70	Nil
27/11/18	34	115/75	Nil

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



- 6 Position.** Height of the uterus and the position of the baby in the womb.



* ROA: Right occipito anterior
LOP: Left occipito posterior

- 7 Fetal heart (FH).** 'FHH' or just 'H' means 'fetal heart heard'.

- 8 Fetal movement.** Most women are first aware of their baby moving when they are 16-22 weeks pregnant. However, if this is your first pregnancy, you may not become aware of movements until you are more than 20 weeks pregnant. If you have been pregnant before, you may feel movements as early as 16 weeks. Pregnant women feel their unborn baby's movements as a kick, flutter, swish or roll.

As your baby develops, both the number and type of movements will change with your baby's activity pattern. Usually, afternoon and evening periods are times of peak activity for your baby. During both day and night, your baby has sleep periods that mostly last between 20 and 40 minutes, and are rarely longer than 90 minutes. Your baby will usually not move during these sleep periods.

The number of movements tends to increase until 32 weeks of pregnancy and then stay about the same, although the type of movement may change as you get nearer to your due date. Often, if you are busy, you may not notice all of these movements. Importantly, you should continue to

feel your baby move right up to the time you go into labour. Your baby should move during labour too.

If you are unsure whether or not your baby's movements are reduced, you should lie down on your left side and focus on your baby's movements for the next two hours. If you do not feel ten or more separate movements during these two hours, you should seek professional help immediately. 'FMF' means 'fetal movement felt'.

Presentation	Position	FH	Fetal Movement	Next	Sign.	Notes
5	6	7	8			
–	–	–	Normal	20/7	JS	u/s arranged for 17/7 to check maturity
–	ROA*	–	FMF	21/8	JS	
–	–	–	Normal	18/9	JS	Taking iron
–	–	H	Normal	28/10	JS	
ceph	LOP*	FHH	Reduced	27/11	JS	MAT B1 given, Hb taken
ceph	–	FHH	Normal	15/12	JS	



My Care app

My Care gives you greater control over your healthcare by providing you with personalised and secure online access to specific parts of your electronic record. Through My Care you can access information like your appointments, medications and some test results. Your pregnancy journey can be followed on My Care with further content planned in the future. My Care is free to use, and it is optional. You can continue interacting with healthcare services via traditional methods – letters, phone calls, etc. For further details and guidance on accessing My Care please visit www.nidirect.gov.uk/services/view-your-medical-records-online-using-my-care

Your antenatal team

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

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

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

The people you are most likely to meet are listed below.

A midwife is specially trained to care for mothers and babies throughout pregnancy and labour and after the birth.

Midwives provide care for the majority of women at home or in hospital.

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

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

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



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

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



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

see a paediatrician at all. Your midwife or GP will check that all is well with you and your baby.

A sonographer is specially trained to carry out ultrasound scans. A sonographer will perform your anomaly scan. Some women are scanned at other points in their pregnancy.

An obstetric physiotherapist is specially trained to help you cope with physical changes during pregnancy, childbirth and afterwards. Some provide antenatal education and teach antenatal exercises, relaxation and breathing, active positions and other ways you can keep yourself fit and healthy during pregnancy and labour.

After the birth, they advise on postnatal exercises to tone up your muscles. Your midwife can help you with these exercises.

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



Dietitians may be available to advise you about healthy eating or special diets, for example if you develop gestational diabetes or have a high BMI at start of pregnancy.

Research

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

Students

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



Antenatal education/ parentcraft

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

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

Choosing an antenatal class

Think about what you hope to gain from antenatal classes so that you can find the sort of class that suits you best. You need to start making enquiries early in pregnancy so that you can be sure of getting a place in the class you choose.

You can go to more than one class. Ask your midwife, health visitor or GP about what is available in your area. Speak to your community midwife if you cannot go to classes. The

midwife can advise of online classes that are available.

The classes

During pregnancy, you may be able to go to some introductory classes on baby care. Most start about 8 to 10 weeks before your baby is due.

Classes are normally held once a week, either during the day or in the evening, for about two hours. Some classes are for pregnant women only. Others will welcome partners or friends, either to all the sessions or to some of them.

In some areas there are classes for women whose first language is not English, classes for single mothers and classes for teenagers.





The kinds of topics covered in antenatal education are:

- health in pregnancy;
- exercises to keep you fit during pregnancy and help you in labour;
- what happens during labour and birth;
- coping with labour and information about different types of pain relief;
- how to help yourself during labour and birth;
- relaxation techniques;
- how to give birth without any intervention;
- information on different kinds of birth and intervention;
- caring for your baby, including feeding;
- your health after the birth;
- 'refresher classes' for those who have already had a baby;
- emotions during pregnancy, birth and the early postnatal period.

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

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

If you have a multiple pregnancy, try to start your classes at around 24 weeks, because your babies are more likely to be born earlier. Some hospitals have special classes for parents who are expecting multiple babies. Parents expecting multiple babies may

also be shown around the neonatal unit because twins and triplets are more likely to need neonatal care after they are born. For more information see chapter 15.

The NCT

The NCT (also known as the National Childbirth Trust) runs a range of classes. The groups tend to be smaller and may go into more depth, often allowing time for discussion and for practising physical skills. For details of antenatal courses, along with information on local support groups, visit www.nct.org.uk



Sure Start

Sure Start is a government programme funded by the Department of Education which provides a range of support services for parents with children under the age of four. There are 38 Sure Start projects in Northern Ireland, covering at least the top 20% most disadvantaged wards.

Sure Start projects deliver a wide variety of programmes to parents and children, which are designed to support preschool children's learning, health and wellbeing, and social and emotional development.

The aims of Sure Start are to complement the work of existing local services and provide families with advice on where to go and who to speak to if they have more specialised needs or difficulties. Sure Start projects do this by:

- improving the ability to learn by encouraging stimulating play, improving language skills and the early identification and support of children with learning difficulties;
- improving health by supporting parents in caring for children and promoting children's health and development;

- improving social development by supporting the development of early relationships between parents and children, good parenting skills, family functioning and early identification and support of children with emotional, learning or behavioural difficulties.

The core elements which must feature in any Sure Start programme are:

- outreach and home visiting services, to make contact as early as possible in the child's life and draw families into using other services;
- family support, including befriending, social support and parenting information, both group and home-based;
- good quality play, learning and childcare experiences for children, both group and home-based;
- primary and community healthcare and advice;
- speech, language and communication support;
- support for all children in the community, recognising their differing needs.



Where are Sure Start services available?

To receive information on Sure Start services you will need to consent to the following details being shared - your name, address, postcode, telephone number and expected date of delivery. Your consent will be recorded at your maternity appointment and should you change your mind you can withdraw consent by contacting Surestartmonitoring@hscni.net

Your details will be shared initially with the HSC who will use the details to identify the relevant local Sure Start provider before passing them on. Once Sure Start have your details they will contact you to provide information on the services they provide. If you avail of services further information on how your personal information is processed will be provided. If you decide not to proceed simply let Sure Start know this and your details will be securely deleted. Your details will not be used or shared for any other purpose.

7

Conditions and problems in pregnancy

7

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



This chapter describes some of the minor and more serious health problems and gives advice on how to deal with them and when you should get help - also see the table on page 43.

Problems in early pregnancy

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

need a second scan to check that all is well.

Common minor problems

Backache

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

How to avoid backache

- Avoid lifting heavy objects.
- Bend your knees and keep your back straight when lifting or picking something up from the floor.





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

When to get help

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

Constipation

You may become constipated very early in pregnancy because of the hormonal

changes taking place in your body.

How to avoid constipation

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

Cramp

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

How to avoid cramp

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

Feeling faint

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

How to avoid feeling faint

- Try to get up slowly after sitting or lying down.
- If you feel faint when standing still, find a seat quickly and the feeling should pass. If it doesn't, lie down on your side.
- If you feel faint while lying on your back, turn on your side. It is advisable not to lie flat on your back at any time in later pregnancy or during labour.
- Ask your doctor or midwife to check your haemoglobin (Hb) level as you may need iron supplements.

Feeling hot

During pregnancy you are likely to feel warmer than normal. This is due to hormonal changes and to an

increase in the blood supply to your skin. You are also likely to sweat more.

How to avoid feeling hot

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

Headaches

Some pregnant women find they get a lot of headaches.

How to ease headaches

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

When to get help

If the headache is severe or is associated with swelling, blurred vision or heartburn type pain contact your doctor or midwife immediately.

Incontinence

Incontinence is a common problem. It can affect you during and after pregnancy. Sometimes pregnant women are unable to prevent a sudden spurt of urine or a small leak when they cough, sneeze or laugh, or when moving suddenly or just getting up from a sitting position. This may be temporary, because the pelvic floor muscles relax slightly to prepare for the baby's delivery.

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

When to get help

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

You can also get help and support from the Bladder and Bowel Community at www.bladderandbowel.org

Indigestion and heartburn

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



is because the valve between your stomach and this tube relaxes during pregnancy.

How to avoid indigestion

- Try eating smaller meals more often.
- Sit up straight when you are eating, as this takes the pressure off your stomach.
- Avoid the foods which affect you, like fried or highly spiced food, but make sure you are still eating well (see page 31 for information on healthy eating).



How to avoid heartburn

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

How to ease heartburn

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

Leaking nipples

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

When to get help

See your midwife or doctor if the milk becomes bloodstained, or if you notice unusual lumps on your breasts.

Iron deficiency anaemia in pregnancy

What is iron deficiency anaemia?

Iron deficiency anaemia is a condition where a lack of iron in the body leads to a lower number of red blood cells. It is common in pregnancy because your body's need for iron is three times higher in pregnancy than when you are not pregnant. This is because you need more red cells for a larger volume of blood and the fetus (unborn baby) needs iron to grow.

How is iron deficiency anaemia identified?

You will be offered blood testing for anaemia at your first booking appointment and at 28 weeks of pregnancy. You may need further blood tests if you are considered at high risk of anaemia, for example, if you:

- had anaemia before pregnancy
- are having twins or more
- have a gap of less than a year between pregnancies
- do not eat enough foods that contain iron
- suffer from hyperemesis (excessive vomiting in pregnancy)
- suffer from bleeding of any cause during the pregnancy.

What does it mean if I have iron deficiency anaemia?

It is important to detect and treat iron deficiency anaemia either before or during your pregnancy to avoid increased risks to you and your baby:

For you:

- higher chance of needing a blood transfusion after giving birth
- increased chance of infection
- increased chance of postnatal depression

For your baby:

- higher chance of low birth weight
- higher of chance of premature birth
- increased chance of iron deficiency
- higher chance of effects on brain development.

What symptoms should I watch out for?

Symptoms include:

- fatigue
- weakness
- shortness of breath
- dizziness
- palpitations
- headache
- chest pain

- poor concentration
- irritability
- cold hands and feet.

What if I need a prescription for iron tablets?

If your blood test shows you have iron deficiency anaemia, the only way to increase your iron is through a prescribed supplement (tablets). You should take your iron tablet before eating, with a source of vitamin C, like a glass of pure orange.

Please do not take your iron tablet at the same time of day as other medications such as methyldopa, levothyroxine, penicillamine or medication for heart burn.

Avoid taking multivitamins as well as iron as this may interfere with iron absorption. If you experience any ill effects from taking your iron tablets or if you follow a vegetarian/vegan diet, please discuss with your midwife. If your iron

levels have not improved on retesting (after 4 weeks), you may need to have other blood tests to find the cause of your anaemia. How can I get more iron in my diet?

The main dietary sources of iron are:

- red meat such as lamb, beef or pork;
- fish and poultry.

Aim to include at least one portion of these every day. (Do not eat more than two portions of oily fish per week.)

Non-meat sources of iron include:

- fortified breakfast cereals (choose the one that has extra iron added);
- pulses (beans);
- eggs;
- bread (wholemeal);
- green leafy vegetables (broccoli, cabbage, spinach);
- dried fruit (apricots, figs);
- tofu;
- nuts and seeds.

Aim to eat at least four portions of these foods each day, especially if you are vegetarian.

Iron absorption

To help your body absorb the

iron in food, eat iron-rich foods alongside foods rich in vitamin C, like:

- fruit (kiwi, oranges, grapefruit, strawberries, raspberries, fruit juice or diluted juice with added vitamin C);
- dark green vegetables (broccoli, cabbage, leeks, peas, broad beans);
- potatoes.

Avoid drinking tea, coffee, milk and antacids for at least one hour after eating iron-rich foods or taking iron supplements, as these can reduce the absorption of iron.

Where can I get more information?

See www.nidirect.gov.uk/conditions/iron-deficiency-anaemia or ask your midwife.

Nausea and morning sickness

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

Hormonal changes in the first three months are probably one cause. Nausea usually disappears around the 12th to 14th week. This can be one of the most trying problems in early pregnancy. It comes at a



time when you may be feeling tired and emotional, and when many people around you may not realise that you are pregnant.

How to avoid nausea and morning sickness

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

Managing pregnancy symptoms

www.youtube.com/watch?v=EheedhgVCI&t=1s

milk puddings, which are simple to prepare.

- Wear comfortable clothes. Tight waistbands can make you feel worse.

When to get help

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

For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/pregnancy-sickness-nausea-and-vomiting-of-pregnancy-and-hyperemesis-gravidarum

Nose bleeds

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

How to stop nose bleeds

- Sit with your head forward.
- Press the sides of your nose together between your thumb and forefinger,



just below the bony part, for 10 minutes and try not to swallow the blood.

- Repeat for a further 10 minutes if this is unsuccessful.
- If the bleeding continues, seek medical advice.

Passing urine often

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

How to reduce the need to pass urine

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

When to get help

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

The growing baby will increase pressure on your bladder. If you find this a problem, you can improve the situation by doing exercises to tone up your pelvic floor muscles (see page 47).

Ask a midwife or maternity physiotherapist for advice.

Pelvic joint pain

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

When to get help

Getting diagnosed as early as possible can help to minimise



the pain and avoid long-term discomfort. Treatment usually involves gently pressing on or moving the affected joint so that it works normally again.

Ask a member of your maternity team for a referral to a manual physiotherapist, osteopath or chiropractor who is experienced in treating pelvic joint problems.

They tend not to get better completely without treatment from an experienced practitioner.

Visit the Pelvic Partnership for support and information at www.pelvicpartnership.org.uk

Piles

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

How to ease piles

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

Skin and hair changes

Hormonal changes taking place in pregnancy will make your nipples and the area around them go darker. Your skin colour may also darken a little, either in patches or all over. Birthmarks, moles and freckles may also darken.



Some women develop a dark line from their belly buttons down to the top of their pubic hair. These changes will gradually fade after the baby has been born, although your nipples may remain a little darker.



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

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

Sleep

Late in pregnancy it can be very difficult to get a

good night's sleep. It can be uncomfortable lying down or, just when you get comfortable, you find that you have to get up to go to the toilet.

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

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

Stretch marks

These are pink or purplish lines which usually occur on your abdomen or sometimes on your upper thighs or breasts. Some women get them, some don't. It depends on your skin type.

Some people's skin is more elastic. You are more likely to get stretch marks if your weight gain is more than average. It is very doubtful whether oils or creams help to prevent stretch marks. After your baby is born, the marks should gradually pale and become less noticeable.

Swollen ankles, feet and fingers

Ankles, feet and fingers often swell a little in pregnancy because your body is holding more water than usual. Towards the end of the day, especially if

the weather is hot or if you have been standing a lot, the extra water tends to gather in the lowest parts of your body.

Suggestions for swollen ankles, feet and fingers

- Avoid standing for long periods.
- Wear comfortable shoes.
- Put your feet up as much as you can. Try to rest for an hour a day with your feet higher than your heart.
- Do foot exercises (see page 47).
- If the swelling does not reduce ask your doctor or midwife to check your blood pressure.

Teeth and gums

Always tell your dentist that you are pregnant as this may affect your treatment. Bleeding gums are caused by a build-up of plaque (bacteria) on your teeth. During



pregnancy, hormonal changes in your body can cause plaque to make your gums more inflamed. They may become swollen and bleed more easily. When your baby is born your gums should return to normal.

How to keep teeth and gums healthy

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

Tiredness

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

Towards the end of pregnancy you may feel tired because

of the extra weight you are carrying. Make sure that you get plenty of rest.

Vaginal discharge

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

When to get help

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

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

Varicose veins

Varicose veins are veins which have become swollen. The

veins in the legs are most commonly affected. You can also get varicose veins in the vulva (vaginal opening). They usually get better after delivery. Tell your doctor or midwife if you have varicose veins or if a close relative has ever had a clot or blood clotting disorder as you will need assessments as pregnancy progresses.

If you have varicose veins:

- Try to avoid standing for long periods of time.
- Try not to sit with your legs crossed.
- Try not to put on too much weight, as this increases the pressure.



- Sit with your legs up as often as you can to ease the discomfort.
- Try support tights, which may also help to support the muscles of your legs.
- Try sleeping with your legs higher than the rest of your body – use pillows under your ankles or put books under the foot of your bed.
- Do foot exercises (see page 47) and other antenatal exercises such as walking and swimming, which will help your circulation.

More serious problems

High blood pressure and pre-eclampsia

During pregnancy your blood pressure will be checked at every antenatal appointment. This is because a rise in blood pressure can be the first sign of a condition known as pre-eclampsia – also called pregnancy-induced hypertension (PIH) or pre-



eclamptic toxemia (PET). It can run in families and affects 10% of pregnancies. Your urine is checked for protein at every visit, as this is a sign of pre-eclampsia.

The symptoms

Some of the symptoms of pre-eclampsia are:

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

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

This can be a serious condition for both mother and baby. It can cause fits in the mother (called eclampsia) and affects the baby's growth. It is life-threatening if left untreated. That is why routine antenatal checks are so important.

Pre-eclampsia usually happens towards the end of pregnancy, but it may happen earlier. It can also happen after the birth. It is likely to be more severe if it starts earlier in pregnancy. Treatment may start with rest at home, but some women need admission to hospital and medicines that lower high blood pressure. Pre-eclampsia can be a reason to deliver the baby early – this may be either by induction of labour or by caesarean section.

When to get help

If you get any of the symptoms described here, or have any



reason to think that you have pre-eclampsia, contact your midwife, doctor or the hospital immediately.

There is evidence to suggest that women at risk of pre-eclampsia are at reduced risk of developing these conditions if they take a low dose of aspirin during their pregnancy as prescribed by their health professional.

For further information see www.nice.org.uk/guidance/NG133 and www.rcog.org.uk/for-the-public/browse-our-patient-information/pre-eclampsia

Placenta praevia

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

The position of your placenta is recorded at your 18 to 21-week ultrasound scan. If it is significantly low you will be offered an extra ultrasound scan later in your pregnancy (usually at around 34 weeks) to recheck its position.

For 9 out of 10 women the

placenta has moved into the upper part of the uterus by this time.

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

For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/placenta-praevia-placenta-accreta-and-vasa-praevia

Itching

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

How to avoid itching

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



Severe itching and intrahepatic cholestasis of pregnancy

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

When to get help

You should see your doctor if:

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



Small babies

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

For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/having-a-small-baby

What should I do if I feel my baby's movements are reduced or changed?

Always seek professional help immediately. **Never go to sleep ignoring a change in your baby's movements.** Do not rely on any home kits you may have for listening to your baby's heartbeat.

You must contact your local maternity unit immediately. You must not wait until the next day to seek help.

You will be asked about your baby's movements. You will have a full antenatal check-up, including checking your baby's heartbeat.

Your baby's heart rate will be

monitored, usually for at least 20 minutes. This should give you reassurance about your baby's wellbeing. You should be able to see your baby's heart rate increase as he or she moves. You will usually be able to go home once you are reassured.

An ultrasound scan to check on the growth of your baby, as well as the amount of amniotic fluid around your baby, may be arranged if:

- your uterus measures smaller than expected;
- your pregnancy has risk factors associated with stillbirth;



- the heart-rate monitoring is normal but you still feel that your baby's movements are less than usual.

The scan is normally performed within 24 hours of being requested.

These investigations usually provide reassurance that all is well but if there are any concerns about your baby, your doctor and midwife will discuss this with you. Follow-up scans may be arranged. In some circumstances, you may be advised that it would be safer for your baby to be born as soon as possible.

Seek medical help

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



More information

For more information see the Royal College of Obstetricians and Gynaecologists' guideline Thrombosis and Embolism during Pregnancy and the Puerperium, Reducing the Risk at pha.site/thrombosis-pregnancy

Vaginal bleeding

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

For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/bleeding-and-or-pain-in-early-pregnancy

Bleeding after sex

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

Ectopic pregnancy

In early pregnancy, bleeding may be a sign of an ectopic pregnancy or a miscarriage (see page 182), although many women who bleed at this time go on to have normal and successful pregnancies.

Bleeding in late pregnancy

The most common sort of

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

Deep vein thrombosis

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

You will have an assessment carried out at booking to see if you have increased risk of developing clots and if so treatment can be given.

When to get help

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

What are blood clots?

Pregnancy increases the risk of having a blood clot during and for about six weeks after pregnancy.

There are two kinds:

1. Deep-vein thrombosis (DVT) is a blood clot that forms in a deep vein, most commonly in the leg or pelvis.

Symptoms (if any):

- swelling (most likely to be in the muscles of your legs);
- red, purple, blue or white discolouration;
- pain or discomfort.

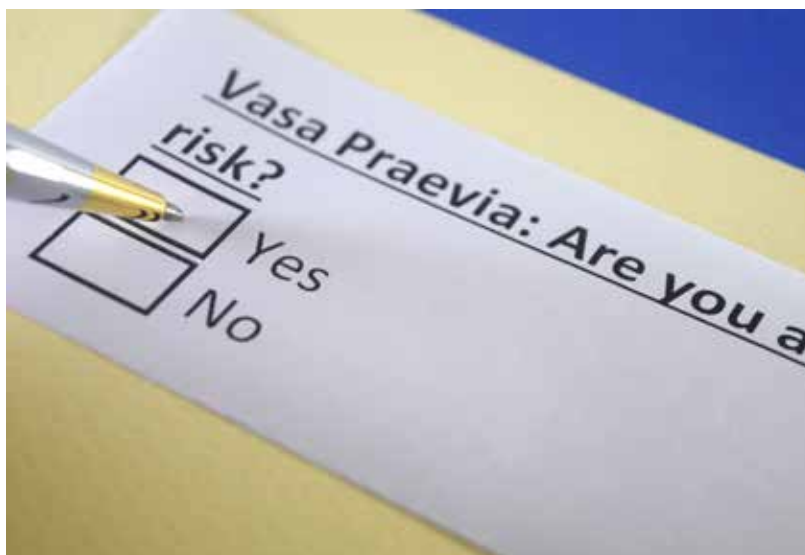
2. Pulmonary embolism (PE) occurs when part or all of the blood clot breaks free and passes through your blood vessels and reaches your lungs.

Symptoms:

- coughing (with blood-stained spit);
- chest pain;
- breathlessness or collapse.

Health professionals use the term venous thromboembolism (VTE) to cover both types of blood clots.

If you develop any of these symptoms during or after your pregnancy, please get medical advice immediately.



For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/diagnosis-and-treatment-of-venous-thrombosis-in-pregnancy-and-after-birth

Vasa praevia

Vasa praevia is a rare condition (occurring between 1 in 1,200 to 1 in 5,000 births). It occurs when the blood vessels of the umbilical cord run through the membranes covering the cervix. Normally the blood vessels would be protected within the umbilical cord. When

the membranes rupture and the waters break, these vessels may be torn, causing vaginal bleeding. The baby can lose a life-threatening amount of blood and die. It is very difficult to diagnose but it may occasionally be spotted before birth by an ultrasound scan. Vasa praevia should be suspected if there is bleeding and the baby's heart rate changes suddenly after rupture of the membranes. It is linked with placenta praevia (see page 87).

8

Feelings and relationships

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

This chapter is about some of the worries that may come up in pregnancy and suggestions on how to handle them. What is a problem for one woman may not be a problem for you, and what is helpful advice for some women may not be right for you. So take from these pages what you find useful. Pregnancy is an exciting time for you and your family. Most women feel very happy during their pregnancy as they look forward to the birth of their new baby.

Feelings

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

Hormonal changes and tiredness

Hormonal changes taking place in your body can make you feel tired, nauseous, emotional and upset – particularly in the first three months. You may find that you cry more easily, sometimes for no reason or lose your temper more often. Being tired and run down can make you feel low. Try to look after your physical health and get plenty of sleep (see chapter 5 on Your health in pregnancy).

Help and support

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





Anxiety

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

You may be worried about practical things like money, work or where you are going to live. You may be anxious about whether you will cope as a parent, or about whether you are ready to be a parent.

Some of these anxieties could be shared by your partner, friends or family. It is a good idea to talk through these feelings together.

Dreams

It is normal to have dreams

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

Ways of coping

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

Depression and mental health problems

It's normal to have some worries while you are pregnant

and to feel a bit down from time to time.

But it is a cause for concern if you are feeling down most of the time. Whatever the reason for your unhappiness, or even if there doesn't seem to be any reason at all, explain how you feel to your midwife, doctor or health visitor. Make sure that they understand that you are talking about something more than just feeling low. Some women do get depressed during pregnancy and you may need treatment and support to help you deal with it.

You will be asked during your pregnancy about your mood and how you are feeling, it is important to be honest with your midwife as then she can provide you with help and support.



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

For further information see www.nice.org.uk/guidance/cg192

Worrying about the birth

It is difficult to imagine what a contraction is like and no one can really tell you – though they may try! Exploring ways of coping with labour may help you to feel more in control.

You can begin by reading the chapter on Labour and birth (page 101) with your partner or a friend or relative who will be with you for the birth. Ask your midwife or doctor for any further information.

Antenatal education will also help to prepare you for labour and the birth and to know what to expect (see page 74).

You will have an opportunity to discuss this in more detail with your midwife, and complete the birth preferences form



within your MHHR to ensure staff are aware of your choices.

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

Concerns about your baby

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

Some women worry because they are convinced that if something does go wrong it will be their fault. You can increase your baby's chances of being born healthy by following the advice outlined in chapter 17. But there are certain problems which cannot be prevented. This is either because the causes are

not known or because they are beyond your control. Of all the babies born in the UK, 97% are healthy and 1% of babies will be born with conditions that can be partly or completely corrected, such as extra fingers or toes. About 2%, however, will suffer from more serious conditions. Regular antenatal care and careful observation during labour helps to pick up any potential problems and allow appropriate action to be taken.

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

They may be able to reassure you or offer you helpful information about tests which can be done during pregnancy (see chapter 6).

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

Looking after yourself

It is not uncommon to feel a bit anxious or depressed during pregnancy. If you are feeling stressed, try to take some time out for you: have a nice relaxing bath or go for a gentle walk. If you are feeling overwhelmed, talk to your GP or midwife. Your relationship with your partner may also be under pressure at this time. If you think you or your partner need further support, you can talk to your midwife in complete confidence.

Couples

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

find it harder. Everybody is different.

It is quite common for couples to find themselves having arguments every now and then during pregnancy, however much they are looking forward to the baby. Some arguments may be nothing to do with the pregnancy, but others may be because one of you is worried about the future and how you are going to cope. It's important to realise that during pregnancy there are understandable reasons for the odd difficulty between you, as well as good reasons for feeling closer and more loving.

One practical question you will

need to discuss is how you will cope with labour, and whether your partner wants to be there. Many partners do want to be present at their baby's birth. The chapter on Labour and birth (page 101) gives some suggestions for ways in which partners can help, and what it can mean for them to share this experience. If your relationship is particularly problematic, or abusive, don't ignore the situation in the hope that it will get better. Get help.

It may be that you do not have a partner in this pregnancy and you need extra support from family or friends. You may wish to talk to your midwife about services that may be available. See single parents on page 95.

Sex in pregnancy

It is perfectly safe to have sex during pregnancy. Your partner's penis cannot penetrate beyond your vagina, and the baby cannot tell what is going on! However, it is normal for your sex drive to change and you should not worry about this, but do talk about it with your partner.

Later in pregnancy, an orgasm – or even sex itself – can set off contractions (known as Braxton Hicks contractions – see page 103). You will feel the muscles of your uterus



go hard. There is no need for alarm, as this is perfectly normal.

If it feels uncomfortable, try your relaxation techniques or just lie quietly till the contractions pass.

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

Some couples find having sex very enjoyable during pregnancy, while others simply feel that they don't want to have sex. You can find other ways of being intimate or of making love. The most important thing is to talk about



Help and support

Gingerbread (www.gingerbread.org.uk)

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



If money is an immediate concern, see the chapter on Rights and benefits (page 190) for information on what you can claim and your employment rights. Your local Social Security or Jobs and Benefits Office or advice agency will be able to give you more advice.

If you have housing problems, contact your local advice agency or your local Housing Executive Office.

Gingerbread helpline 0808 802 0925 (9am–5pm, Mon–Fri).

your feelings with each other. While sex is safe for most couples in pregnancy, it may not be all that easy. You will probably need to find different positions. This can be a time to explore and experiment together.

Single parents

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

Don't feel that, just because you don't have a partner, you have to go to antenatal visits and cope with labour on your own. You can take whoever you like – a friend, sister, or perhaps your mum. Involve your 'birth partner' in antenatal classes if you can, and let them know what you want from them. Ask your midwife if there are antenatal classes in your area that are run especially for single women.

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

Same sex couples

Many same sex couples are choosing to start a family together. However, some couples may not feel comfortable disclosing their relationship status to a health professional. Like every other couple, you should expect that any information you share is treated confidentially. The care you receive is tailored to meet individual need, so it is important that you feel comfortable discussing your circumstances with the midwife or the doctor.



Family and friends

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

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

Work

If you work, and you like the people you work with, you may have mixed feelings when you go on maternity leave. Try to make the most of these few weeks to enjoy doing the

things you want to do at your own pace.

It is also a good opportunity to make some new friends. You may meet other mothers at antenatal classes (see page 74) or you may get to know more people living close by.

You may have decided that you are going to spend some time at home with your baby, or you may be planning to return to work, either full or part-time, fairly soon after the birth. If you think that you will be going back to work, you need to start thinking about who will look after your baby in advance.

It is not always easy to find satisfactory childcare arrangements, and it may take you some time.

You may have a relative willing to look after your child. If not, you should visit

www.familysupportni.gov.uk for a list of registered childminders and nurseries. You may also want to think about organising care in your own home, either on your own or sharing with other parents.

Care in your own home does not need to be registered, but you should make sure that your carer is experienced and trained to care for babies. However, if you are to claim financial help with the costs, either through tax credits or tax relief or help from your employer, the carer must be registered with Social Services. You can find out more at pha.site/childcare

After the birth

Having a baby and becoming a parent are major events



for all the family. Becoming a parent usually brings changes to your home life, social life and relationships. Parents of a new baby experience a variety of emotions after the birth. You will feel happy and proud of yourself, and probably very relieved that it is all over.

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

You may expect to love your baby immediately, but this can take a while and is not always

instinctive, and does not mean that you are not a 'good' or 'natural' mother. Many women experience these feelings.

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

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



Mood changes that can develop after the birth of a baby

If you experience any of the following mood changes, do not feel ashamed of how you are feeling. You are not alone: asking for and accepting help is the first stage of recovery – particularly for the more serious conditions. If you think you are in any way depressed, talk to a healthcare professional as soon as you can. Your midwife, health visitor and GP are all trained to help you, and many voluntary organisations offer advice (see the list of useful organisations on page 195).

The baby blues

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

How does it affect you?

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

tense, lacking in confidence or worried.

Becoming a parent for the first time can feel like an overwhelming responsibility and it is very easy to feel inadequate when other parents around you seem to be coping well.

Give yourself plenty of time to adjust to your new life. Find time to rest and eat a healthy diet, as this will help you to become and stay physically and emotionally healthy.

Talk to someone you can trust such as your partner, your mum, a friend, or to your midwife or health visitor, about how you are feeling.

It can help a lot just to confide in someone else. Once they know how you are feeling, they will be able to give you support.

If you become more unhappy or upset, or if your low mood lasts more than a week, then you are probably experiencing something other than the baby blues.

Postnatal depression

Postnatal depression affects 1 in 10 women following the birth of their baby. It usually begins in the first six months after childbirth, although for some women the depression begins

in pregnancy. It can occur at any time within the first year of the birth of your baby.

How does it affect you?

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

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

If you think you are depressed, contact your GP, midwife or health visitor and explain how you are feeling. Your partner or a friend could contact them for you if you want.

If you have twins or triplets, you are more likely to experience postnatal and longer-term depression. This is mainly because of the additional stress of caring for more than one baby. Getting out of the house can be difficult and this can make you feel isolated. Twins Trust (www.twinstrust.org) can help you to make contact with other mothers through local twins clubs and

through their helpline, Twinline (0880 138 0509).

Postpartum psychosis

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

Symptoms include:

- hallucinations;
- delusions;
- mania;
- loss of inhibitions;
- feeling suspicious or fearful;
- restlessness;
- feeling very confused;
- behaving in a way that's out of character.

How does it affect you?

The symptoms of this illness can be very severe and sometimes very frightening for you, your partner, and your family. In fact, your partner may be the first to notice that you are unwell. It is important that your partner or someone close to you knows the symptoms to look out for. They can appear suddenly, often within the first

two weeks following the birth of the baby. Seeking help quickly will ensure that you are treated as early as possible, to help you get well again.

Postpartum psychosis is a serious mental illness that should be treated as a medical emergency. If not treated immediately, you can get rapidly worse and could neglect or harm your baby or yourself.

Usually women with this illness will require admission to hospital.

Postnatal post-traumatic stress disorder and birth trauma

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

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

How does it affect you?

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

How to get help:

Talk to your midwife or health visitor, about your experience and feelings.

Domestic abuse and coercive control

Domestic abuse is any type of controlling, bullying, threatening or violent behaviour between people in a relationship. It isn't just physical violence - domestic abuse includes emotional, physical, sexual, financial or psychological abuse.

One in four women experience domestic abuse at some point in their lives. Of this, 30% starts in pregnancy, and existing abuse may get worse during pregnancy or after giving birth. On average, Women's Aid NI support around 260 pregnant women a year who have experienced domestic abuse.

Some examples of abusive behaviour include: Constantly criticising your appearance, undermining your decisions, opinions and



blaming everything on you. Demanding to know where you are at all times including constantly messaging, calling and tracking your movements. Acting jealously, being possessive and continually accusing you of being unfaithful.

Constantly wanting you to justify what you spend money on and trying to take control of all finances.

Trying to isolate you from your friends, family and colleagues and make you justify any absences.

Physically hurting you in any way or throwing items in your direction to scare or threaten you.

Pressuring you or forcing you into unwanted sexual activities.

Domestic abuse during pregnancy puts a pregnant woman and her unborn child in danger. It increases the risk of miscarriage, infection, premature birth, low birth weight, fetal injury and fetal death.

Domestic abuse is never acceptable, and support is available when you are ready. You can speak in confidence to your GP, midwife, obstetrician, health visitor or social worker. Or call the confidential 24-hour

Domestic and Sexual Abuse Helpline number on 0808 802 1414, or email: help@dsahelpline.org.

You can also contact your local Women's Aid group. You can find your local group's contact details by visiting womensaidni.org

If you are in immediate danger, call 999.

Bereavement

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

Family and friends can help you by spending time with you.

Grief is not just one feeling but a whole succession of feelings, which take time to get through and which cannot be hurried.

If you need help or advice, contact your GP or midwife.

If your partner dies

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

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

Try to choose someone who knows you very well.

Financially, you may need urgent advice and support. You can get more information from your local Social Security Office or Jobs and Benefits Office (see page 190).



9

Labour and birth

9

Labour and birth

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

Getting ready

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

Packing your bag

Wherever you are having your baby your midwife can help you decide what you will need to pack. You may want to include the following:



- ☐ Something old, loose and comfortable to wear during labour, such as an old shirt. It should not restrict you from moving around or make you too hot. You may need about three changes of clothes.
- ☐ Three comfortable and supportive bras, including nursing bras if you are planning to breastfeed. Remember, your breasts will be much larger than usual.
- ☐ About 24 super-absorbent sanitary towels.
- ☐ Breast pads x 24.
- ☐ Your wash bag with toothbrush, hairbrush, flannel, etc.
- ☐ Fruit juices and boiled sweets to give you energy in labour.
- ☐ Towels, preferably not white.
- ☐ Things that can help you pass the time and relax, for example books, magazines, music.
- ☐ A sponge or water spray to cool you down.
- ☐ Front-opening nightdresses or pyjamas if you are going to breastfeed.
- ☐ Light dressing gown and slippers.
- ☐ Five or six pairs of pants or disposable pants.
- ☐ A loose, comfortable outfit to come home in.
- ☐ Clothes (including a hat) and 24 nappies for the baby.
- ☐ A shawl or blanket to wrap the baby in.
- ☐ Car seat for taking your baby home.
- ☐ Maternity notes. Birth preferences.
- ☐ Any other letters or test results.



Transport

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

Home births

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



Stocking up

When you come home you will not want to do much more



than rest and care for your baby, so do as much planning as you can in advance:

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

Important numbers

Keep a list of important numbers in your handbag or near your phone. There is space for you to write them down in your notes and at the back of this book. You need to include the following:

- Your hospital and midwife's phone numbers.
- Your partner and birth partner's phone numbers.

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

The signs of labour

You are unlikely to mistake the signs of labour when the time really comes, but if you are in

any doubt, don't hesitate to contact your midwife.

Regular contractions

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

Other signs of labour

- **Backache** or the aching, heavy feeling some women get with their monthly period.
- **The 'show'.** The plug of mucus in the cervix, which has helped to seal the uterus during pregnancy, comes away and comes out of the vagina. This small amount of sticky pink mucus is called the 'show'.

It usually comes away before or in early labour. There should only be a little blood mixed in with the mucus. If you are losing more blood, it may be a sign that something is wrong, so phone your hospital or midwife straight away.

- **Your waters break.** The bag of water surrounding your baby may break before labour starts.
- To prepare for this, you could keep a sanitary towel (not a tampon) handy if you are going out, and put a plastic sheet on your bed.
- If your waters break before labour starts, you will notice either a slow trickle from your vagina or a sudden gush of water that you cannot control. Phone your midwife when this happens.

- **Nausea or vomiting.**

- **Diarrhoea.**

Pain relief in labour

For most women labour is painful, so it is important to

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

Coping at the beginning

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





have agreed what you will do when labour starts.

Arriving at the hospital or midwifery-led unit

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

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

Examination by the midwife

The midwife will ask you about what has been happening so

When to go to hospital or your midwifery-led unit

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

- If your waters have broken, you will probably be told to go in to be checked.
- If it is your first baby and you are having contractions but your waters have not broken, you may be told to wait. You will probably be told to come in when your contractions are regular, strong, are about five minutes apart and are lasting about 60 seconds.

- If you don't live near to your hospital, you may need to go in before you get to this stage.
- Second and later babies often arrive more quickly, so you may need to contact the hospital, midwifery-led unit or your midwife sooner.

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

Home birth

You and your midwife should

Delivery rooms

Delivery rooms have become more homelike in recent years. Most have easy chairs, beanbags and mats so that you can move about in labour and change position. Some have baths, showers or birthing pools.





far and will examine you. If you are having a home birth, then this examination will take place at home. The midwife will:

- Take your pulse, temperature and blood pressure and check your urine.
- Feel your abdomen to check the baby's position and listen to your baby's heart.
- Probably do an internal examination to find out how much your cervix has opened. Tell her if a contraction is coming so that she can wait until it has passed. She will then be able to tell you how far your labour has progressed. If you would prefer not to have an internal examination you don't have to have one. However, if there are any concerns about your own or your baby's condition, vaginal examinations can help the doctor and midwife to

make the most appropriate decisions about any risks and plan your care.

These checks will be repeated at intervals throughout your labour.

If you and your partner have birth preferences, show your midwife so that she knows what kind of labour you want and can help you to achieve it.

What happens in labour

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

The first stage of labour – dilation

The dilation of the cervix

The cervix needs to open to about 10cm for a baby to

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

If you go into hospital or your midwifery unit before labour is established, you may be asked if you would prefer to go home again for a while, rather than spending extra hours in hospital. If you go home, you should make sure that you eat and drink, as you will need energy. At night, try to get comfortable.

Get some sleep if possible. A warm bath or shower may help you to relax. During the day, keep upright and remain active. This helps the baby to move down into the pelvis and helps the cervix to dilate.

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

Your midwife should be with you all the time to support you.

Pain relief

Option	Pros	Cons
Position and movement	• Maximises your body's ability to give birth. • No lasting side-effects for you or your baby.	• Try not to overdo it; saving energy is also important. Lying on your side for a while or sitting up supported by lots of pillows can help your body to work really well while you conserve energy.

Option	Pros	Cons
Water and birthing pools 	• Water soothes pain and, in a large birthing pool, supports you, enabling you to glide into any position. • You can combine it with other options, such as Entonox (gas and air) and massage. • Women who labour in water need fewer interventions and are less likely to need other drugs. • No lasting side-effects.	• Water can sometimes slow down labour, particularly if you get in too early. • You won't be able to use TENS (see below), injectable drugs or an epidural while you're in water. • Birthing pools might not be available or an option everywhere.

Option	Pros	Cons
TENS A TENS (Transcutaneous Electrical Nerve Stimulation) machine transmits mild electrical impulses to pads on your back. These block pain signals and help your body to produce endorphins.	• You can keep moving and it won't directly interfere with your labour. • You can use it for as long as you want. • There are no lasting side-effects for you or your baby. • It doesn't need an anaesthetist, doctor or midwife. • It can be used at a home birth and in hospital.	• You'll probably need someone to help you to position the pads. • It may only help in the early stages of labour. • It may have to be removed if your baby's heart has to be monitored electronically. • You can use TENS before you get into water, but not when you're in the water. • It might make it more difficult for your birth partner to massage your back. • The clinical evidence in support of TENS is lacking though many women say that it helped them.

Option	Pros	Cons
Complementary therapies (including acupuncture, aromatherapy, reflexology, yoga, self-hypnosis and massage).	• Some studies show acupuncture is helpful. • Massage or pressure on the lower part of your back can help reduce levels of stress and ease discomfort, too. • You can learn self-hypnosis techniques for labour by attending a course or online; you don't have to have a hypnotherapist with you in labour.	• There is little research proving the effectiveness of these treatments though lots of women say that they found these techniques useful. • Apart from massage and self-hypnosis, you will need a registered practitioner to perform the therapies.

Option	Pros	Cons
Gas and air (Entonox) 	- You can control it and the effects wear off very quickly once you stop inhaling. - It's fast-acting (taking effect after 20 to 30 seconds). - Your baby doesn't require extra monitoring while you're using it. - You can use it in a birthing pool. - It should be available wherever you give birth, including birth centres and at home.	- It may make you feel sick and light-headed initially but the nausea usually passes. - It can dry your mouth out if you use it for long periods. - Keeping hold of the mask or mouthpiece may stop you from moving around and getting into a comfortable position. - It can take a few contractions to get the hang of it so that it's effective at the peak of contractions. - If used with pethidine or diamorphine, it may make you feel even drowsier.

Option	Pros	Cons
Painkilling drugs in labour Opioids such as morphine, diamorphine and remifentanyl are pain relieving drugs given by injection into the thigh. Some hospitals offer remifentanyl, which is a very strong, short-acting painkiller given via a drip that you can control yourself using a machine. 	- Opioids may help you to relax and get some rest; especially if your early labour has been long and uncomfortable. - Diamorphine /morphine can be given by a midwife, so there's no need to wait for a doctor although they may have to prescribe the drug. - Remifentanyl infusions are set up by an anaesthetist. - These drugs don't appear to slow labour down, if you're already in established labour. - They may help you to postpone or avoid having an epidural if you're finding your contractions hard to cope with. - Not all opioids are available at a home birth so talk to your midwife about what you could have if you're planning to give birth at home. In some areas, drugs like these are prescribed in advance by a GP. Remifentanyl is not available at home or in a birth centre. - It is possible to still use a birth pool or bath during labour, but not usually within two hours of a single dose of an opioid, or if you feel drowsy. Protocols vary so it's good to check with your midwife if you are considering using a painkilling drug in labour.	- Once you've had an injection of an opioid the effects last for up to four hours, so if you don't like the sensation you can't do anything about it. For instance, it may make you feel out of control, and feel sick. (This is not the case with remifentanyl, as the drip can be turned off and the effects fade away). - All opioids pass through to a baby and can occasionally make them slower to breathe at birth. This is particularly true if your labour progresses more quickly than expected and your baby is born within two hours of you having the drug. (Effects on babies are less likely with a remifentanyl infusion than they are with other opioids because remifentanyl is active in the body for a much shorter amount of time.) - Your baby may also stay sleepy for several days, making breastfeeding harder to establish.

Option	Pros	Cons
Epidural Epidural analgesia is a local anaesthetic injected through a tube into the space between two vertebra in your back. It usually removes all pain and most feeling from the waist down. The combined spinal epidural (CSE) injection contains a low dose of pain-relieving drugs and works more quickly than an epidural alone. At the same time, a catheter will be inserted into your bladder. When the CSE injection starts to wear off, your anaesthetist will pass the epidural solution through the tube to give ongoing pain relief. 	• It gives total pain relief in 90% of cases; partial pain relief in the remainder. • Top-ups can usually be given by an experienced midwife once the epidural is in place so you don't need to wait for a anaesthetist. • You may still be aware of your contractions, and have a clear mind, but you'll feel no pain.	• Epidurals are only available in obstetric-led maternity units. • Labour may slow down as you'll be less able to move around. • It takes about 20 minutes to insert and set up and another 20 minutes to work once injected. • You may not feel contractions or – later on – the baby moving down so there is an increased chance of needing forceps or suction (ventouse) to help the baby out. • Having an epidural will mean increased monitoring for mum and baby. • A catheter might need to be inserted to empty the bladder (as you won't feel when you need to wee) and you may need a drip to help if your blood pressure drops. • Some low-dose (mobile) epidurals now contain less anaesthetic but include a small amount of fentanyl, an opioid drug. The fentanyl makes the epidural really effective without taking away all of your mobility but the fentanyl might cross the placenta and make the baby sleepy. hard to say how much of a problem this is but there have been studies showing different feeding behaviours in babies born after low-dose epidurals were used.

Fetal heart monitoring

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

- Your midwife may listen to your baby's heart intermittently, for at least one minute every 15

minutes when you are in established labour, using a hand-held ultrasound monitor (often called a Sonicaid). This method allows you to be free to move around.

- Your baby's heartbeat and your contractions may also be monitored electronically using a CTG machine. The monitor will be strapped to your abdomen on a belt.
- Alternatively, a clip can be put on your baby's head to monitor the heart rate. The



clip is put on during a vaginal examination and your waters will be broken if they have not already done so.

Your midwife or doctor should explain why they feel that the clip is necessary for your baby. Further information is available at <https://www.nice.org.uk/guidance/ng229>

Speeding up labour

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

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

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

The second stage of labour – the baby's birth

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

She will tell you to try not to push until your cervix is fully



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

Find a position

Find a position that you prefer. You can help the baby's head descend:

- If you stand up, sit forward, kneel or squat (squatting may be difficult if you are not used to it).
- If you are very tired, you might be more comfortable lying on your side. This position is better for your baby than lying on your back.
- You may find kneeling on



all fours might be helpful if you suffer from backache in labour.

- It can help if you have tried out these positions beforehand and explained to your birth partner how they will help you.

Pushing

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

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

This stage is hard work, but your midwife will help and encourage you all the time. Your birth partner can also give you lots of support. This stage may take two hours or more.



The birth

During the second stage, the baby's head moves down the birth canal.

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

The skin of the perineum usually stretches well, but it may tear. Sometimes to avoid a tear or to speed up the delivery, the midwife or doctor will inject local anaesthetic and perform an episiotomy if needed. Once your baby's head is born, most of the hard work is over. With one more gentle push the body is usually born quite quickly and easily.

You can have your baby lifted straight onto your abdomen before the cord will be cut by your midwife or birthing partner if you prefer.

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

Skin-to-skin contact

Even if you have a caesarean section or a difficult delivery, try to have skin-to-skin contact with your baby as soon as possible after the birth. This will:

- keep your baby warm and calm;
- help regulate your baby's breathing and heartbeat;
- release your mothering hormones to help with bonding.

Try the following:

- place the baby on your tummy with his head near your breast;
- gently stroke and caress your baby;
- allow the baby to focus on your face;
- ask to be left undisturbed to get to know your baby.

Even if you decided before the birth not to breastfeed, this may be a really good time to give it a go and see what you think. You might change your mind!

The first milk you produce in the days after the birth (called colostrum) contains antibodies that will help protect your baby from infection, so even if you decide not to continue breastfeeding, your baby will benefit from those first few feeds.

The third stage of labour – the placenta

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

The injection contains a drug called Syntocinon, which makes the uterus contract and helps to prevent the heavy bleeding which some women experience.





After the birth

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

Delayed cord clamping

Delayed cord clamping (DCC) is defined as not clamping the umbilical cord for between 30 seconds to two minutes following delivery. Immediate cord clamping (ICC) refers to clamping of the cord within 30 seconds of delivery. The World Health Organization recommends deferring cord clamping until at least one minute after birth. This is an evidence-based simple but effective intervention that improves neonatal outcomes.

Vitamin K

You will be offered an injection of vitamin K for your baby, which is the most effective way of helping to prevent a rare bleeding disorder (haemorrhagic disease of the newborn). Your midwife should have discussed this with you

beforehand. If you prefer that your baby doesn't have an injection, oral doses of vitamin K are available. If given orally further doses will be necessary.

Stitches

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

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

In some cases, a larger tear can happen during birth. This is called a 3rd- or 4th-degree



tear. These deeper tears involve the muscles around the back passage and will need to be repaired in an operating theatre. You'll be given appropriate pain relief or anaesthetic, and the repair will be done by an experienced doctor. Most women heal well with proper care and follow-up.

Further information is available at:

www.rcog.org.uk/for-the-public/browse-our-patient-information/care-of-a-third-or-fourth-degree-tear-that-occurred-during-childbirth-also-known-as-obstetric-anal-sphincter-injury-oasi

www.rcog.org.uk/for-the-public/perineal-tears-and-episiotomies-in-childbirth

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

Special cases

Labour that starts too early (premature labour)

About 1 baby in every 13 will be born before the 37th week of pregnancy. In most cases labour starts by itself, either with contractions or with the sudden breaking of the waters or a 'show'. About one

early baby in six is induced and about one early baby in five is delivered by caesarean section (see page 116).

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

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

Many multiple birth babies are born prematurely and twins and triplets may be more likely to need care in a neonatal unit. Your doctor may offer you a planned birth earlier than 38 weeks. The timing of the planned birth depends on the number of babies and whether or not your babies share a placenta.

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



For further information see www.nice.org.uk/Guidance/NG25

Overdue pregnancies

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

If your labour does not start by 41 weeks, your midwife will offer you a 'membrane sweep'.

This involves having a vaginal examination, which stimulates the neck of your uterus (known as the cervix) to produce hormones which may trigger natural labour.

If your labour still doesn't start, your midwife or doctor will suggest a date to have your labour induced (started off) usually seven days after your due date. If you don't want

labour to be induced and your pregnancy continues to 42 weeks or beyond, you and your baby will be monitored. Your midwife or doctor will check that both you and your baby are healthy by giving you ultrasound scans, CTG monitoring and checking your baby's movement and heartbeat. If your baby is showing signs of distress, your doctor and midwife will again suggest that labour is induced.

Induction

Labour can be induced if your baby is overdue or there is any sort of risk to you or your baby's health – for example, if you have high blood pressure or if your baby is failing to grow and thrive.

Induction is always planned in advance, so you will be able to talk over the benefits and disadvantages with your doctor and midwife and find out why they recommend your labour is induced.

Contractions can be started mechanically. A catheter with a balloon at the tip is inserted through the cervix. The balloon is filled with a sterile fluid and puts gentle pressure on the cervix to soften and open it. Contractions are usually started by inserting a hormone into the vagina, and sometimes both are used. Induction of labour may take a while, particularly if the neck of the uterus (the cervix) needs to be softened with pessaries or gels. Sometimes a hormone drip is needed to speed up the labour.

Once labour starts it should proceed normally, but it can sometimes take 24–48 hours to get you into labour. An information leaflet is available.

For more detailed information see www.nice.org.uk/guidance/ng207

Assisted vaginal birth

What is an assisted vaginal birth?

An assisted vaginal birth involves using a ventouse (vacuum cup) or forceps (like large tongs) to guide your baby as you push with your contractions.

Your doctor may recommend that you have an assisted vaginal birth if your baby needs to be delivered quickly.

This document will give you information about the benefits and risks to help you to make an informed decision. If you have any questions that this

document does not answer, ask your obstetrician or the healthcare team.

Why may I need an assisted vaginal birth?

The following are the more common reasons why an assisted vaginal birth may be recommended.

- You have been pushing for too long.
- You may have run out of energy to deliver your baby safely.
- Your baby's heart rate may be going above or below normal levels or they may not be getting enough oxygen.

Sometimes, if you have high blood pressure, your obstetrician may recommend an assisted vaginal birth if the second stage of labour goes beyond a certain time and your blood pressure goes higher.

On average, 10 to 15 in 100 births are assisted vaginal births. You are more likely to need an assisted vaginal birth for your first baby. Your obstetrician will discuss with you why an assisted vaginal birth is the safest method of birth for both you and your baby.



Are there any alternatives to an assisted vaginal birth?

You can continue pushing and try to birth your baby without a ventouse or forceps.

Another option is to have a caesarean section (procedure to birth a baby by a surgical operation).

If you are worried or have any questions about why an assisted vaginal birth has been recommended for you, you should discuss this carefully with your obstetrician.

What does an assisted vaginal birth involve?

Before the procedure

Your obstetrician will examine your abdomen to find out how large your baby is. They will perform an internal examination to check the position of your baby and how dilated your cervix is. Your obstetrician will also want to check that your pelvis is large enough for an assisted vaginal birth.

If you are already having an epidural and there is enough time, you will be given more anaesthetic through the epidural. Otherwise, local anaesthetic may be injected either into the skin at the opening of your vagina or through your vagina to block the pudendal nerve that supplies your lower vagina

and perineum (the area between your vagina and back passage). You may need to have a spinal, which involves injecting anaesthetic into the subarachnoid space (an area near your spinal cord).

Your legs will be put in 'stirrups' (the lithotomy position).

Your obstetrician may place a catheter (tube) in your bladder to help you to pass urine.

Forceps birth

Your obstetrician will place metal forceps either side of your baby's head. When the forceps are in position, your obstetrician will hold them together.

If your baby's head is not facing towards your spine, your obstetrician will need to turn the head using the forceps. They will pull gently as you push with your contractions to guide your baby's head out. This can take several pulls and usually involves an episiotomy to help reduce the risk of you tearing.

Ventouse birth

Your obstetrician will place the ventouse cup onto your baby's head. The cup may be attached to a special vacuum machine or to a hand-held suction pump that creates a vacuum seal between the cup and your baby's head.

Your obstetrician will make sure that none of your vaginal skin is caught in the vacuum seal. Your obstetrician will guide your baby out, as you push with your contractions. This can take several pulls and you may need an episiotomy.

Listen carefully to your obstetrician and midwife during the birth so you know when to push and when to pant.

Once your baby's head is birthed, your obstetrician will remove the forceps or ventouse from your baby's head and your baby will be birthed onto your abdomen, 'skin-to-skin'. Once the cord has been cut, your baby will be covered to keep them warm.

Your obstetrician will close an episiotomy or any tears with dissolvable stitches.

What complications can happen?

The healthcare team will try to make the procedure as safe as possible but complications can happen. The possible complications of an assisted vaginal birth are listed below. Any numbers which relate to risk are from studies of women who have had this procedure. Your doctor may be able to tell you if the risk of a complication is higher or lower for you.



- Pain, once the local anaesthetic or epidural wears off. You will usually be given a painkilling suppository (tablet placed in your back passage) to keep you comfortable. You may get pain in your abdomen or, more usually, around the stitches. However, an episiotomy or any tears usually heal quickly and if any pain continues it can be controlled with simple painkillers such as paracetamol.
- Bleeding. On average, women lose less than half a litre of blood. You may be given medication through a drip (small tube) in a vein in your arm or by an injection to help your uterus (womb) to contract. This will help to reduce any bleeding. If you bleed heavily, you may need a blood transfusion. You may need to take iron tablets.
- Tears (risk of a major tear: 1 in 5 for forceps delivery, 1 in 10 for ventouse delivery). Minor tears are common. Tears are closed with stitches.

- Damage to your back passage caused when a major tear or episiotomy extends to the muscle around your anus or to your anus itself (risk: less than 3 in 100 for a ventouse, less than 7 in 100 for forceps).
- Healing problems. Sometimes an episiotomy or tear will open slightly. However, this usually does not need any treatment and still heals well.
- Difficulty passing urine. You may need a catheter for one to two days.
- Infection. This is easily treated with antibiotics.
- Marks and bruises on your baby (risk of serious damage: less than 2 in 1,000). A ventouse can leave a suction mark and the forceps can bruise your baby's face. These do not usually cause any problems and settle in one to two days. Sometimes a ventouse can bruise one of the bones of your baby's skull (risk 1 to 2 in 100). This does not cause any problems and gets better within a few weeks. A paediatrician (doctor who specialises in babies and children) will be present at the birth if they are needed.
- Shoulder dystocia, where your baby's shoulders get stuck for a short while on the way out (risk: 1 in 50, compared to 1 in 100 for normal deliveries). Visit www.rcog.org.uk/for-the-public/browse-our-patient-information/shoulder-dystocia/ for more information.
- Your baby having jaundice (the eyes and skin turning yellow) (risk: 5 to 15 in 100) and having bloodshot eyes (risk: 17 to 38 in 100) after birth. This is only a small increase compared to normal deliveries and does not cause any long-term problems.
- You should discuss these possible complications with your doctor if there is anything you do not understand.

For further information see www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/assisted-vaginal-birth-green-top-guideline-no-26 and www.nice.org.uk/guidance/ng235

Care during labour and birth for women with a medical condition or complication in pregnancy or labour

Most women have no problems during labour and birth, but some need



extra care because they have a higher chance of complications. For example, this could be because:

- they have had a caesarean section in a previous pregnancy;
- the baby is thought to be either very small or large;
- a problem happens during early labour, for example, the baby turns bottom down (called 'breech') instead of being head down;
- they have a medical condition, like heart or kidney disease.

If you require extra care during labour and birth your care teams should:

- involve you in decisions about care at every stage;
- explain what it means if a complication happens during labour and how this might affect any choices you have made in your birth plan;

- explain why continuous monitoring of the baby's heart rate might be recommended during labour to check the baby is coping well;
- discuss options for labour and birth if you have a medical condition and include specialists for those conditions.

For further information see www.nice.org.uk/guidance/ng121

Cord prolapse

Cord prolapse is a rare but serious complication. It happens when the umbilical cord slips down in front of the baby after the waters break. This can affect the baby's oxygen supply and needs urgent medical attention. If cord prolapse is suspected, you will be moved into a safe position and monitored closely, and birth is usually recommended quickly - often by emergency caesarean section - to keep your baby safe.

For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/umbilical-cord-prolapse-in-late-pregnancy

How soon will I recover?

In hospital

You will stay in the delivery room for one to two hours while

all the routine checks on your baby are carried out. You will then be transferred to the ward.

The midwives will give you advice about your postnatal care, including how to look after your stitches. The healthcare team will tell you about abdominal and pelvic-floor exercises to help you to recover.

You will be able to go home when you can walk around without any help and are able to care for your baby. If you go home the same day, a responsible adult should take you home in a car or taxi and stay with you for at least 24 hours. Be near a telephone in case of an emergency.

Do not drive, operate machinery or do any potentially dangerous activities (this includes cooking) for at least 24 hours and not until you have fully recovered feeling, movement and co-ordination. If you had a general anaesthetic or sedation, you should also not sign legal documents or drink alcohol for at least 24 hours.

If you are worried about anything, in hospital or at home, contact the healthcare team. They should be able to reassure you or identify and treat any complications.

Returning to normal activities

The healthcare team will tell you when you can return

to normal activities. It is important to have plenty of help at home in the first few days so that you have time to recover and to spend with your new baby.

An episiotomy or any tears should heal quickly. If you have any concerns, ask your midwife when they visit you at home, or contact your GP.

The future

You should make a full recovery. An assisted vaginal birth should not affect your ability to become pregnant or deliver a baby in the future.

Summary

An assisted vaginal birth is a common procedure and is usually a safe method of delivery for you and your baby.

However, complications can happen. You need to know about them to help you to make an informed decision about the procedure. Knowing about them will help to detect and treat any problems early.



Caesarean birth (planned and unplanned)

There are situations where the safest option for you or your baby is to have a caesarean section.

As a caesarean section involves major surgery, it will only be performed where there is a real clinical need for this type of birth.

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

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

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

For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/considering-a-caesarean-birth

Urgent (emergency) caesareans

Emergency caesarean section

Your obstetrician can recommend an emergency caesarean birth to deliver your baby safely. However, it is your decision to go ahead with the operation or not.

They will give you information about the benefits and risks to help you to make an informed decision. Ask your obstetrician, anaesthetist or midwife if there is anything you do not understand.

What does the operation involve?

A caesarean birth can usually be performed under a spinal or epidural anaesthetic. You will be awake so you can see your baby and have 'skin-to-skin' contact as soon as your baby is born. Your birth partner will also be able to be with you. However, this will not be possible if you need a general anaesthetic.

Your obstetrician will make a horizontal cut on your 'bikini' line. They will separate the muscles of your abdominal wall and open your uterus (womb). They will deliver your baby through the cut and repair your womb and abdomen.

A midwife will be with you and a paediatrician (doctor who specialises in babies and children) may also attend to your baby when it is born.

A caesarean birth is usually safe and your obstetrician believes it is the safest way to deliver your baby. However, complications can happen. Some of these can be serious and can even cause death.

Complications of anaesthesia

Your anaesthetist will be able to discuss with you the possible complications of having an anaesthetic.

What complications can happen?

- Pain. The healthcare team will make sure you are given enough pain relief.
- Bleeding during or after the operation. If you bleed heavily (risk: less than 8 in 100), you may need a blood transfusion. For information on blood transfusions see www.rcog.org.uk/for-the-public/browse-our-patient-information/blood-transfusion-pregnancy-and-birth
- Blood clots in your legs (deep-vein thrombosis – DVT) (risk: 7 in 1,000) or, more rarely, in your lungs (pulmonary embolism). The healthcare team will take measures to reduce this risk.
- Infection of the surgical site (wound) or in your womb (endometritis), which usually settles with antibiotics.

- Developing a hernia in the scar caused by the deep muscle layers failing to heal.
- Bladder damage. The risk is higher if you have had previous caesarean sections.
- Small scratch on your baby's skin, when your obstetrician makes the cut on your womb. Sometimes the scratch can be on your baby's face (risk: 2 in 100). This usually does not need any treatment.
- Breathing difficulties for your baby, where your baby takes longer than normal to clear the fluid from their lungs (risk: 6 in 1,000).

How soon will I recover?

You should be able to go home after one to three days. However, your doctor may recommend that you stay a little longer.

If you are worried about anything, in hospital or at home, contact the healthcare team. They should be able to reassure you or identify and treat any complications.

It is important to have plenty of help at home in the first few days so that you have time to recover and to spend with your new baby.

For the first two weeks do

little other than care for your baby. You can then gradually increase the amount you do. Bleeding usually lasts for 2 to 4 weeks. Use sanitary pads rather than tampons.

Do not lift anything heavy or do strenuous exercise, such as vacuuming or ironing, for 6 weeks. Do not push, pull or carry anything heavier than your baby during this time.

Do not have sex until you feel comfortable.

Most women take at least three months to recover. You should wait until you are physically and emotionally ready before trying for another baby.

The operation

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

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

Planned (elective) caesareans

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

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

After a caesarean section

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

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

You will be encouraged to become mobile as soon as possible, and your midwife or

hospital physiotherapist will give you advice about postnatal exercises that will help you in your recovery. As soon as you can move without pain, you can drive – as long as you are able to make an emergency stop. This may be six weeks or sooner. Always check with your insurance company as they may have specific post-operative conditions about how soon you can drive again.

Once a caesarean always a caesarean?

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

Further information is available at www.rcog.org.uk/for-the-public/browse-our-patient-information/birth-after-previous-caesarean and www.nice.org.uk/guidance/NG192

Breech birth

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

for your breech baby to be born. You will be advised to have your baby in hospital.

External cephalic version

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

Caesarean section

If an ECV doesn't work, you will probably be offered a caesarean section. This is the safest delivery method for breech babies but there is a slightly higher risk for you.

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

Further information is available at www.rcog.org.uk/for-the-public/browse-our-patient-information/breech-baby-at-the-end-of-pregnancy

Twins, triplets or more

If you are expecting twins, labour may start early because of the increased size of the uterus. It is unusual for multiple pregnancies to go beyond 38 weeks. If there are no complications in your pregnancy your doctor





may offer you a planned birth earlier than 38 weeks. The timing of the planned birth depends on the number of babies and whether or not your babies share a placenta. Your doctor will discuss this with you during your pregnancy. More health professionals will usually be present at the birth. For example, there may be a midwife, an obstetrician and two paediatricians (one for each baby).

Your doctor will discuss with you what type of delivery may be appropriate. Although you are more likely to have a caesarean section, in some cases twins can be delivered vaginally.

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

If the second baby is in a good position to be born, the waters surrounding the baby will be

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

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

For further information see www.nice.org.uk/guidance/NG137 and www.rcog.org.uk/for-the-public/browse-our-patient-information/multiple-pregnancy-having-more-than-one-baby

What your birth partner can do

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

They can:

- Keep you company and help to pass the time in the early stages.

- Hold your hand, wipe your face, give you sips of water, massage your back and shoulders.
- Help you move about or change position, or to get more comfortable.
- Encourage you as your labour progresses and your contractions get stronger.
- Remind you how to use relaxation and breathing techniques, perhaps breathing with you if it helps.
- Support your decisions about pain relief.
- Help you to discuss your options with the midwife or doctor. This can help you to feel much more in control of the situation.
- Tell you what is happening as your baby is being born if you cannot see what is going on for yourself.



For many couples, being together during labour and welcoming their baby together is a wonderful experience that they will never forget.

Many partners who have seen their baby born and who have played a part themselves say they feel much closer to the child from the very start.

10

Feeding your baby

10

Feeding your baby



It's never too early to start thinking about how you are going to feed your baby. Breastfeeding gives your baby the best possible start in life as it has lots of benefits for both you and your baby that last a lifetime. Discuss your plans with your partner and family as their help is important. You might like to watch the Bump to Breastfeeding video

together to see what feeding your baby might be like. The video can be seen at pha.site/bump-to-breastfeeding

- Your breastmilk is the only food designed for your baby. It contains everything your baby needs for the first six months of life. After that, giving your baby breastmilk along with solid food will help them continue to grow and develop, and provide protection. The World Health Organization recommends breastfeeding for two years and beyond.
- Breastfeeding helps build a strong bond between mother and baby, both physically and emotionally, which promotes infant brain development
- Breastfeeding can significantly reduce the risk of sudden infant death.
- Breastfeeding provides ongoing protection that cannot be replicated. It also offers health benefits for mums. Every day makes a difference to your baby, as the longer you breastfeed, the longer the protection lasts. Formula milk cannot provide your baby with the same ingredients and offers no protection.

What does breastfeeding help protect against?

Your baby:

- Ear infections
- Allergies
- Sudden infant death
- Childhood leukaemia
- Chest infections
- Obesity
- Gastro-intestinal infections
- Type 1 diabetes
- Urinary tract infections

You:

- Breast cancer
- Type 2 diabetes
- Ovarian cancer
- Postnatal Depression and more.





Breastfeeding

Just like any new skill, breastfeeding may take time and practice to work. In the first few days, you and your baby will be getting to know each other. Close contact and holding your baby against your skin can really help with this.



You can learn more about breastfeeding from the Public Health Agency booklet ***Off to a good start*** ask your midwife for a copy or visit pha.site/good-start

The more time you spend with your baby, the quicker you will learn to understand each other's cues and signals. The next few pages will help you to understand how breastfeeding works. And remember, it's OK to ask for help.

Immediately after your baby is born

Every pregnant woman has milk ready for her baby at birth. This milk is called colostrum and it is sometimes quite yellow in colour. It is very concentrated, so your baby only needs a small amount at each feed. In the first few days it may seem like your baby wants to feed all the time or some babies can be sleepy and will need to be encouraged to feed. Colostrum is full of antibodies to boost your baby's ability to fight off infection.

Holding your baby against your skin straight after birth will calm

Help and support

Midwives, health visitors, neonatal nurses, trained volunteers and peer supporters can all offer advice and practical help with breastfeeding. Peer supporters are mothers who have breastfed their own babies and have had training to help them support other mothers. Talk to your midwife or health visitor about the help that is available in your area.

A map of support groups can be seen at pha.site/breastfeeding-support

Mother-to-mother support on social media can be extremely helpful, such as the 'Breastfeeding in Northern Ireland' Facebook group. It should however be noted that the Public Health Agency (PHA) is not responsible for content on non-PHA social media accounts.

them, steady their breathing and keep them warm. It will also encourage them to breastfeed. Babies are often very alert in the first hour after birth and keen to feed. Your midwife can help you with this.

The first few days

Each time your baby feeds, they are letting your body

know how much milk it needs to produce. The amount of milk you make will increase or decrease in line with your baby's needs. Most babies will want to breastfeed at least 8-10 times in a day.

Around the 2nd–4th days your breasts will become fuller and warmer. This is often referred to as your milk 'coming in'. To keep yourself as comfortable as possible, feed your baby as often as they want for as long as they want. Your milk supply will vary according to your baby's demands. It will look quite thin compared with colostrum, but gets creamier as the feed goes on. Let your baby decide when they have had enough.

You may need to wear breast pads and to change them frequently, if you need to quickly stop your milk flowing you can apply some pressure

to your nipple with the flat of your hand for a few seconds.

In the beginning, your baby will need to be fed frequently. This helps to ensure you build up a good supply of milk. Gradually your baby may get into a pattern of feeding and the amount of milk you produce will adapt to the baby's needs. Your baby will be happier if you keep them near you and feed them in a responsive way, this means that you offer a breastfeed as early as possible when baby shows any signs of wanting to be fed. It also helps if you offer your breast if baby is upset and needs comforted or if your breasts feel full. This will quickly help your body to produce the amount of milk your baby needs. At night, your baby will be safest sleeping in a cot in the same room as you. This makes feeding easier and will reduce the risk of sudden

infant death. Try to take each day as it comes. If your breasts are uncomfortable or sore, ask for help. See pages 169-172 for further info on safe sleep.

First steps: starting to breastfeed

You can breastfeed in a number of different positions. Find one that is comfortable for both of you. If you are lying back in a well-supported position with your baby lying on your tummy, they will often move themselves onto your breast and begin to feed. Remember at all times to keep your baby safe.

You can try feeding lying on your side, in bed or in a chair, supported in an upright position. This will make it easier to hold your baby so their neck, shoulders and back are supported and they can reach your breast easily. Their head and body should be in a straight line.



'Liquid gold': the perfect food for your newborn

Colostrum is sometimes called 'liquid gold'. This extra-special breastmilk is full of germ-fighting antibodies that will help protect your baby against infections that you have had in the past. The first few feeds 'coat' your baby's gut to protect them from germs and reduce the chances of them developing allergies as they get older. This is particularly important if your baby is born early or unwell.

Later on, your breastmilk will still contain antibodies, and as you come across new infections you will produce new antibodies in your milk. This means that if you get colds or flu while you are breastfeeding, your baby will automatically get some immunity from those illnesses.

Colostrum harvesting

Colostrum harvesting is a method of collecting and storing your milk in the last weeks of pregnancy.

Colostrum is the first milk you produce for your baby. Small amounts of colostrum can be collected by hand expression and frozen until required, from 36 weeks (unless advised otherwise). Colostrum provides all of your baby's nutritional needs in the first few days of life and contains antibodies and other immune factors,



which help to protect your baby from infections and allergies.

Some women are unable to harvest colostrum in the antenatal period, this is not necessarily a reflection on your ability to successfully breastfeed.

Colostrum harvesting is not advised for everyone as it is often not necessary, nor a 'normal' activity in pregnancy. However, colostrum harvesting may be advised where women may have the following circumstances. This supports the milk supply and the avoidance of formula use:

- Diabetes (Gestational, Types 1 and 2)
- Multiple pregnancy (twins or triplets)
- History of breast hypoplasia or previous breast surgery

- Pregnancy induced hypertension and/or taking blood pressure medication(e.g. labetalol)
- Strong family history of dairy intolerance or inflammatory bowel disease
- Previous difficulty with breastfeeding i.e. low milk supply
- Babies likely to be born prematurely or with a known condition such as cardiac issues, cleft lip/palate, gut conditions etc)
- Babies who are thought to be small for gestational age or are expected to be under 2.5kg at birth

There are a number of pregnancies where colostrum harvesting is not advised for medical reasons so therefore it is important to speak to a midwife or member of the medical team if you plan to harvest.

How to help baby breastfeed

There are many different positions you can use to breastfeed, such as sitting up, lying down or feeding your baby in the underarm position. In the beginning, your baby will need your help in order to stay comfortable during a feed and to help them attach well to the breast. The following four words may be helpful to remember when starting off breastfeeding. It may be helpful if you remember the first letter of these five words as CHINS.

Close (hold your baby in close so that they can reach your breast easily).

Head free (do not hold the back of your baby's head as they need to be able to tilt their head back, instead support their neck and shoulders and allow their head to be free to tilt back).

In-line (make sure the baby's head and body are all facing you and not twisted).

Nose to nipple (start the feed with your baby's nose opposite your nipple so that when the baby attaches your nipple goes up over the baby's tongue and into the top of the baby's mouth).

Sustainable (the position should be comfortable for both mum and baby for the duration of the feed).

CHINS developed by Dr Lynette Shotton

Your baby's sucking causes milk stored in your breasts to be squeezed down ducts inside your breasts towards your nipples. This is called the 'let-down' reflex. Some women get a tingling feeling which can be quite strong, while others feel nothing at all. You will see your baby more easily respond and their quick sucks change to deep rhythmic swallows as the milk begins to flow more easily. Babies often pause after the initial quick sucks while they wait for more milk to be

'delivered'. If your baby falls asleep quickly before the deep swallowing stage, check that they are properly attached at the breast. It might be easier to get someone else to check for you. Sometimes you will notice your milk flowing in response to your baby crying or when you have a warm bath.

After your baby has finished feeding, you can hold them upright on your shoulder to see if they need to burp. Breastfed babies don't usually get as much wind as bottle-fed babies.



1 Hold your baby's whole body close with the nose level with your nipple.



2 Let your baby's head tip back a little so that their top lip can brush against your nipple. This should help your baby to make a wide open mouth.



3 When your baby's mouth opens wide, the chin is able to touch the breast first, with the head tipped back so that the tongue can reach as much breast as possible.



4 With the chin firmly touching, and with the nose clear, the mouth is wide open, and there will be much more of the darker skin visible above your baby's top lip than below their bottom lip. The cheeks will look full and rounded as your baby feeds.



How do I know that my baby is attached properly?

- Your baby has a large mouthful of breast.
- Your baby's chin is firmly touching your breast.
- It doesn't hurt you to feed (although the first few sucks may feel strong).
- If you can see the dark skin around your nipple, you should see more dark skin above your baby's top lip than below their bottom lip.
- Your baby's cheeks stay rounded during sucking.
- Your baby rhythmically takes long sucks and swallows (it's normal for your baby to pause from time to time).

- Your baby finishes the feed and comes off the breast on their own.

If you have any concerns about any of these points, talk to your peer supporter, midwife, GP or health visitor, or contact the National Breastfeeding Helpline on 0300 100 0212.

Note that if your baby seems unusually sleepy and/or is slow to start feeding, they may be ill, so contact your GP or seek medical advice as soon as possible.

How do I know my baby is getting enough milk?

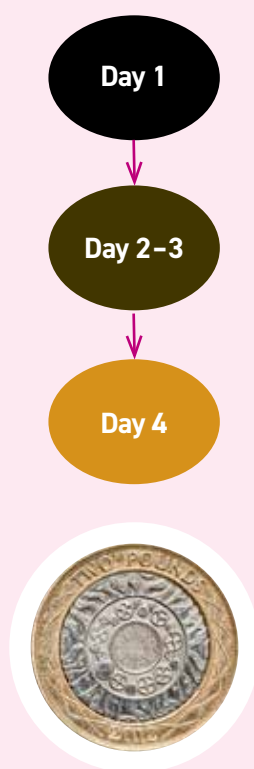
- Your baby should be healthy and alert.
- In the first 48 hours, your

baby is likely to have only two or three wet nappies. Wet nappies should then start to become more frequent, with at least six every 24 hours from day five onwards.

- Most babies lose weight initially. They should be weighed by a health professional some time around the 3rd–5th day. From then on, they should start to gain weight. Most babies regain their birth weight in the first two weeks.
- At the beginning, your baby will pass a black tar-like poo called meconium. By the 3rd day, this should be changing to a lighter, runnier, greenish stool that is easier to clean up. From the 4th day and for the first few weeks, your baby should pass at least two yellow stools every day. These stools should be at least the size of a £2 coin. It's normal for breastfed babies to pass loose stools.
- Your breasts and nipples should not be sore. If they are, do ask for help.
- Your baby will be content and satisfied after most feeds and will come off the breast on their own.

If you are concerned about any of these points, speak to your midwife or health visitor.

Colour guide for a baby's poos for the first few days



Tips for breastfeeding

- Make sure your baby is well attached to your breast (see pictures on page 125). This will help your body make the right amount of milk and stop your breasts getting sore. The more you breastfeed your baby, the more milk you will produce. When your baby comes off the first breast, offer the second. It doesn't matter if they are not interested or don't feed for long, or even if they feed for longer on the second breast. This is fine – just start with this breast next time. Sometimes your baby might seem hungrier than usual and feed for longer or more often. Your body responds automatically

and makes more milk to provide the extra needed. This is why you can feed more than one baby at the same time (see page 128).

- There is no need to offer formula milk in addition to breastmilk. If your baby seems more hungry, feed more often, rather than offer formula milk.
- Breastfeeding mums are now encouraged to practice responsive feeding. This means offering feeds before crying starts (such as when your baby is restless or sucking her fingers). It involves offering the breast for food and comfort, which helps maintain a good milk supply, as the more often your baby is fed, the more milk is produced. Breastfeeding can be a nice chance to sit down and rest; it can soothe, comfort and calm both baby and mum. By the time a newborn baby starts crying, they will normally have been hungry for a while.
- Breastfeeding can help you feel close to your baby and get to know them. It can help your baby feel closer to you and get them used to listening to your voice.
- Try not to give your baby any other food or drink before the age of about six months as less frequent



breastfeeding will reduce your milk supply.

- From birth to one year infants (including babies who are exclusively or part breastfed) drinking less than 500ml (1 pint) or more of infant formula each day should receive a supplement of 10 micrograms of Vitamin D per day throughout the year. See pha.site/vitaminD
- If you do decide to give formula, keep your milk supply going by continuing breastfeeding, or expressing, as much as possible.
- Try not to give your baby a dummy until breastfeeding is going well, as this can confuse the baby too much and also reduce your milk supply.
- If you are worried about breastfeeding when you are out and about, wear a t-shirt or a vest top and a cardigan so that you can lift your top up from the waist to feed. If you are worried about showing your tummy you can wear a belly band or a second vest.

The Public Health Agency Breastfeeding Welcome Here Scheme helps support mums who are breastfeeding, by asking businesses to display a sticker which says breastfeeding is welcome; you will see the pink and white heart in over 1000 venues throughout Northern Ireland. Visit breastfed babies to see where your local members are www.breastfedbabies.org



Breastfeeding

Good for baby. Good for mum

Breastfed babies cannot be overfed so you can breastfeed to calm and soothe your baby, or as a lovely way of spending time together, or just for having a rest.

Breastfeeding more than one baby

Twins, triplets or more can be breastfed. Because multiple babies are more likely to be born prematurely and to have a low birth weight, breastmilk is especially important for their wellbeing. You will be supported to express if needed, until your babies are able to orally feed.

To start with, you may find it easier to feed each of your babies separately, until you feel confident about handling them at the same time and feeding

is well established. This may take up a lot of your time, so it can be really helpful to accept any offers of help around the house from family and friends.

Over time, you will learn what works best for you and your babies. Triplets can be breastfed either two together and then one after, or all three rotated at each feed. Alternatively, you can use a combination of breast and formula, depending on the babies and your milk supply. The Twins Trust, the twins and multiple birth association, provides information and support on feeding. To find out more visit www.twinstrust.org

How long should I breastfeed?

Exclusive breastfeeding (with no other food or drink) is recommended for the first six months of a baby's life. After this, you can carry on giving your baby breastmilk along with other foods for as long as you and your baby want. This can be into the second year or beyond.

Every day you breastfeed

makes a difference to you and your baby. There is no need to decide at the beginning how long you will breastfeed. Many mothers continue to breastfeed when they return to work or education. Don't forget to ask for help if you need it! The practicalities will depend on how old your baby is and how many feeds they need while you are apart, but it's often easier to manage than people think. Your peer supporter, midwife, health visitor, local support group or the National Breastfeeding Helpline (0300 100 0212) can explain the options and talk them through with you.

If you stop breastfeeding, it can be difficult to start again. Giving formula milk to a breastfed baby can reduce your supply of breastmilk.

Dummies

Try not to give your baby a dummy until breastfeeding is established, usually when your baby is about a month old. Using dummies has been shown to reduce the amount of breastmilk that is produced. If





your baby becomes accustomed to using a dummy while sleeping, it should not be stopped suddenly in the first six months. Try to reduce using the dummy by the time your baby is 6-9 months old as it may affect the development of the baby's teeth and speech.

Expressing milk

Expressing milk means removing milk from your breast. You may want to express milk if your breasts are feeling uncomfortably full, or if your baby is not sucking well, or is unable to feed, but you still want to give them breastmilk.

If you have to be away from your baby – for example, because your baby is ill or premature, or because you are going back to work – you may wish to express milk so that somebody else can feed your baby.

You can express milk very effectively by hand or with a breast pump. Different pumps suit different women, so ask for

information to compare them. A pump needs to be clean and sterilised each time it is used.

Expressing by hand

It is more effective to express milk by hand than to use a pump in the first few days. If you want to collect the milk, you will need a sterilised container. The following suggestions should help:



1. Before you start, wash your hands thoroughly then gently massage your breast to stimulate the milk to start flowing.
2. If you are going to collect the milk, use a sterilised jug or bowl to catch the milk. If your baby is in hospital storage bottles will be provided to you.



3. Place your thumb on top of your breast and the rest of your fingers below about 2–3 centimetres from the base of your nipple, with your thumb and fingers in a sort of C-shape.



4. squeeze and release in a rhythmic fashion. Avoid sliding your fingers over the skin. At first, only drops will appear, but just keep going as it will increase. With practice, and a little time your milk will flow freely.
5. When no more drops are coming, move your fingers round to try a different section of your breast and repeat.
6. When the flow slows down, swap to the other breast. Keep changing breasts until the milk is dripping very slowly or stops altogether.
7. If the milk doesn't flow, try moving your fingers slightly towards the nipple or further away, and try giving your breast a gentle massage.



Breastfeeding and returning to work

Many mothers continue to breastfeed when they return to work or education. Your employer may wish to carry out a risk assessment as detailed in the HSE leaflet *New and expectant mothers who work* available at pha.site/working-mothers

The Public Health Agency has also produced a guide for employers, which can be downloaded from pha.site/breastfeeding-work

If you are planning to continue to breastfeed after returning to work, it is important that you plan ahead as much as possible. Let your employer know in writing that you intend to continue breastfeeding and that you will need some privacy and a little extra time at breaks to express milk or, if possible, to feed your baby.

Checklist for breastfeeding and returning to work:

- Before you return to work, write to your employer and let them know you are breastfeeding.

- Decide how your baby will be fed while you are at work such as bottle or cup, breastmilk or formula.
- Decide if you need to express milk while at work.
- Practise expressing your milk using a pump or by hand.
- Learn about safe storage of breastmilk.
- Have a few trial runs before you go back to work.

Expressing milk if your baby is premature or ill

It is important to start expressing your milk within two hours of birth. To ensure that you produce plenty of milk, you will need to express at least 8 to 10 times in 24 hours, including during the night, just as your baby might be doing if they were able to feed directly. Ask the hospital staff about having skin-to-skin contact with your baby as soon as possible after the birth. This will help with bonding and keeping up your milk supply.

Neonatal units/Children's wards often have breast pumps for expressing milk,

and staff will show you how to use one. If you go home from hospital before your baby you may need to use an electric breast pump for many weeks.

Your hospital may be able to provide a loan breast pump, alternatively you may be able to borrow one from Tiny Life the premature baby charity by contacting them on 028 90815050.

If you want to freeze breastmilk because your baby is premature or ill, ask the staff caring for your baby for support and information.

Your midwife, health visitor, neonatal staff or peer supporter can also give you practical help and answer any questions. You can watch a video online at pha.site/small-wonders The video is called Small Wonders and it tells you all you need to know about breastfeeding an ill or premature baby.



Helpful tips

Breastfeeding should feel comfortable. Your baby should be relaxed. You should hear a soft swallowing. If it doesn't feel right, start again. Slide one of your fingers into your baby's mouth, gently break the suction and try again.



Storing breastmilk

You can store breastmilk for healthy babies:

- up to five days in the fridge at 4°C or lower. This means putting the milk in the coolest part of the fridge, usually at the back (do not keep it in the door);
- up to two weeks in the freezer compartment of a fridge;
- up to six months in a domestic freezer, at -18°C or lower.

Breastmilk must always be stored in a sterilised container. If you use a pump, make sure you wash it thoroughly after use and sterilise it before use.

Milk should be defrosted in the fridge. Once it's defrosted, it can be stored in the fridge but needs to be used within 24 hours of being thawed. Heat the bottle of milk in a jug of warm water.

Test the temperature of the milk on your forearm before giving it to your baby. Milk that has been frozen is still good for your baby and better than formula milk. Milk should not

be refrozen once thawed. Never use a microwave oven to warm or defrost breastmilk as this can alter the proteins in your milk and there is a risk of scalding.

Some common breastfeeding problems and how to solve them

It can be hard to ask for help, but tackling any problems as soon as they start will help you to enjoy these early days. In lots of cases, the solution is as simple as changing your baby's position slightly or feeding them a bit more often.

Unsettled feeding

If your baby is unsettled at the breast and doesn't seem satisfied by feeds, it may be that they are sucking on the nipple alone, and so are not getting enough milk. Ask for help to get your baby into a better feeding position.

Sore or cracked nipples

If your nipples hurt, take your baby off the breast and start again. If the pain continues or your nipples start to crack or bleed, ask for help so you get your baby attached comfortably (see page 138 for information on how to get help). It can sometimes take a little while to sort out how to prevent the soreness, but it is important to get support as soon as possible.

The following suggestions may also help:

- Try expressing a drop or two of your milk at the end of a feed and gently rubbing it into your skin. Let your nipples dry before covering them.
- If you are using breast pads, they need to be changed at each feed (if possible, use pads without a plastic backing).
- Avoid soap as it dries your skin out.
- Wear a cotton bra, so air can circulate.
- Some mothers treat any cracks or bleeding with a thin smear of white soft paraffin or purified lanolin. Put the ointment on the crack (rather than the whole nipple) to help it heal and prevent a scab forming.

Tender breasts, blocked ducts and mastitis

Milk can build up in the ducts for a variety of reasons. The most





common are wearing a too-tight bra, missing a feed, or a blow to the breast. It's important that you deal with a blocked duct as soon as possible so that it doesn't lead to mastitis (inflammation of the breast).

If you have mastitis, your breasts will feel hot and tender. You may see a red patch of skin which is painful to touch. You can feel quite ill, as if you have flu, and you may have a temperature. This can happen very suddenly. It is very important to carry on breastfeeding, or expressing, as this will help you get better more quickly.

If you think you might have mastitis (or a blocked duct), try the following:

- Take extra care to make sure your baby is attached well to your breast.
- Continue to feed your baby responsively.
- Let your baby feed on the tender breast first.
- If your breasts still feel full

after a feed, or your baby cannot feed, massage your breasts and express your milk (see page 129 for more information on how to do this).

- Applying warmth to your breast, for example using a warm flannel before a feed, can help milk flow and make you feel more comfortable.
- While your baby is feeding, gently stroke the lumpy area with your fingertips towards your nipple. This should help the milk to flow.
- Apply a cold compress after feeding.
- Get lots of rest. Go to bed and catch up on your sleep whenever you can.
- Take a painkiller such as paracetamol or ibuprofen (follow instructions on the pack). These are safe to take while breastfeeding.
- Ask for help with how you get your baby latched on properly (see page 138 for information on where to get help).

Mastitis may also be a sign of infection. If there is no improvement within 12 to 24 hours, or you start to feel worse, contact your GP or healthcare professional. If necessary, they can prescribe antibiotics that are safe to take while breastfeeding.

Thrush

If you suddenly get sore, bright pink nipples after you have been feeding without problems for a while, you might have an infection known as thrush. The pain may be felt right inside the breasts. Ask for help to check that your baby is latched on properly, and make an appointment with your GP.

You and your baby will both need treatment. You can easily give thrush to each other, so if your baby has it in their mouth they will need medication and you will still need some cream for your nipples to stop it spreading to you. You can also ask your pharmacist for advice. Some antifungal creams can be bought over the counter from a pharmacy but you need to ensure it is suitable for continued breastfeeding. You can also obtain more information on breastfeeding and thrush from www.breastfeedingnetwork.org.uk

Tongue-tie

Some babies are born with a tight piece of skin between the underside of their tongue and the floor of their mouth. This is known as tongue-tie, and while it doesn't always affect breastfeeding, it can make feeding painful in some cases as it is harder for your baby to attach to your breast.



Tongue-tie can be treated easily with a minor surgical procedure called a frenulotomy but only requires treating if affecting feeding.

Some babies sleep through the procedure, however, most babies cry. A small amount of blood loss is expected, however heavy bleeding following the procedure is rare and research shows the risk of infection is very small.

With increased tongue movement some babies must relearn how to feed and may be unsettled feeding for a day or two. Occasionally (about 4 out of every 100 babies) scar tissue can form which may restrict your baby's feeding. If you notice significant feeding difficulties 2 to 3 weeks after the procedure, contact your midwife or health visitor.

Staying healthy

You don't need to eat anything special while you are breastfeeding, just make sure you have a varied and balanced diet.

Eating well for breastfeeding

www.youtube.com/watch?v=664t0wkerhE

Your milk is good for your baby whatever you eat, but there are a few foods to avoid (see next page). Being a new mother is hard work though, so it's important to look after yourself and try to eat as varied and balanced a diet as you can. Aim to eat healthily as a family. A healthy range of food includes:

- at least five portions of a variety of fruit and vegetables a day (including fresh, frozen, tinned, dried and juiced);
- starchy foods such as wholemeal bread, pasta, rice and potatoes;
- plenty of fibre, found in wholegrain bread and breakfast cereals, pasta, rice, pulses (such as beans and lentils) and fruit and vegetables. After childbirth, some women experience bowel problems and constipation – fibre and fluid helps with both of these;
- protein, such as lean meat and poultry, fish, eggs and pulses;
- at least two portions of fish each week, including one portion of oily fish;
- dairy foods, such as milk, cheese and yogurt, which contain calcium and are a useful source of protein.

It's also important to drink plenty of fluid. Aim for at least 1.2 litres (six to eight glasses) each day. It's a good idea to have a drink and a healthy snack beside you when you settle down to breastfeed. Water, milk and unsweetened fruit juices are all good choices.

To find out more about healthy eating, go to pha.site/healthy-eating and www.rcog.org.uk/for-the-public/browse-our-patient-information/healthy-eating-and-vitamin-supplements-in-pregnancy

Healthy snack ideas

The following snacks are quick and simple to make and will give you the energy and strength you need:



- fresh fruit;
- sandwiches or pitta bread filled with salad vegetables, grated cheese;
- salmon or sardines or cold meat;
- yogurts and fromage frais;
- hummus and bread or vegetable sticks;

- ready-to-eat dried apricots, figs or prunes;
- vegetable and bean soups;
- fortified unsweetened breakfast cereals, muesli or other wholegrain cereals with milk;
- milky drinks or unsweetened fruit juice;
- baked beans on toast or baked potato.



Vitamins

You should be able to get all the vitamins and minerals you need by eating a varied and balanced diet. While you are breastfeeding (just as when you were pregnant) you should take supplements containing 10 micrograms (mcg) of vitamin D each day.

Ask your GP, pharmacist or health visitor where to get vitamin D supplements. You may be able to get free vitamin supplements without a prescription if you are eligible for Healthy Start (see page 38).

Foods to avoid

Eating fish is good for your health. But if you are breastfeeding don't eat shark, marlin and swordfish, and limit the amount of tuna you eat to no more than two tuna steaks

a week (about 140g cooked or 170g raw each) or four medium-sized cans of tuna a week (about 140g when drained). These types of fish contain high levels of mercury, which can damage your baby's developing nervous system. Don't eat more than two portions of oily fish per week. Oily fish includes salmon, mackerel, sardines and trout. Fresh tuna was classified as an oily fish until recently. Recent studies have shown the fish oil content of fresh tuna is similar to that of white fish.

Small amounts of whatever you are eating and drinking can pass to your baby through your breastmilk, so it's a good idea to think about how much alcohol and caffeine you are having. These may affect your baby in the same way they affect you.

If you think a food or foods that you are eating are affecting your baby, talk to your GP or health visitor, or contact the National Breastfeeding Helpline on 0300 100 0212.

Drinks containing caffeine can also affect your baby and may keep them awake, so drink them only occasionally rather than every day while your baby is young.

See page 135 for more information on alcohol and breastfeeding.

Caffeine

Caffeine occurs naturally in lots of foods and drinks, including coffee, tea and chocolate. It's also added to some soft drinks and energy drinks and to some cold and flu remedies.



In the early days, it is important that you don't have too much caffeine. Try decaffeinated tea and coffee, fruit juice or water and limit the number of energy drinks, which might be high in caffeine.

Helpful tips

- Eat when you feel hungry, and choose healthy snacks.
- You will probably feel quite thirsty. Have a drink and a healthy snack beside you before you sit down to breastfeed.
- Try to eat a wide variety of foods (see page 31).
- Try not to restrict your diet unless you think a food is upsetting your baby. Always talk to your health visitor or doctor before cutting out foods.



- Keep your alcohol intake low. Alcohol in breastmilk can affect your baby's feeding or sleeping. Avoid drinking alcohol shortly before feeding your baby.
- Avoid drinking too much strong tea or coffee.

Peanuts

Peanuts are one of the most common causes of food allergy. Peanut allergy affects about 1% of people and can cause severe reactions. Your baby may be at higher risk of developing a peanut allergy if you, the baby's father, brothers or sisters have a food allergy or other allergic condition such as hayfever, asthma and/or eczema.

What you need to know

- If you would like to eat peanuts or foods containing peanuts (such as peanut butter) while breastfeeding, you can choose to do so as part of a healthy balanced diet, unless you are allergic to them or your health professional advises you not to.
- You may have heard that some women have, in the past, chosen not to eat peanuts while they were breastfeeding. This is because the government

previously advised women that they may wish to avoid eating peanuts while they were breastfeeding if there was a history of allergy in their child's immediate family (such as asthma, eczema, hayfever, food allergy or other types of allergy), in case small amounts of peanut in their breastmilk increased the chance of the baby developing a peanut allergy. But this advice has now been changed because the latest research has shown that there is no clear evidence to say that eating or not eating peanuts while breastfeeding has any effect on your baby's chances of developing a peanut allergy.

- If you have a child under six months and are not breastfeeding (for example because you are feeding your baby on formula), then there is no reason why you should avoid consuming peanuts or foods containing peanuts.

Alcohol

Generally, adult women should not regularly drink more than two to three units of alcohol per day. During pregnancy, women are advised to avoid drinking. By breastfeeding, you are giving your baby the best possible start in life. We do know that alcohol passes through to the baby in very small amounts in your breastmilk.

Because of this, when you are breastfeeding it is sensible to avoid drinking alcohol.

If you drink alcohol or take other drugs and breastfeed, it can affect your baby in a number of ways:

- your milk may smell different and put your baby off feeding;
- the alcohol may make your baby too sleepy to feed;
- your baby may have difficulties with digestion and problems with their sleeping patterns.

For more on the effects of alcohol and the units found in typical drinks, visit pha.site/alcohol-units

Further information is available at www.rcog.org.uk/for-the-public/browse-our-patient-information/alcohol-and-pregnancy

Smoking

Smoking is bad for you, bad for your partner and bad for your baby.

One of the best things you can do for your own and your baby's health is to stop smoking. Each year in the UK, more than 17,000 children under the age of five are admitted to hospital because of the effects of secondhand smoke.

Avoid smoking in the home and ask your partner, friends and family to do the same when they are around your baby. Since 1 February 2022, it has been an offence to smoke in a vehicle where a child or young person aged under 18 is present. It is also an offence if the driver does not prevent smoking in a private vehicle.

If you do smoke and you are finding it difficult to quit, breastfeeding will still protect your baby from infections and give them nutrients they cannot get through formula milk. Smoking after feeds, rather than before, will help reduce your baby's exposure to nicotine.



Pregnancy and nicotine replacement therapy (NRT)

You are up to four times more likely to stop smoking successfully using specialist support and licensed stop smoking medication.

Visit www.stopsmokingni.info for further information.

You can speak to your GP or pharmacist about the stop smoking medications available to help you manage your cravings and become smoke-free. For more information on NRT ask your midwife for



a copy of the Pregnancy and NRT leaflet.

For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/smoking-and-pregnancy

Medicines and breastfeeding

Many illnesses, including depression (see page 92), can be treated while you are breastfeeding without harming your baby. Small amounts of whatever medicines you take will pass through your breastmilk to your baby, so always tell your doctor, dentist or pharmacist that you are breastfeeding.

Medicines that can be taken while breastfeeding include:

- most antibiotics;
- common painkillers such as paracetamol or medications containing codeine (co-codamol) and ibuprofen (but not aspirin);

- hayfever medicines such as loratadine and cetirizine;
- cough medicines (provided they don't make you drowsy);
- asthma inhalers;
- normal doses of vitamins.

You can use some methods of contraception but not all, so check with your GP or pharmacist. Some cold and flu remedies are not suitable.

Non-prescribed drugs - illegal drugs

If you are breastfeeding and you take any street drugs, or any drugs that have not been prescribed for you it is really important, to get the right advice. Talk to your midwife, health visitor or doctor as the drugs may be dangerous to your baby.

It's fine to have dental treatments, local anaesthetics, vaccines (including measles, mumps and rubella (MMR), tetanus and flu injections) and most types of operations. You can also dye, perm or straighten your hair, use fake tan and wear false nails.

Illegal drugs are dangerous for your baby, so talk to your midwife, health visitor, GP or pharmacist if this is a concern.

More information

For more information go to pha.site/drugs-in-breastmilk

Your GP or pharmacist can check the information from the National Formulary for Children at <https://bnfc.nice.org.uk> to see what medicines can be given to babies and children, as these are likely to be safe for mothers to take when breastfeeding.

Why is aspirin sometimes given during pregnancy?

Some pregnant women are at risk of developing pre-eclampsia (a serious condition which usually presents as high blood pressure and protein in the urine) and intrauterine growth restriction (when the baby is smaller than usual due to not growing at a normal rate in the womb). There is evidence to suggest that this group of women are at reduced risk of developing these conditions if they take a low dose of aspirin during their pregnancy.

Medicines for minor ailments

- Make sure the medicine is safe to take when breastfeeding.
- Watch your baby for side effects such as poor feeding, altered bowel movements, drowsiness and irritability. Stop taking the medicine if your baby gets side effects.
- Not enough is known about herbal remedies to guarantee they are safe to use when breastfeeding.
- For further information, speak to your pharmacist.



Minor ailment	First choice	Second choice	Do not use
Constipation	Eat more fibre Bulk laxatives that contain ispaghula Lactulose	Bisacodyl Senna	
Cough	Honey and lemon in hot water Simple linctus		Medicines that contain codeine (such as co-codamol, co-dydramol) or guaifenesin
Diarrhoea	Oral rehydration sachets	Occasional doses of loperamide	
Haemorrhoids (piles)	Soothing creams, ointments or suppositories	Ice pack	
Hayfever, house dust mite and animal hair allergy	Antihistamine eye drops or nasal sprays Steroid nasal sprays	Antihistamines – cetirizine or loratadine	Other antihistamines unless advised by your doctor
Head lice	Wet combing Dimeticone lotion	If ineffective, then head lice lotions that contain permethrin	
Indigestion	Antacids (indigestion mixtures)	On your doctor's recommendation: medicines that reduce acid production, such as omeprazole	
Nasal congestion (stuffy or runny nose)	Steam inhalation	Oxymetazoline or xylometazoline nasal sprays. Occasional doses of pseudoephedrine	Decongestants that come as tablets, liquids or powder that you swallow
Pain (such as headache, mastitis, toothache)	Paracetamol	Ibuprofen	Medicines that contain aspirin Medicines that contain codeine (such as co-codamol, co-dydramol), unless advised by your doctor
Threadworms	Mebendazole		
Vaginal thrush	Clotrimazole pessaries or cream	Fluconazole	

Breastfeeding help and support

Don't be afraid to ask for the support and information you need to make breastfeeding work for you and your baby. No problem is too small – if something is worrying you, the chances are that other mothers will have felt the same.

You can get help from a peer supporter, your midwife or health visitor. You might also want to join a local breastfeeding group. It's a great way of making new friends as well as sharing the ups and downs of looking after a new baby. Most groups usually include a mix of healthcare professionals and local trained volunteer mothers (peer supporters). These mothers have breastfed their own babies and have had some training in basic breastfeeding techniques. Some peer supporters will have had more in-depth training to help them support new mothers.

A map of all breastfeeding groups for Northern Ireland can be found on www.breastfedbabies.org

To find out what is available in your area, talk to your midwife or health visitor, or contact the [National Breastfeeding Helpline](http://www.nationalbreastfeedinghelpline.org.uk) on 0300 100 0212 (lines are open from 9.30am to

9.30pm) or go to the website at www.nationalbreastfeedinghelpline.org.uk

You can also get information online from the [Association of Breastfeeding Mothers](http://www.abm.me.uk) (www.abm.me.uk) and the [Breastfeeding Network](http://www.breastfeedingnetwork.org.uk) (www.breastfeedingnetwork.org.uk).

The Breastfeeding Network runs a Supporterline on 0300 100 0210, and also offers a helpline for speakers of Bengali/Sylheti on 0300 456 2421. Lines are open from 9.30am to 9.30pm.

Breastfeeding information and support contacts are available from the Public Health Agency website www.breastfedbabies.org

The booklet *Off to a Good Start* should have been given to you in hospital soon after or before you gave birth. You can also view this at pha.site/good-start

The following voluntary organisations can also provide information and advice:

La Leche League
0345 120 2918
www.laleche.org.uk

NCT Breastfeeding Line
0300 330 0700
www.nct.org.uk

The **Unicef Baby Friendly** site at www.babyfriendly.org.uk

provides information and links to useful resources about the benefits of breastfeeding.

All these voluntary organisations provide training for peer supporters.

The *Bump to Breastfeeding (Best Beginnings)* video is a useful source of information and will give you an insight into other mothers' experiences of breastfeeding. You can view the video at pha.site/bump-to-breastfeeding

Donating Breast Milk to the Human Milk Bank

In Northern Ireland the Human Milk Bank is located within the South West Acute Hospital, Enniskillen. The Human Milk Bank always welcomes prospective donors. If you wish to become a milk donor you will be asked to undergo medical screening consisting of a questionnaire and a blood test. The donor milk you provide is pasteurised before being distributed to Neonatal Units and Paediatric Wards throughout the island of Ireland. Donor Milk is supplied to premature babies and critically ill or low birth weight babies as an addition to or substitute for mother's own milk. You will always be encouraged to feed your own baby first. If you would like to donate your extra breast milk please contact the Human Milk Bank.

Tel 028 6862 8333 (NI)/00 353 44 28 6862 8333 (RoI) or via email on TMB.SWAH@westerntrust.hscni.net

Informal sharing of breastmilk

Informal milk sharing involves a mother providing extra expressed breastmilk to another mother who may have low milk supply. This practice is not recommended

as human milk obtained from outside the Northern Ireland Human Milk Bank carries risks as it will not have been processed in a way that follows accepted guidelines. There are significant risks associated with using informally shared human milk as it could be contaminated with disease causing bacteria; it may contain viruses as a result of the mother having unknown infections such

as HIV, hepatitis; and it may contain medications taken by the mother as well as alcohol, nicotine, drugs and other contaminants. Any mother experiencing difficulties with milk supply should talk to a midwife or health visitor. With good support it is very possible to increase a mother's milk supply to meet the needs of her baby.

What partners should know about breastfeeding

The father or partner's support is vital to helping you continue to breastfeed, as they can help by:

- making sure you and your baby are comfortable while feeding;
- explaining to family and friends about the importance of breastfeeding;
- bringing you a drink or a healthy snack to eat, such as a piece of fruit or a slice of toast;
- preparing meals and doing the housework so you can concentrate on feeding your baby;
- encouraging you, particularly when you are very tired or finding things difficult;
- protecting you from

others' opinions about breastfeeding which may be undermining.

How fathers and partners can help

After the first few weeks when breastfeeding is going well, you might decide to express some milk so someone else can help with an occasional feed.

Expressing milk can be done by hand or, more usually, by using a pump to collect milk from the breast and store it in a bottle. Your health visitor or community midwife will be able to give advice on this. See also www.breastfedbabies.org

It's important to remember:

- breastfeeding must be well established before a bottle is introduced as some babies can get confused or develop a preference for the bottle. This is because the sucking action required to feed

from a bottle is different to that used to feed from the breast;

- maintaining a good milk supply depends on milk being removed regularly either by breastfeeding or expressing. Long periods between expressing or feeds may lower milk supply.

Knowing what helps

- There are very few women who cannot breastfeed because of medical reasons. However, many women experience difficulties if the baby is attached onto the breast properly.
- The more often your baby breastfeeds the more milk will be made – it works on supply and demand. Most babies will want to feed frequently, especially in the first weeks, so some feeds will seem very close together.

- You and your partner may worry that your baby is not getting enough milk because you can't measure the amount he gets. But if they are having wet and dirty nappies and gaining weight at a normal rate, that means they are getting enough.
- In fact, as your baby gets both a drink and food from the breast, there is no need for anything else for the first six months.
- You and your partner may feel self-conscious about breastfeeding in public but it can be done without anyone noticing. You can lift your top from the waist and perhaps use a blanket, scarf or shawl. It can look as if your baby is just having a cuddle.
- Breastfeeding is sometimes used as a method of contraception. If you definitely don't want to have another baby just yet, it is best to use other more reliable methods of contraception which are suitable while breastfeeding.
- Keeping you and baby together at night is important as it makes it easier for you to feed baby in a responsive way.
- Breastfeeding is handier

than bottlefeeding at night and when away from home as there's no need to worry about keeping milk fresh and heating bottles, plus it's free.

- You will lose weight more quickly after the birth if you breastfeed.

How dads and partners can get involved

If your baby is breastfed it is important for mum to feed baby initially, but dads and partners can be involved in many other ways of caring for, and being close to, your baby. Here are some suggestions that might be useful:

- change your baby's nappy;
- settle your baby after a feed by winding them;
- hold and soothe your baby;
- play with your baby;
- place your baby on your bare chest for skin-to-skin contact;
- give your baby a massage;
- carry your baby in a sling or baby carrier;
- talk, read and sing to your baby;
- take your baby for a walk in the pram;
- bath your baby.

Your relationship with your partner

Some parents worry that breastfeeding will affect the physical side of their relationship with their partner. Some women lose interest in sex after having a baby and for most couples it is difficult to find the time and energy to make love, but it is possible for you both to enjoy an active sex life.

It is a good idea for mum to feed baby first so that she is more comfortable and your baby is settled so you are less likely to be disturbed by crying.

Remember that breastfeeding may make your partner's breasts feel more sensitive.

Some partners really like the changes in a mother's breasts during breastfeeding whereas others may be concerned that breastfeeding makes breasts less attractive, but there is no evidence that any breast changes due to breastfeeding are permanent.

You and your baby

The more partners are involved with caring for your baby, the more quickly they will develop a strong bond. Try to enjoy this time – it is busy and tiring but the rewards are amazing and it won't last forever!



Types of milk to avoid

Cows' milk should not be given as a main drink to a child under the age of one year. Small amounts of cows' milk can be used for cooking after six months of age.

Condensed milk, evaporated milk, dried milk, sheep's milk, goats' milk, or any other type of 'milk' drink (such as rice, oat, almond, soy, coconut, flax or hemp drinks) should never be given to a baby under the age of one year. You should not use soya formula unless it has been prescribed by your GP.

If you are giving your baby infant formula, first infant formula (whey-based) is the only formula they will need in the first year.

Follow-on formula is not suitable for babies under six months.



Formula feeding (bottlefeeding)

The following advice is based on guidance from the Department of Health and the

Food Standards Agency. It may differ from what you have done before if you have older children, but to minimise any risk it is recommended that you follow this advice.

Using a baby formula preparation machine

If you use a machine to make up bottles of formula, make sure the water that comes out of the machine is at least 70 degrees Centigrade when combined with the formula. Water at this temperature will kill any harmful bacteria that may be in the formula.

You can check the temperature using a simple digital food thermometer. If you find that the water is less than 70C, we recommend that you stop using the machine. You may also wish to contact the manufacturer, or local Trading Standards Department to report that your machine is faulty.

www.nhs.uk/start-for-life/baby/feeding-your-baby/bottle-feeding/how-to-make-up-a-feed

Helpful tips

There are a number of different brands of infant formula milk available in the shops. While baby milk companies may claim their formula is closest to breastmilk and better than others, all must meet regulated

standards and there is actually very little difference between them all. The most expensive milk is not necessarily the best, supermarket own brands are much cheaper and meet the required regulations.

In the past it was thought better to stick to one brand, but there is no evidence to suggest that changing brands does any good or any harm.

Choosing a formula

Infant formula milk usually comes in powder form and is based on processed, skimmed cows' milk, and is treated so babies can digest it. Vegetable oils, vitamins, minerals and fatty acids are added to make sure the milk contains the vitamins and minerals that young babies need. This information will be on the contents list on the pack. Infant formula powders are not sterile, so it is important to follow the **cleaning and sterilising** instructions on page 142.

Formula is either 'whey dominant' or 'casein dominant', depending on the balance of proteins it contains. It may also be referred to as stage one or stage two milk.

Whey-dominant milk is thought to be easier to digest than casein-dominant milk,

so should always be the first formula you give your baby.

There is little nutritional difference in the two forms of milk, so if whey-dominant formula milk suits your baby, they can stay on it for the first year or even longer.

'Ready-to-feed' infant formula milk in cartons is also available. This is generally more expensive than powdered milk. Once opened, the carton should be stored in the fridge with the cut corner turned down. Discard any unused milk after 24 hours.

Vitamin drops

Infants drinking less than 500ml (1 pint) or more of infant formula each day should receive a supplement of 10 micrograms of Vitamin D per day throughout the year. See pha.site/vitaminD. You can buy suitable drops at any pharmacy.

You can continue giving your baby infant formula when they are older than six months.

If you have any worries about the infant formula milk you are giving your baby, ask your midwife, health visitor or GP for advice.

Responsive bottlefeeding

Hold your baby close in a semi-upright position so that you can see their face, look into their eyes and talk



to them during the feed. Encourage your baby to open their mouth by gently rubbing the teat against their top lip.

Gently insert the teat into your baby's mouth and keep the bottle in a slightly tipped position not too upright so that you can stop milk from flowing too fast.

Learn to notice their early feeding cues, such as getting restless and hand sucking, which tell you your baby wants to be fed. Try not to wait until they are really crying and upset before you offer a feed. When feeding, notice when they have had enough and don't try to force them to take more than they want.

Don't let too many other people feed your baby, keep feeding as a special time for you, your partner and a few family members as this will help your baby feel safe and secure and will build up a close and loving bond with your baby.

Using formula milk safely

Powdered infant formula milk must be prepared as carefully as possible. It is not a sterile product, and even though tins and packets of milk powder are sealed, they can contain bacteria such as *Cronobacter*

sakazakii (formerly known as *Enterobacter sakazakii*) and, more rarely, salmonella.

If the feed is not prepared safely, these bacteria can cause infections. Infections are very rare, but can be life-threatening. Very young babies are at most risk, and it is better to use sterile, liquid ready-to-feed products for premature or low birth weight babies. Formula must therefore be made up with water hot enough to kill the bacteria – at least 70°C.

In practice, this means **boiling the kettle and leaving it to cool for no longer than 30 minutes**. Mix the formula and water and **cool quickly to feeding temperature in cold water**.

It's also essential to **make up a fresh bottle for each feed**. Throw away unused formula within two hours. Bacteria multiply rapidly at room temperature and can even survive and multiply slowly in some fridges, so storing formula milk for any length of time increases the risk.

Sterilising

All the equipment used for feeding your baby must be sterilised. By sterilising your feeding equipment, washing your hands and keeping the preparation area clean, you will reduce the chance of your baby getting sickness and diarrhoea.

The following cleaning and sterilising instructions apply whether you are using expressed breastmilk or infant formula milk.

- 1. Clean and rinse.** Clean the bottle and teat in hot soapy water as soon as possible after a feed, using a clean bottle brush. Rinse all equipment in cold, clean running water before sterilising.
- 2. Cold water sterilising.** Follow the manufacturer's instructions. Change the sterilising solution every 24 hours, and leave feeding equipment in the solution for at least 30 minutes. Make sure there is no air trapped in the bottles or teats when putting them in the sterilising solution once it is sterilised. Keep all the equipment under the solution with a floating cover. If you are using a cold water steriliser, shake off any excess solution from the bottle and the teat or rinse the bottle with cooled boiled water from the kettle (not the tap).
- 3. Steam sterilising (electric or microwave).** Follow the manufacturer's instructions. Make sure the openings of the bottles and teats are facing down in the steriliser. Any equipment not used straight away should be re-sterilised before use.

Preparing a feed

Step 1: Before making up a feed, clean and disinfect the surface you are going to use. Wash your hands carefully, stand the bottle on a clean surface. Keep the teat and cap on the upturned lid of the steriliser. Don't put them on the work surface.

Step 2: Use fresh tap water to fill the kettle. After it has boiled, let the water cool for no more than 30 minutes. Don't use artificially softened water or water that has already been boiled. If you have to use bottled water, you will still need to boil it. The water must still be hot, otherwise any bacteria in the milk powder might not be destroyed.

Always put the partially cooled boiled water in the bottle first.

Be careful – at 70°C, water is still hot enough to scald. Always check that the water

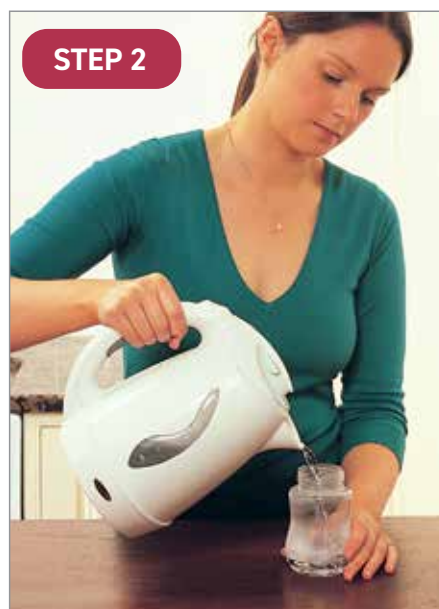
level is correct. Failure to follow the manufacturer's instructions may make your baby ill.



Step 3: Loosely fill the scoop with milk powder and level it off using the flat edge of a clean, dry knife or the leveller provided. Do not pat it down.



Step 4: Add the milk powder to the water. Repeat, until you have added the number of scoops specified in the manufacturer's instructions. It is important to use only the scoop that is enclosed with that milk powder. Using too much powder can give



your baby constipation and lead to dehydration; too little could mean that your baby is not getting the nutrients they need. Don't add sugar or cereals to the feed in the bottle.



Step 5: Holding the edge of the teat, put it on the bottle. Screw the retaining ring onto the bottle. Cover the teat with a cap. Shake the bottle until the powder dissolves.



Make sure you make up a fresh bottle each time you feed your baby and throw away unused feed

after two hours. Using stored formula milk can increase the chance of your baby becoming ill.

You can download the leaflet ***Bottlefeeding*** at pha.site/bottlefeeding

Feeding your baby

Always cool your baby's milk down before feeding. At 70°C, it is still hot enough to scald. To cool it, hold the bottle, with the cap covering the teat, under cold running water. Test the temperature of the feed by dropping a little onto the inside of your wrist. It should just feel warm to the touch, not hot.

If the milk is too cool, and your baby doesn't like it that way, you can warm it up a little by putting the bottle upright in some hot water, keeping the teat out of the water. Never warm milk in a microwave oven. It will continue to heat up for a time after you take it out of the microwave, even though the outside of the bottle may feel cold.

The milk inside may be very hot and could scald your baby's mouth.

Get everything you need ready before you start feeding. Find a comfortable position to hold your baby while you are feeding. You may need to give your baby time. Some babies take some milk, pause for a nap, and then wake up for more. So you might have to be patient. Remember, feeding is an opportunity to feel close to your baby and get to know them. Even when your baby is a little older, they should never

be left alone to feed with a propped-up bottle, as they may choke. You should check regularly that teats are not torn or damaged.

When feeding, make sure you keep the teat full of milk, otherwise your baby will take in air and get wind. If the teat becomes flattened while you are feeding, pull gently on the corner of your baby's mouth to release the vacuum. If the teat gets blocked, replace it with another sterile teat.

Bottles and teats

You might find it useful to have about six bottles and teats, so you can always have at least one or two bottles clean, sterilised and ready for use.

You should always buy new teats for your new baby. They come in different shapes and with different hole sizes, and you may have to try several before you find the one that suits your baby. If the hole is too small, your baby will not get enough milk. If it's too big, the milk will come too fast.

It's best if you can buy new bottles too. Check regularly to make sure the bottles are in good condition. If they are badly scratched, you will not be able to sterilise them properly. If in doubt, ask your midwife or health visitor for more information.



Bottled water

Bottled water is not a healthier choice than tap water and usually is not sterile. In fact, some natural mineral waters are not suitable for babies because of the amount of minerals they contain. If you need to use bottled water, remember that any bottled water that is labelled 'natural mineral water' might contain too much sodium for babies.

If you are giving bottled water to babies under six months, you should boil and cool it just like tap water. If you need to use bottled water to make up infant formula (for babies of any age), you should boil it and allow it to cool for no more than half an hour. Make up the formula feed and cool as previously stated.

At the end of the feed, sit and hold your baby upright and gently rub or pat their back for a while to bring up any wind. There is no need to overdo it – wind is not as big a problem as many people think. Talk to your baby as you rub or pat. This will help them feel closer to you and get them used to listening to your voice. Don't forget to

throw away any milk that is not used within two hours.

Most babies gradually settle into a pattern. Babies vary in how often they want to feed and how much milk they want to take. Feed your baby when they are hungry, just as you would if you were breastfeeding, and don't try to force your baby to finish a bottle. They may have had enough for the time being or just want a rest.

Feeding away from home

The safest way of feeding your baby away from home is to use a ready-to-feed milk. If this is not possible carry a measured amount of milk powder in a small clean and dry container, a flask of boiled hot water and an empty sterilised feeding bottle. Make up a fresh feed whenever you need it. The water must still be hot when you use it, otherwise any bacteria in the milk powder might not be destroyed. Remember to cool the bottle under cold running water before you use it.

If it's not possible to make up a fresh feed, or if you need to transport a feed – for example to a nursery or childminder –

you should prepare the feed at home and cool it in the back of the fridge for at least one hour. Take it out of the fridge just before you leave, and carry it in a cool bag with an ice pack and use it within four hours.

If you reach your destination within four hours, take it out of the cool bag and store it at the back of a fridge for a maximum of 24 hours. Re-warm for no more than 15 minutes.

Coping with allergies

If you think your baby might be allergic to formula milk, talk to your GP. They can assess the baby and, if necessary, prescribe formula feeds called extensively hydrolysed protein feeds.

Some formulas are labelled as hypoallergenic, but they are not suitable for babies with a diagnosed cows' milk allergy. Talk to your GP or health visitor before using this milk. Always get their advice before using soya-based infant formulas, too. Babies who are allergic to cows' milk may also be allergic to soya.

Babies sometimes grow out of allergies, and you may find that you can introduce cows' milk into your baby's diet as they get older. Always ask your GP or health visitor for advice before making any changes to your baby's diet.



under eight weeks old and has not passed a stool for a few days, talk to your health visitor or GP.

Water

In very hot weather, babies fed on infant formula milk can get thirsty. If this happens, you can give them cool boiled tap water if they seem unsettled between feeds. Talk to your health visitor or GP if you have any concerns.

Breastfed babies do not need any water. Instead, you may notice that they have shorter, more frequent feeds if the weather is hotter.

Breastfeeding is the healthiest way to feed your baby. If you use formula milk, it is very important to follow all instructions carefully. It is possible to reverse a decision not to breastfeed or to restart breastfeeding once you have stopped. Introducing partial bottlefeeding will reduce a mother's breastmilk supply.

Some common problems with formula feeding

Crying and colic

For information about crying and colic, see page 169.

Sickness and vomiting

Some babies bring up more milk than others during or just after a feed. This is called 'possetting', 'regurgitation' or 'gastric reflux'. It is not unusual for babies to bring up quite a lot, but it can be upsetting when it happens and you may be worried that something is wrong.

As long as your baby is gaining weight, there is usually nothing to worry about. But if your baby is violently sick or appears to be in pain, or you are worried for any other reason, talk to your health visitor or GP.

Cover your baby's front when feeding and have a cloth or paper towels handy to mop up any mess. Check too that the hole in your baby's teat is not too big, as giving milk too quickly can cause sickness. Sitting your baby upright in a baby chair after a feed can also help.

The problem usually stops after six months when your baby is starting on solid foods and drinking less milk.

If your baby brings up a lot of milk, remember that they are likely to be hungry again quite quickly. Don't force your baby to take on more milk than they want during a feed. Remember, every baby is different. Some prefer to feed little and often.

Constipation

Always stick to the recommended amount of infant formula milk powder. Using too much can make your baby constipated or thirsty.

Breastfed babies don't usually get constipated. If your baby is



Having a new baby is a very exciting time for the whole family, but the first few days with your baby can be a very emotional time for you and your partner. There is a lot to learn and do even if it is not your first baby. Getting to know your baby is the priority, but you will also be tired and your body will be recovering from labour and the birth.

How you feel

You may feel tired for the first few days, so make sure you get plenty of rest. Even just walking and moving about can seem like hard work.

For a lot of mothers, the excitement and the pleasure of the new baby far outweigh any problems. But you can begin to feel low or rather depressed, as your hormones change dramatically in the first few days. Some women get the 'baby blues' and feel rather weepy around three to five days after giving birth (see page 98).

This can be worse if your labour was difficult, you are very tired or you have other worries. Some women worry because they don't feel love for their baby immediately. You may just need to give yourself some time to adapt to motherhood.

If you feel you are not bonding with your baby, talk to your

partner or a family member.

Discuss your feelings with your midwife, health visitor or GP – help is available.

Postnatal care

If you have your baby in hospital, you may be able to return home with your baby

straight from the labour ward or you may be moved to a transfer lounge or a postnatal ward where you will be with other mothers and babies.

You should discuss your postnatal care with your midwife during pregnancy

Safety precautions during your stay in hospital

Smoking is not permitted and increases the risk of cot death. If you feel you may fall asleep while holding your baby, safely transfer your baby into the cot or call for assistance if you feel unable to do this safely. Always place babies in their own cot to sleep. Your baby should be dressed, changed, top and tailed in the cot. NEVER on the bed.

Reducing the risk of falls during your hospital stay

The height of your bed should be lowered to the lowest possible level before bringing a baby in beside you to breast feed. If you have limited mobility

you should call for help when moving a baby to and from the cot. If your call bell is not within reach or you need urgent help or assistance, shout "Help" as loud as you can. The safest position to breastfeed a baby in bed is where the mother is on her side facing the baby. It is important to ensure that your baby cannot fall on to the floor or become trapped in any way by bedding, the mother's body and the cot sides. Mothers may also be encouraged to hold and feed their baby in a semi-recumbent position. Parents and visitors should not carry babies between postnatal areas. The baby must be placed in a cot and wheeled.

although this may change depending on your labour and birth. You are likely to need quite a lot of help and advice with your first baby. Whether you are in hospital or at home, the midwives are there to guide and support you as well as to check that you are recovering from the birth. Don't hesitate to ask for help if you need it. A midwife will be available in your community to help you look after yourself and your baby.

For further information see www.nice.org.uk/guidance/ng194

Stitches

If you have had stitches, bathe the area often in clean warm water to help it to heal. Have a bath or shower with plain warm water. Afterwards, dry yourself carefully. In the first few days, remember to sit down gently and lie on your side rather than on your back. Pelvic floor exercises can also help you to heal (see page 47).

If the stitches are sore and uncomfortable, tell your midwife as they may be able to recommend treatment. Painkillers will also help. If you are breastfeeding, check with your midwife, GP or pharmacist before you take any over the counter products like ibuprofen or paracetamol (see page 136).

Usually stitches just dissolve by the time the cut or tear has healed, but sometimes they have to be taken out.

Going to the toilet

The thought of passing urine can be a bit frightening at first if you are sore or cannot feel what you are doing. Drinking lots of water dilutes your urine, but if it is difficult to pass urine, tell your midwife.

You probably will not need to open your bowels for a few days after the birth, but it's important not to let yourself become constipated. Eat fresh fruit, vegetables, salad and wholemeal bread and cereals, and drink plenty of water. Whatever it may feel like, it's very unlikely that you will break the stitches or open up the cut or tear again.

Bleeding

After the birth you will bleed from your vagina. This will be quite heavy at first, which is why you will need super-absorbent sanitary towels. Do not use tampons until after your postnatal check, as they can cause infections.

While breastfeeding you may notice that the discharge is redder or heavier. You may also feel cramps like period pain, known as 'after pains'. These are both because feeding causes the uterus to contract.

Gradually, the discharge will become a brownish colour and may continue for some weeks, getting less and less until it stops. If you find you are losing blood in large clots or notice an offensive odour, you should

save your sanitary towels to show the midwife as you may need some treatment.

If your bleeding becomes heavy

If your bleeding becomes heavy, soaks through pads quickly, contains large clots, or if you feel dizzy or unwell, seek medical help immediately. Contact your maternity team, GP, or go straight to the Emergency Department. For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/heavy-bleeding-after-birth-postpartum-haemorrhage

Rhesus negative mothers

If your blood group is rhesus negative and your baby's father's is rhesus positive, blood samples will be taken after the delivery to see whether your baby is rhesus positive. You may need an injection which will help to protect your next baby from anaemia. This should be given within 72 hours of delivery (see page 64).

Sex and contraception

Soon after your baby is born, a midwife or doctor will talk to you about contraception. If this doesn't happen, ask. You can become pregnant straight away, even if you are breastfeeding or have not had a period.

Make sure you are using a reliable form of contraception before you and your partner

have sex again, unless you want to get pregnant (see page 162 for your different contraceptive options). If you are breastfeeding, you may not have another period until you stop feeding, or even for some weeks or months after that. If you are not breastfeeding, your first period might start as early as a month after the birth, or it might be much later.

Your body

Your body will have gone through some major changes over the past few days.

Your breasts

Many women experience changes in the size of their breasts during pregnancy and breastfeeding. See chapter 10 for more information about this.

If you don't intend to breastfeed from the start, you need not do anything. But on the third or fourth day, your breasts may be tender as the milk is still being produced. Wearing a firm, supportive, well-fitting bra may help. Your breasts will reduce in size in a week or so. Speak to your midwife if you are very uncomfortable.

Your abdomen

Your abdominal muscles will probably be quite loose after delivery. Despite having delivered your baby plus the placenta and a lot of fluid, you will still be quite a lot bigger than you were before

pregnancy. This is partly because your muscles have stretched. If you eat a balanced diet and exercise, your shape should soon return to normal.

Breastfeeding helps because it makes the uterus contract. Sometimes, you may feel a quite painful twinge in your abdomen or period-type pain while you are breastfeeding.

Your bladder

It's quite common after having a baby to accidentally leak urine if you laugh, cough or move suddenly. Pelvic floor exercises (see page 47) will help with this. If the problem persists after three months, see your doctor, who may refer you to a physiotherapist.

For further information see www.rcog.org.uk/for-the-public/browse-our-patient-information/pelvic-organ-prolapse

Your bowels

Haemorrhoids, commonly known as piles (see page 83) are very common after delivery but they usually disappear within a few days. Eat plenty of fresh fruit, vegetables, salad, brown bread and wholegrain cereals, and drink plenty of water. This should make it easier and less painful when you pass a stool (bowel movement). Try not to push or strain as this will make the piles worse. Let

the midwife or GP know if you feel very uncomfortable. They will be able to give you an ointment to soothe the piles.

If you feel unwell after having your baby

If you feel unusually unwell at any time after the birth, trust your instincts. This includes feeling feverish, shivery, short of breath, very tired, confused, or in severe pain. These symptoms may be caused by an infection, which can sometimes lead to sepsis. Sepsis can develop quickly, so it's important to get help straight away. Contact your maternity team, GP, or go to the Emergency Department without delay. Always tell them that you have recently given birth.

Further information is available at www.nice.org.uk/guidance/ng255

Your baby's health

When your baby is born, they will have a head to toe examination to check that there are no major problems that need urgent treatment. Within 72 hours of birth, another more detailed examination will be carried out. Your baby will also have some other routine health checks and care.

Cord care

Shortly after birth, the midwife will clamp the umbilical cord close to your baby's navel with a plastic clip. They then cut the cord, leaving a small bit of cord

with the clamp attached. The cord will take about a week to dry out and drop off. Use warm water to clean the navel and dry carefully until this happens. If you notice any bleeding, smell or discharge from the navel, tell your midwife, health visitor or doctor at once.

Vitamin K

We all need vitamin K to make our blood clot properly so that we will not bleed too easily. Some newborn babies have too little vitamin K. Although this is rare, it can cause them to bleed dangerously into the brain.

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

Newborn hearing screening

Your baby will be offered a newborn hearing screening test shortly after birth.

The aim of this screening programme is to identify babies born with a permanent childhood hearing impairment (PCHI) at an early stage, to allow for timely intervention and improved outcomes for baby.

Approximately 1-2 babies in every 1,000 are born with a permanent hearing loss in one or both ears. (This increases to approximately 1 in every 100, for babies who spend more than 48 continuous hours in a neonatal intensive care unit or special care baby unit.)

Consent to participate must be provided by the person(s) with parental responsibility. The screening test is carried out by a trained screener and will usually be done in the maternity unit before you go home or at an outpatient clinic, within the first few weeks following birth. The test is painless and is usually done while baby is sleeping.

Further information regarding this screening programme can be found at www.publichealth.hscni.net/directorate-public-health/service-development-and-screening/newborn-screening

It is important to note that hearing loss can occur at any age, therefore, if you have any concerns regarding your baby's hearing you should discuss this with your health visitor or GP.

Newborn blood spot screening programme (heel prick test)

In the first week after your baby's birth, ideally when they are five days old, your midwife will offer to take a

sample of blood from their heel. This is used to screen for nine rare but potentially serious illnesses. All babies are offered this screening test for cystic fibrosis, congenital hypothyroidism (CHT), sickle cell disease (SCD) and six inherited metabolic disorders: phenylketonuria (PKU), medium-chain acyl-coA dehydrogenase deficiency (MCADD), maple syrup urine disease (MSUD), isovaleric acidemia (IVA) glutaric aciduria type 1 (GA1) and homocystinuria (HCU). Most babies who are screened will not have any of these conditions but, for the small numbers who do, early treatment can improve their health and prevent severe disability or even death.

More information

For further information on newborn blood spot screening visit: www.publichealth.hscni.net/directorate-public-health/service-development-and-screening/newborn-screening

Inherited metabolic disorders

As early as possible, before your baby is born, you should inform the health professional (obstetrician or midwife) looking after you if you or your baby's father have a family history of an inherited metabolic disorder (IMD). You may be offered referral to a genetic specialist, who will be able to answer any questions or discuss any concerns you may have.

Medium-chain acyl-coA dehydrogenase deficiency (MCADD)

If a family member has MCADD tell your midwife and doctor as soon as possible. They will make a record on your notes and refer you to the genetics clinic for further advice.

Tuberculosis (TB)

TB is a serious infectious disease that can lead to TB meningitis (swelling of the lining of the brain) in babies.

In young people and adults it usually affects the lungs, but it can also affect the glands, brain or bones. Prevention is by the BCG vaccine which helps your baby develop protection (immunity) against the disease.

You will be asked the following questions during pregnancy and again after birth:

- Are you, your family or your baby's father or his family from a country with high rates of TB?
- Are you likely to be living for more than a month, or travelling frequently, in a country with high rates of TB?
- Does anyone in your house, or anyone else who is likely to have long term contact with your baby, have TB, or have had it in the past, or come from one of these countries?

If you answer 'yes' to any of these questions then you will be offered the BCG vaccine for your baby.

Your baby's appearance

Your baby's appearance will change in the first few days after birth and as you get to know your baby you will notice every detail – the colour and texture of their hair, the shape of their hands and feet, and the different expressions on their face. If you see anything that worries you, however small, ask your midwife. Your baby will be examined by a midwife, paediatrician or neonatal nurse practitioner to make sure everything is all right.

The fontanelle

On the top of your baby's head, near the front, is a diamond-shaped patch where the skull bones have not yet fused together. This is called the fontanelle. It will probably be a year or more before the bones close over. You may notice the fontanelle moving as your baby breathes. Don't worry about touching it gently or washing the area. There is a tough layer of membrane under the skin but be careful not to bump this area accidentally.

Marks and birthmarks

Some newborn babies are born with a swelling and bruises on the head, and perhaps bloodshot eyes. This is just the

result of the squeezing and pushing that is part of being born and will soon disappear.

Once you begin to look closely at your baby, you may find some marks and spots, mainly on their head and face. Most of them will go away eventually. Ask the doctor or midwife who examines your baby if they should disappear completely.

Some babies have little pink or red marks commonly known as 'stork marks'. Marks on the forehead and upper eyelids gradually fade, though it may be some months before they disappear altogether. Marks on the nape of the neck can stay for much longer.

Strawberry birth marks are also quite common. They are dark red and slightly raised. They sometimes appear a few days after birth and may gradually get bigger. They take a while to go away.

Spots and rashes are quite common in newborn babies and may come and go. However, you should tell your doctor or midwife immediately if you also notice a persistent rash and a change in your baby's behaviour, for example if your baby is not feeding properly, very sleepy or very irritable.

Your baby's skin

At birth, the top layer of your baby's skin is very thin and

easy to damage. Over the first month (longer in premature babies) your baby's skin matures and develops its own natural protective barrier. Vernix is the white sticky substance that covers your baby's skin in the uterus. It should always be left to absorb naturally. This is nature's own moisturiser and gives added protection against infection in the first few days.

Premature babies' skin is even more delicate. Staff in a specialised neonatal area will advise you on skin care.

If your baby is overdue, their skin may well be dry and appear cracked. This is to be expected, as the protective vernix has all been absorbed. Don't be tempted to use any creams or lotions as they may do more harm than good. The top layer of your baby's skin will peel off over the next few days, leaving perfect skin underneath. Wash your baby with plain water only for at least the first month.

Breasts and genitals

A newborn baby's breasts can be a little swollen and ooze some milk, whether the baby is a boy or a girl. Girls also sometimes bleed a little or have a white, cloudy discharge from their vagina. These are a result of hormones passing from the mother to the baby before birth and are no cause for concern.

The genitals of male and female newborn babies may appear rather swollen, this will settle fairly quickly.

Jaundice

When they are about three days old, many babies develop mild jaundice. This will make their skin and the whites of their eyes look a bit yellow. This usually fades within 10 days or so. If you are concerned about your baby's jaundice in the first 10 days contact your community midwife. More severe jaundice may need treatment (see page 180). If jaundice develops in the first 24 hours expert medical advice is required.

Rubella

If you were not immune to rubella (German measles) when tested early in your pregnancy, you will usually be offered the MMR (measles, mumps and rubella) immunisation.

You should get the first dose before you leave hospital and the second from your GP. If it is not offered, speak to your doctor or midwife. You should ensure you do not get pregnant again for one month after the injection. For more information about rubella, visit pha.site/rubella

If you have previously had two doses of MMR then you will not require further vaccination.

Tests for hepatitis B and C

All babies born to mothers who are infected with hepatitis B should receive a course of immunisation to prevent them getting hepatitis B. Your baby will be offered immunisation within 24 hours of birth, at one month and 12 months of age as well as having hepatitis B in the routine vaccinations at two, three and four months of age. Your baby should be tested at 12 months to check that immunisation has worked. For more information about hepatitis B immunisation, refer to page 51.

If you are infected with hepatitis C when your baby is born, there is a small risk that you could pass on the infection. Your baby will be tested at an appropriate time.

Personal child health record (PCHR)

You will be given a PCHR for the baby (also known as the red book) within a few days of their birth. This book records important information about your child. Take it with you whenever you see anyone about your child's health or development. This is your record, so do add information yourself. This could be a note of when your child does something for the first time or advice given to you by a healthcare professional.

12

What you need for your baby

12

What you need for your baby

It can be easy to get confused about what you really need for your baby. You can always ask your midwife or health visitor for advice on what to buy, and you may be given a list of essentials at your antenatal classes or by your maternity service. There are some essentials that every new mother needs, as well as extras that you might want to think about. There is extensive marketing and a wide range of products available for infants and babies. It is not essential to have all of these items and remember babies grow out of things very quickly. You may be able to borrow some items, and then pass them on later to another mother or keep them for a second child.

Nappies

Cloth nappies

Washable cloth nappies are cheaper than disposable nappies, even when you take into account the cost of washing them at home or getting them washed by a laundry service. They are more environmentally friendly and are easily laundered in a 60°C wash. You can get shaped cloth nappies with Velcro or popper fastenings and waterproof wraps.

For cloth nappies, you will need:

- nappy pins for nappies without Velcro or fasteners;
- nappy liners – either disposable or cloth, which you can wash and use again;
- a bucket with a lid and nappy sterilising powder or liquid for sterilising nappies;

- about four pairs of plastic pants that are either tie-on or elasticated. Tie-on ones will fit small babies better. Some cloth nappies have the waterproof wraps attached.

Nappy services

Nappy laundry services deliver freshly laundered nappies to your home and take away the soiled ones to wash each week.

They supply everything you need – wraps, liners and storage bins. Ask your health visitor or check online for local services.

Disposable nappies

Disposable nappies are convenient to use and are available from supermarkets and other retail outlets.



Nappy changing

To change nappies, you will need:

- white cotton wool, for washing and drying - rolls are usually cheaper than balls, or plain water wipes if preferred although these will be more expensive;
- a changing mat;
- container for plain water;
- a bag to carry all the nappy-changing equipment when you go out - a carrier bag will do but you can get special bags that include a changing mat.

Safety

The safest place to change a nappy is on a mat on the floor. If you use a higher surface, keep your hand on your baby at all times to stop them rolling off. See page 172 for how to change your baby's nappy.



Bathing

It is a personal choice how frequently you bathe your baby; a wash will often be enough to keep your baby clean and ensure they are comfortable. Some babies enjoy the bath and for some a warm bath may help them to sleep.

You will need:

- A baby bath or any large, clean bowl.
- Two towels, the softer the better. Keep them only for your baby's use. There is no need for special baby towels, unless you want them.

Washing your baby with just plain water is recommended for the first month. See page 175 for how to bathe your baby.

Sleeping

For the first few months, you will need a crib, a carry cot or a moses basket (a light, portable bassinet).

Your baby needs somewhere to sleep that is flat, safe and warm and not too far away from you. If you are borrowing a crib or cot, or if you have one that has been used by another of your children, you will need a new mattress.

You will also need:

- A firm mattress that fits the cot snugly without leaving space round the edges so that your baby cannot trap their head and suffocate.
- Sheets to cover the mattress. You need at least four because they need to be changed often. Fitted sheets make life easy but they are quite expensive.
- Light blankets for warmth. Specially designed sleeping bags are useful for babies who are kicking off their blankets. However if using check the weight and size of the sleeping bag is suitable for your baby. Make sure it is fitted with neck and armholes, and no hood.

Reducing the risk of unexpected death in infancy

Sudden infant death that remains unexplained is very rare. An infant is at higher risk of sudden infant death during sleep.

Never sleep with your baby on an armchair or sofa. Never allow your baby to share a bed with anyone who has been smoking, drinking alcohol, or taking drugs including prescription medication.

Speak to your midwife, health visitor, family nurse or GP if

The safest place for your baby to sleep is on their back in a moses basket or cot in your room for the first six months.

The baby on the left is sleeping in the 'feet to foot' position (also see page 170). This means that the baby's feet are right at the end of the cot to prevent the baby wriggling under the covers and overheating.



you need more information about reducing the risk of sudden infant death, or if you feel strongly that you wish your baby to sleep with you instead of in a cot or Moses basket. For more detailed information on sudden infant death see page 169.

Cot safety

Your baby will spend many hours alone in a cot, so make sure it's safe. It is recommended that a new cot mattress is used for each baby.

- The mattress must fit snugly with no space for your baby's head to get stuck.

Immunisation reduces the risk of sudden infant death. For more information about immunisation, visit pha.site/immunisation-and-vaccinations

- The bars must be smooth and securely fixed, and the distance between each bar should be not less than 1 inch (25mm) and not more than 2½ inches (60mm) so that your baby's head cannot become trapped.
- The cot should be sturdy.
- The moving parts should work smoothly so that fingers or clothing cannot get trapped.

- Infants should never sleep using cushioned sleeping pods, nests, baby hammocks or cot bumpers.
- Never leave anything with ties – for example, bibs or clothes – in the cot in case they get caught around your baby's neck.
- Do not hang toys or objects that could be hazardous on the cot or bed.
- If you are buying a new cot, look for the British Safety Standard BS1877-10:2011.
- If you are buying a new mattress look for British Safety Standard BS 1877-10: 2011.

Do

- For at least the first six months your baby must be in the same room as you or their carer for every sleep (day and night). Your baby must have a clear, flat sleep surface (no pillows, no quilts or duvets, no bumpers, no soft toys or comforters, no pods, nests or sleep positioners).
- Place your baby to sleep on their back in the 'feet to foot' position (feet touching the bottom of the cot).
- Use a light blanket firmly tucked no higher than the baby's shoulders.
- Use a clean, firm, well-fitting mattress.
- Breastfeed if you can, because it reduces the risk of sudden infant death.
- Put your baby back to sleep in their cot after any feeding.
- If using a baby sleeping bag, make sure it is fitted with neck and armholes, and no hood.

Don't

- Allow your baby to share a bed with anyone who has been smoking, drinking alcohol, taking drugs (including medication) or is feeling exhausted.
- Sleep with your baby on an armchair or sofa.
- Allow your baby to sleep alone in an adult bed.
- Cover your baby's head.
- Allow anyone to smoke around your baby.
- Allow your baby to become overheated as they can't control their own body temperature.
- Leave your baby sleeping in a car seat for long periods or when not travelling in the car.
- Put pillows, loose blankets, cot bumpers, soft toys, comforters or sleep positioners in your baby's cot.
- Sleep with your baby if they were born prematurely (before 37 weeks of pregnancy) or weighed under 2.5kg (5.5 pounds) when they were born.

Tips for safer bedsharing

- Put your baby on their back in a clear, flat sleep space.
- Keep pillows and adult bedding away from your baby to avoid obstructing breathing or overheating.
- Do not leave your baby alone in an adult bed.
- Make sure your baby cannot be trapped, wedged or fall out of bed or get trapped between the mattress and wall.
- Do not have other children or pets sharing the bed as this may lead to suffocation or overheating your baby.

Out and about

Spend some time looking at what is available for getting

around with your baby. Think about what will suit you best. Always choose transport that allows your baby to face you and not forward to ensure you can communicate with the baby when out. You could always ask other mothers what they have found useful.

A baby sling or carrier lets you hold your baby close. Slings that use knots or rings to hold the two ends of the fabric pose a safety risk because the knots can loosen or the fabric can slip through the rings, causing your baby to fall.

- Choose a carrier that fits you and your baby. A sling should be tight enough to keep your baby close to your body.



- Your baby's face should be easily visible.
- Your baby should be close enough to kiss the top their head.
- Make sure there is a gap, at least one finger width between your baby's chin and chest so your baby can breathe easily.
- The baby's back should be supported in its natural position with the tummy and chest against you.
- Choose a carrier that comes with detailed, easy to follow instructions and follow them carefully.
- Be cautious when bending over while wearing the carrier. Hold onto the baby with one hand and bend at the knees.
- Don't cook with the baby in the carrier. Your baby could get burnt.

Blind cord safety

Looped cords such as blind cords and chains can pose a risk to small children. Research indicates that most accidental deaths involving blind cords happen in the bedroom and occur in children between 16 months and 36 months, with the majority happening at around 23 months.

Making it safe

To reduce the risk posed by looped cords, including blind cords, cords should be kept out of the reach of children.

Install blinds that do not have a cord, particularly in a child's bedroom.

Do not place a child's cot, bed, playpen or highchair near a window.

Pull cords on curtains and blinds should be kept short and out of reach of children.

Tie up the cords or use one of the many cleats, cord tidies or clips that are available.



Pushchairs are only suitable for young babies if they have fully reclining seats that let your baby lie flat. Wait until your baby can sit up before using any other type of pushchair. You should also consider the weight of the pushchair if you use public transport as you might have to lift it onto trains or buses.

Prams give your baby a lot of space to sit and lie comfortably, although they take up a lot of space and are hard to use on public transport. If you have a car, look for a pram that can be dismantled easily. Buy a pram harness at the same time, as you will soon need it.

Carrycot on wheels. Your baby can sleep in the carrycot for the first few months and the cot can be attached to the frame to go out. It can also be taken in a car with appropriate restraints.

Three-in-one. This is a carrycot and transporter (set of wheels) that can be converted into a pushchair when your baby outgrows the carrycot.

Shopping trays that fit under the pushchair or pram can be very useful when you are out.

Before buying a pushchair or pram, check that:

- baby can face you at all times;
- the brakes are in good working order;
- the handles are at the right height for pushing, and;
- the frame is strong enough.

In the car

If your child travels in a car they are required by law to travel in an appropriate child car seat until they are 12 years old or 135cm tall, whichever comes first.



There are a few different types of seat that will be suitable for your new born baby, the most commonly used are infant carriers, which have a carry handle and can be easily removed from the car, however some seats that are fixed in the vehicle will also be suitable.

Currently there are two safety regulations that seats sold in the UK must comply with. ECE **R44/04**, which is height based and the more recent **R129** or **"i-Size"** which is weight based. The best seat for your baby is one that gives a solid installation in the vehicle that it is intended to be used in AND gives a good fit for baby.

Important points to consider when choosing your baby's seat:

- Rear-facing is the safest way to travel for all young children, preferably until **at least** age four.
- Seat belt installation is just as safe as ISOFix, provided it is installed correctly. Always check the manual that comes with your child seat and ensure the retailer shows you how to install it correctly.
- **Never** buy a second hand seat, it may have been in an accident and would not

protect your baby in any future accident.

- Be aware of a seats weight and height restrictions. A seat must **never** be used beyond the manufacturers stated limits, this will be shown on the orange label attached to the seat. I-Size infant carriers can have different height limits, check the seat before you buy it, a bigger height limit means the seat will last longer before being outgrown.
- Although it is still legal to use seats tested to R44/03 standard (but not to sell) it is not recommended. R44/03 seats could be up to 25 years old and although seats do not have an expiry date the materials can degrade over time. Manufactures recommend 6-10 years of use before a seat should be replaced. This also allows for advances in safety.

Important safety considerations:

- Babies should not be in their car seat for extended periods of time, **maximum 30 minutes for very young babies**. This is because their neck muscles are not developed enough to support their heads and the upright position of the seat can lead to breathing difficulties if in this position for a long time.

- Head flop is dangerous in babies under six months as it can affect breathing.
- It is **illegal**, and very dangerous, to put a rear facing seat in the front seat of a car with an active airbag. Some cars come with the function to deactivate the airbag (usually with the vehicle key) or your car dealership may be able to do this, check your vehicle manual. Your vehicle manual will also tell you which seat positions can be used for different child restraints. Always check the manufacturers website to ensure that the seat is compatible for the vehicle it is to be used in.
- **Never** add anything to your car seat that has not been crash tested, as it may affect how your seat preforms in an accident.
- **Never** place a baby/child in a car seat with thick clothes on, as they can affect how well the harness hugs the body. Always layer blankets over the harness to keep baby warm and remove if needed, young babies can overheat easily.
- Never leave your baby/child unattended in the car. Cars can get very hot very quickly and children can die in hot cars.

Feeding

If you are going to breastfeed, you may want:

- Nursing bras that open at the front and have adjustable straps. Cotton is best because it allows air to circulate. If you try on bras at about 36–38 weeks, they should fit when you need them.
- Breast pads. You put these into your bra to prevent milk from leaking onto your clothes.

If you are going to formula feed, you will need:

- Six bottles with teats and caps.
- Sterilising equipment.
- A bottle brush.
- Infant formula milk. Avoid buying this too far in advance, as infant formula milk has a 'use by date' printed on the package.

See chapter 10 for how to feed your baby.

Clothes

There is extensive marketing and a wide range of products available for infants and babies. It is not essential to have all of these items and remember babies grow out of things very quickly. All you need for the first few weeks are

enough clothes to make sure that your baby will be warm and clean. You will probably need:

- Six stretch suits for both day and night.
- Two cardigans. They should be wool or cotton rather than nylon, and light rather than heavy. Several light layers of clothing are best for keeping your baby warm.
- Six vests.
- A shawl or blanket to wrap your baby in.
- A woollen or cotton hat, mittens and socks or booties for going out if the weather is cold. It's better to choose close-knitted patterns for safety.
- A sun hat for going out if the weather is hot or the sun is bright.

Washing baby clothes

If you use a washing machine, don't use washing powders with enzymes (bio powders) or fabric conditioner, as they may irritate your baby's skin. Always rinse clothes very thoroughly.



13

The early weeks: you

13

The early weeks: you



Your first few weeks at home can be an exciting but anxious time as you get used to caring for your new baby.

If you have been in hospital or a midwifery unit, you may feel apprehensive about being on your own without staff on call to help you. The more you handle your baby, the more your confidence will increase. Your community midwife, health visitor and GP are there to support you

if you have any worries or problems. Ask your midwife or health visitor for a copy of the book *Birth to five*, which has advice on looking after your child up to the age of five.

Help and support

You will probably need a lot of practical help, as well as emotional support. You are bound to feel up and down and to get tired easily in the first few weeks. Many women want to have their partner around so that you get to know the baby together and have help with the work. Being together at this time helps you to start to adjust to the changes in your life. If you are on your own, or your partner cannot be with you, ask your mother or a close friend to be there.

Even with help, you will probably feel tired. Here are some things you could try:

- Keep meals simple but healthy. You need to eat well but this need not involve a great deal of preparation and cooking.
- Try to space visitors out and say no to visitors if you feel too tired or need some time with your baby.
- Too many visitors in a short time can be very tiring. If visitors do come, don't feel you have to tidy up or lay on a meal. Let them do things for you, like the washing up, making a meal or bringing some groceries.
- Get help with the housework.



- If you need extra help, ask. Friends or neighbours will probably be very willing to help you by doing things like shopping.

Looking after yourself

Although you may feel like your every waking hour is spent caring for your baby, it's important to look after yourself as well.

Rest

While you are feeding your baby at night and your body is recovering from childbirth, it is essential to get as much rest as possible.

It's tempting to use your baby's sleep times to catch up on chores, but try to have a sleep or a proper rest, preferably in bed, at least once during the day.

Exercise

Continue with any postnatal exercises you have been

shown by your midwife. You can also do this deep stomach exercise when you feel well enough.

1. Lie on your side with your knees slightly bent.
 2. Let your tummy relax and breathe in gently.
 3. As you breathe out, gently draw in the lower part of your stomach like a corset, narrowing your waistline.
 4. Squeeze your pelvic floor.
 5. Hold for a count of 10 then gently release.
 6. Repeat 10 times.
- You should not move your back at any time. After six weeks, progress to the box position (see page 46).

Besides these exercises, try to fit in a walk with your baby every day. This can help you lose weight and feel better.

Eating properly

It's very important to eat properly (see chapter 5). If you want to lose weight, don't rush it. A balanced varied diet and regular activity will help you lose weight gradually. Try to make time to sit down, relax and enjoy your food so that you digest it properly. It doesn't have to be complicated. Try food like baked potatoes with baked beans and cheese, salads, pasta, French bread pizza, scrambled eggs or sardines on toast, followed by fruit mixed with yogurt or fromage frais.



A healthy diet is especially important if you are breastfeeding. Breastfeeding can help mothers to lose weight. Some of the fat you put on in pregnancy will be used to help produce milk, but the rest of the nutrients will come from your diet. This means that you may be hungrier than usual. If you do need a snack, try having beans on toast, sandwiches, bowls of cereal or fruit (see page 31).

Further information is available at www.nice.org.uk/guidance/ng235

Sure Start Centres give advice about healthy eating plans for mothers, as well as support for breastfeeding. You can find out more about the services offered in your area by visiting pha.site/sure-start

Eating well as a new mum

www.youtube.com/watch?v=kVilOLT3itE





Your relationships

After you have had a baby, the relationships around you can change. Many women find that they turn to their own mother for help and support. But your mother may not be sure about how much to get involved. You may find that she is trying to take over or that she is so anxious not to interfere that she doesn't help at all. Try to let her and others know what help and support you want from them.

Your relationship with your

partner will also change. It is very easy in those exhausting early weeks just to leave things to sort themselves out. You may wake up six months later to find that you have not spent an hour alone together and have lost the knack of easily talking



your problems through. You both need time alone, without the baby, to recharge your own batteries. You also need time together, without the baby, to keep in touch with each other.

Your relationship with your baby may not be easy either, particularly if you are not getting much sleep. Don't feel guilty if you sometimes feel resentful at the demands your baby makes, or if your feelings are not what you expected them to be. Talk to your midwife or health visitor if you are upset or worried. If you are on your own and don't have family to support you, ask a friend to help you in the early weeks.

Sex and contraception

There are no rules about when to start having sex again. Don't rush into it – if it hurts, it will not be pleasurable. You may

Partners

As the mother's partner, you can get involved in caring for your baby from day one. In the first weeks, you can:

- help your partner to breastfeed by:
 - spending time with her while the baby is feeding;
 - bringing your baby to your partner when they need feeding in the night;
 - helping to wind your baby;
- change your baby's nappies;
- bathe and dress your baby;
- cuddle and play with your baby;
- getting specialist help and information on breastfeeding if your partner has any concerns;
- provide emotional support and encouragement;
- make nutritious meals and snacks for your baby's mother;
- clean the house, go shopping and do other household chores.

You may feel quite nervous about handling the baby at first but you will get more confident. Don't be embarrassed to ask for help or advice.



want to use lubricating jelly the first time because hormone changes may make your vagina feel drier than usual.

It might be some time before you want to have sex. Until then, you both may feel happier finding other ways of being loving and close. If you or your partner have any worries, discuss them with your GP or health visitor.

It is possible to get pregnant even if you have not started your periods again or if you are breastfeeding. It is therefore important to use contraceptives as soon as you start having sex again.

Your midwife or doctor should talk to you about contraception before you leave hospital and again when you go for your six-week postnatal check. Alternatively, you could talk to your midwife or health visitor when they visit at home or go to your GP or family planning clinic.

For further information about methods of contraception visit www.sexualhealth.info or www.sexwise.fpa.org.uk

Short-acting contraceptive methods

Short-acting contraceptive methods rely on you taking them every day or when you have sex.



- The condom. This may be the easiest choice for the early weeks after childbirth. Condoms offer the best protection against sexually transmitted infections (STIs). If you think you or your partner may have been exposed to an STI you should use a condom in addition to your other choice of contraception. Ask your GP to investigate and provide treatment.
- The progestogen-only pill. If you are breastfeeding, you can take a progestogen-only pill, which will not affect your milk supply. This can also be started 21 days after you give birth. It has to be taken at the same time every day. If you start it later than the 21st day, it will not be reliable for two days. So for this time you will have to use some other form of contraception (like a condom) as well. There is no evidence to suggest that this pill affects your baby in any way. Even so, some women prefer not to take it while they are breastfeeding and use another form of contraception instead.



- The combined pill. If you are not breastfeeding, you can start taking this pill 21 days after you give birth. If you start it later than the 21st day, it will not be reliable for the first seven days. So for this time you will have to use another contraceptive (like a condom) as well. Don't take this pill if you are breastfeeding as it reduces milk supply.
- The cap or diaphragm. These can be used six weeks after you give birth. If you had a cap before, it probably will not be the right size any longer. You can have a new one fitted at your family planning clinic (FPC), see sexualhealthni.info/contraception for more information.

Long-acting contraceptive methods

Long-acting contraceptive

methods last between three months and ten years. They may be suitable if you think you will forget to take or use a short-acting contraceptive.

- The IUD (intra-uterine device) or IUS (intra-uterine system). These can be fitted from the fourth week after you give birth. They can be fitted at your postnatal check-up or FPC when your uterus is back to its normal size.
- The contraceptive injection. It is recommended that you wait until six weeks after you give birth before you are given this. It can be given earlier in some circumstances. The contraceptive injection will not affect your milk supply if you are breastfeeding.
- The contraceptive implant. This contains a long-lasting progestogen and is effective for three years. It can be fitted 21 days after you give birth or earlier in some circumstances. If it's fitted after 21 days, you

will have to use another contraceptive for seven days. The contraceptive implant will not affect your milk supply if you are breastfeeding.

The 'baby blues' and postnatal depression

As many as 8 out of 10 mothers get the 'baby blues', most often about three to five days after the birth. You might feel upset, mildly depressed, or just keep bursting into tears for no apparent reason. It usually only lasts for a few days.

Around 1 in 10 mothers become depressed. This is usually mild but sometimes can be quite severe. You must get help if you are feeling sadness and hopelessness, irritable and anxious, or have difficulty sleeping and coping with even the smallest task. See page 92 for more information.

Mood Matters

Mood Matters Parent and Baby is a mental health awareness programme from Aware which can give you knowledge and

skills to help you look after the mental health of you and your baby. It is delivered using a range of methods including group activities, discussions, video clips, and animation, music and fun activities.

Mood Matters Parent and Baby lasts one-and-a-half to two hours and is available in a range of settings. Content is tailored to meet the needs of each group and the programme is available to expectant parents and parents with young children.

For further information visit www.aware-ni.org and www.nice.org.uk/guidance/cg192

Help and support

If you think you are depressed, contact your GP or health visitor and explain how you are feeling. Your partner or a friend could contact them for you if you want.

If you have twins or triplets, you are more likely to experience postnatal and longer-term depression. This is mainly because of the additional stress of caring for more than one baby. Just getting out of the house can be difficult when you have more than one baby, and this can make you feel isolated. Twins Trust (www.twintrust.org) can help you make contact with other mothers of multiples via local twins clubs.





Your postnatal check

You should have your postnatal check about six weeks after your baby's birth to make sure that you are recovering from the birth. You may be offered an appointment to go back to the hospital or midwifery unit where you gave birth, but otherwise you should see your GP.

It's a good opportunity to ask any questions and sort out any problems that are troubling you. You may like to make a list of questions to take along with you so that you don't forget what you want to ask.

What usually happens

- You will be weighed and can get weight loss advice if you need it.
- You should be asked about how you are feeling.
- Your urine will be tested to make sure your kidneys are working properly and that there is no infection.

- Your blood pressure will be checked.
- You may be offered an examination to see if:
 - your stitches (if you had any) have healed;
 - your uterus is back to its normal size;
 - all the muscles used during labour and delivery are returning to normal.

Tell the doctor if the examination is uncomfortable.

- Your breasts are unlikely to be examined unless you have a particular concern.
- A cervical screening test may be discussed if you have not had one in the past three years (see page 66). This is usually delayed until three months after delivery.
- If you are not immune to rubella (German measles) and received your first immunisation before you left hospital, you will be offered your second one

now. If you received no immunisation in hospital you will need two doses. You should ensure you do not become pregnant for one month after this immunisation.

- You will be asked if you still have any vaginal discharge and whether you have had a period yet.
- Tell your doctor if:
 - you are having trouble holding in urine or wind, or you are soiling yourself;
 - intercourse is painful;
 - you are feeling very tired, have a low mood or depressed;
 - you are worried about anything.

You can also ask your doctor about contraception. You may wish to choose a different method to the one you had previously used (especially if your pregnancy was not planned). The doctor or nurse can help you decide which method is right for you now.

Your baby's check

You will need to arrange separately for your baby's six-week check. Remember to take the Personal Child Health Record, also known as the PCHR or 'red book'.



In the first few weeks, you will be learning how to look after your baby. You will start to understand them and will learn what is normal and what may be a sign that something is wrong. But the most important thing to do in the first few weeks is to enjoy your baby. Spending time with them is the best way to help them feel safe and loved.

Getting to know your baby

Keeping your baby warm, fed and safe will be your first priority in the first weeks. Every second that your baby is awake, they are learning from you. Learning about what it feels like to be touched gently, the sound of your voice and your very special smell.

They are learning about what the world is like and, above all, what it feels like to love and be loved.

Talking to your baby

It is very important to talk to your baby. You can talk to them about anything and everything. Talking to young children, even very young babies helps them become good communicators later in life. It will also help your baby build their early bond with you. If you or your family speak

Changing Time is Chatting Time

Changing Time is Chatting Time is a video by Sure Start SLTs encouraging parents to smile, talk and interact with their baby as they change their nappies.

www.youtube.com/watch?v=DkTf2BzoahQ

another language, use it to speak to your baby. It is quite amazing how babies and small children pick up and respond to two different languages. See chapter 4 for more on Getting to know your baby.

Registering the birth

Your baby's birth must be registered within six weeks from when they were born. This will take place at the registration office in the district where they were born.

Tummy time

- Helps build muscles that your baby need for activities like sitting and crawling.
- Helps promote a more rounded head shape.
- Tummy time should be carried out as often as possible when your baby is awake, alert and happy. If your baby has medical problems and you need further advice regarding tummy time, please contact your health visitor or health care professional.

Remember your baby must always sleep on their back to reduce the risk of cot death.

You can find details online at pha.site/register-baby



If you live in a different district from the one where your baby was born, you can go to your nearest registration office. The registrar will take details from you and then send them to the district where your baby was born. You will then be sent the birth certificate. You cannot claim benefits, such as Child Benefit, until you have a birth certificate.

Many parents choose to purchase a 'long' birth certificate as this may be necessary in the future, such as for passport applications.

Who can register a birth

Opposite-sex couples

Married parents

Either parent can register the birth on their own. They can include both parents' details if they were married when the baby was born or conceived.

Unmarried parents

The details of both parents can be included on the birth certificate if one of the following happens:

- they sign the birth register together;
- one parent completes a statutory declaration of parentage form and the other takes the signed form to register the birth;

- one parent goes to register the birth with a document from the court (for example a court order) giving the father parental responsibility.

The mother can choose to register the birth on her own if she isn't married to the child's father. The father's details won't be included on the birth certificate.

It might be possible to add the father's details at a later date by completing an application for the re-registration of a child's birth.

Same-sex female couples

Female couples can include both their names on their child's birth certificate when registering the birth.

Married or civil-partner parents

Either parent can register the birth on her own if all of the following are true:

- the mother has a child by donor insemination or fertility treatment;
- she was married or in a civil partnership at the time of the treatment.

Unmarried, non-civil-partner parents

When a mother isn't married or in a civil partnership, her partner can be seen as the child's second parent if both women:

- are treated together in the UK by a licensed clinic;
- have made a 'parenthood agreement'.

However, for both parents' details to be recorded on the birth certificate, they must do one of the following:

- register the birth jointly;
- complete a 'Statutory declaration of acknowledgement of parentage' form and one parent takes the signed form when she registers the birth;
- get a document from the court (for example a court order) giving the second female parent parental responsibility and one parent shows the document when she registers the birth.



Same-sex male couples

Male couples must get a parental order from the court before they can be registered as parents.

Other people who can register a birth

If the parents can't register the birth (for example for medical reasons), certain other people can do it:

- someone who was present at the birth;
- someone who is responsible for the child;
- a member of the administrative staff at the hospital where the child was born.

Crying

All babies cry. It's their way of communicating. Most often you will be able to find the reason for your baby's crying and deal with it. If it's not obvious why your baby is crying, think of possible reasons.

Are they:

- Hungry?
- Hot, cold or uncomfortable?
- Feeling tired and unable to sleep?
- Lonely and wanting company?



- Bored and wanting to play?

Do they have:

- A wet or dirty nappy?
- Wind?
- Colic? (see page 169)

When crying gets too much

Some babies do cry more than others and it's not really clear why. Don't blame yourself, your partner or your baby if they cry a lot. It can be very exhausting so try to get rest when you can. Share soothing your baby with your partner. You could ask a friend or relative to take over for an hour from time to time, just to give you a break. If there is no one to turn to and you feel your patience is running out, leave your baby in the cot and go into another room for a few

minutes. Put on some soothing music, take some deep breaths, make yourself a cup of tea. If you are very angry or upset, telephone someone who will be able to help.

Never shake a baby!

It doesn't matter how upset, stressed, tired or angry you feel. You must never, ever grab or shake the baby. This will not stop the crying. It can cause severe injury or even death. For support visit <https://iconcope.org>

Play gently with your baby. You should avoid:

- Tossing your baby into the air.
- Jogging with your baby on your back or shoulders.



- Bouncing your baby roughly.
- Swinging your baby on your leg.
- Swinging your baby around by the ankles.
- Spinning your baby around.

Getting help

If you feel you are having difficulties coping with your baby's crying, talk to your midwife or health visitor. Or contact Cry-sis on 08451 228669 – they will put you in touch with other parents who have been in the same situation. If you have twins or more, the crying can seem relentless – Twinline, 0800 138 0509, can offer support.

If your baby's crying sounds different or unusual, it may be the first sign of illness,

particularly if they are not feeding well or will not be comforted. If you think your baby is ill or in pain, contact your doctor immediately. If you cannot contact your doctor and it's an emergency, take your baby to the nearest hospital emergency department.

Comforting your baby

Holding your baby close and talking in a soothing voice or singing softly will reassure them.

Movement often helps to calm down crying. Gently sway or rock your baby or take them for a walk or for a ride in a car. Sucking can also be comforting. You can put your baby to your breast or give them a dummy, as long as breastfeeding is well established.

Make sure the dummy is sterilised and don't dip it in honey or sugar to make your

baby suck. They will suck anyway. Using sugar will only encourage a craving for sweet things, which are bad for their teeth.

Importance of a warm home

A warm home is important for a child's health and comfort. The World Health Organization recommends a minimum household temperature of 18°C for adults and minimum of 20°C for children.

Living in cold, damp homes can be damaging to the health and development of children in various ways. Baby weight gain can be affected as a baby will need to burn more calories to keep warm.

- Research shows infants living in a cold home are more likely to be admitted to hospital.
- Children in cold homes are more likely to suffer from a variety of respiratory problems, such as asthma and bronchitis.

THE LETTERS IN PURPLE STAND FOR

P	U	R	P	L	E
PEAK OF CRYING	UNEXPECTED	RESISTS SOOTHING	PAIN-LIKE FACE	LONG LASTING	EVENING
Your baby may cry more each week, the most in month 2, then less in months 3-5	Crying can come and go and you don't know why.	Your baby may not stop crying no matter what you try.	A crying baby may look like they are in pain, even when they are not.	Crying can last as much as 5 hours a day, or more.	Your baby may cry more in the late afternoon and evening.

THE WORD PERIOD MEANS THAT THE CRYING HAS A BEGINNING AND AN END

The Period of PURPLE Crying begins at about 2 weeks of age and continues until about 3-4 months of age. There are other common characteristics of this phase, or period, which are better described by the acronym PURPLE. All babies go through this period. It is during this time that some babies can cry a lot and some far less, but they all go through it. See www.purplecrying.info

For more information

Households in Northern Ireland may be eligible for financial support towards the cost of energy saving measures. You can find out more at pha.site/energy-wise

- Children in cold homes have more severe colds and flus.



If you are breastfeeding keep a food diary to see if anything in particular that you are eating is upsetting your baby.

Colic

Colic is the term used when a baby cries a lot but there is no obvious cause. All babies cry but your baby may have colic if they cry more than three hours a day, three days a week for at least one week.

Although it may appear that your baby is in distress, colic is not harmful. Your baby will continue to feed and gain weight normally. There is no evidence that colic has any long-term effects.

Colic can be very upsetting for parents. You may feel like you are letting your baby down or that you are doing something wrong.

Although colic can be distressing at the time, it is a common phase that should last only a few weeks at the

most. It may help to remind yourself that you are not causing the crying and it is not under your control.

If you are concerned, talk to your health visitor or GP.

Sleep

The amount that babies sleep, even when they are very small, varies a lot. During the early weeks some babies sleep for most of the time between feeds. Others will be wide awake. As they grow older, they begin to develop a pattern of waking and sleeping. Some babies need more sleep than others and at different times. Try not to compare what your baby does with other people's babies. All babies are different, and their routines will change as they grow.

Routines

Some babies respond well to routines. Just before or after the last feed try bathing your baby before bedtime. Dim the lights, put on some soft music, read to your baby or sing a lullaby. Put the baby to bed at the same time each night. Try putting the baby to bed before they are asleep so that they get used to being awake in their cot.

You will gradually begin to recognise when your baby is ready for sleep and is likely to settle. Some babies settle better after a warm bath. Most sleep after a good feed. A

baby who wants to sleep is not likely to be disturbed by ordinary household noises, so there is no need to keep your whole home quiet while your baby sleeps. It will help you if your baby gets used to sleeping through a certain amount of noise.

Twins, triplets or more can have specific sleeping issues and it may be difficult for you to get them into a routine. They can sleep in the same cot – there is information from Twins Trust (www.twinstrust.org) on how you can do this safely.

Reducing the risk of unexplained death in infancy

Sadly we don't know why some apparently healthy babies die suddenly. We do know that placing a baby to sleep on their back reduces the risk, and that exposing a baby to cigarette smoke or overheating a baby increases the risk.

The risks of co-sleeping

The safest place for your baby to sleep is on their back in a moses basket or cot in the same room as you for the first six months, even during the day They should be placed on their back with their feet touching the bottom of their moses basket or cot. Do not use pillows, loose blankets, cot bumpers soft toys, comforters or sleep positioners.



You should never sleep with your baby on an armchair or sofa. If you are feeling tired or sleepy put your baby back in their cot in case you fall asleep.

Co-sleeping with your baby is associated with a higher risk of sudden infant death.

It is dangerous to share a bed with your baby if:

- you or anyone in the bed has recently drunk alcohol;
- you or anyone in the bed smokes;
- you or anyone in the bed has taken any drugs that make you feel sleepy.

In these situations, always put your baby in their own safe

sleep space such as a cot or a moses basket. Keeping the cot or moses basket next to the bed might make it easier to do this.

Whether you choose to co-sleep, or it is unplanned, there are some key risks you should avoid:

- Ensure there are no pillows, sheets, soft toys, comforters, blankets or other items in the bed that could obstruct your baby's breathing or cause them to overheat. A high proportion of infants who die as a result of sudden infant death are found with their head covered by loose bedding.
- Make sure your baby cannot fall out of bed or become trapped between the mattress and wall.
- Never leave your baby alone in the bed, as even

very young babies can wriggle into a dangerous position.

- Never let pets or other children into the bed with your baby.

Remember, co-sleeping is not a risk-free activity. You are responsible for ensuring your baby's safety. No studies have found that the parents' bed is safer than a cot or moses basket beside the bed.

Speak to your midwife, health visitor, family nurse or GP for advice if you feel strongly that you wish your baby to sleep with you instead of in a cot or moses basket. They can help you understand the increased risks.

You should never sleep with your baby on an armchair or sofa. If you are feeling tired or sleepy put the baby back in their cot in case you fall asleep.

To reduce the risk of sudden infant death:

Do:

- Put your baby to sleep in a cot or moses basket in the same room as you for the first six months even during the day.
- Always place your baby on their back to sleep.
- Place your baby in the 'feet to foot' position (with their feet touching the end of the cot, moses basket, or pram).
- Keep your baby's head uncovered – use a light blanket firmly tucked no higher than the baby's shoulders.
- Use a mattress that's firm, flat, waterproof and in good condition.
- Breastfeed your baby (if you can) and put your baby back to sleep in their cot after feeding.
- Make sure, if using a baby sleeping bag, it is fitted with neck and armholes, and no hood.

Place your baby on their back to sleep

Place your baby on their back to sleep from the very beginning for both day and night sleeps. This will reduce the risk of sudden infant death. Side sleeping is not as safe as sleeping on the back. Healthy babies placed on their backs are not more likely to choke. When your baby is old enough to roll over, they should not be prevented from doing so.

Babies may get flattening of the part of the head they lie on (plagiocephaly). This will become rounder again as they grow, particularly if they are encouraged to lie on their tummies to play when they are awake and being supervised. Experiencing a range of different positions and a variety of movement while awake is also good for a baby's development.

Don't let your baby get too hot (or too cold)

Overheating can be dangerous. Babies can overheat because of too much bedding or clothing, or because the room is too hot. Remember, a folded blanket counts as two blankets. When you check your baby, make sure they are not too hot. If your baby is sweating or their tummy feels hot to the touch, take off some of the bedding. Don't worry if your baby's hands or feet feel cool – this is normal.

- It is easier to adjust the temperature with changes of lightweight blankets. A folded blanket counts as two blankets.
- Babies do not need hot rooms; all-night heating is rarely necessary. Keep the room at a temperature that is comfortable for you at night. About 18°C (65°F) is comfortable.

- If it is very warm, your baby may not need any bedclothes other than a sheet.
- Even in winter, most babies who are unwell or feverish do not need extra clothes.
- Babies should never sleep with a hot-water bottle or electric blanket, next to a radiator, heater or fire, or in direct sunshine.
- Babies lose excess heat from their heads, so make sure their heads cannot be covered by bedclothes during sleep periods.

More information

Buy a simple room thermometer for your baby to help you monitor the room temperature. For more information on reducing the risk of sudden infant death, visit the Lullaby Trust at www.lullabytrust.org.uk

Do not:

- Sleep on a sofa or armchair with your baby.
- Allow your baby to sleep alone in an adult bed.
- Allow your baby to share a bed with anyone who has been smoking, drinking alcohol, taking drugs or is feeling overly tired.
- Cover your baby's head.
- Smoke during pregnancy or let anyone smoke in the same room as your baby (both before and after birth).
- Let your baby get overheated, light bedding or a lightweight baby sleeping bag will provide a comfortable sleeping environment for your baby.
- Leave your baby sleeping in a car seat for long periods or when not travelling in the car.
- Put pillows, loose blankets, cot bumpers, soft toys, comforters or sleep positioners in your baby's cot.



Don't let your baby's head become covered

Babies whose heads are covered with bedding are at an increased risk of suffocation..

To prevent your baby wriggling down under the covers, place your baby on their back, feet to foot in the crib, cot or pram.

Make the covers up so that they reach no higher than the shoulders.

Covers should be securely tucked in so they cannot slip over your baby's head. Use one or more layers of lightweight blankets.

Sleep your baby on a mattress that is firm, flat, well-fitting and clean. The outside of the mattress should be waterproof. Cover the mattress with a single sheet. Remember, do not use duvets,

quilts, baby nests, wedges, bedding rolls or pillows.

Don't let your baby overheat.

Remove hats and extra clothing as soon as you come indoors or enter a warm car, bus or train, even if it means waking your baby.

Feeding

Breastfeeding your baby reduces the risk of sudden infant death. See chapter 10 for everything you need to know about breastfeeding.

It is possible that using a dummy at the start of any sleep period reduces the risk of sudden infant death. Do not begin to give a dummy until breastfeeding is well established, usually when your baby is around one month old. Stop giving the dummy when your baby is between six and 12 months old. If possible remove the dummy when the baby falls asleep.

Continuous sucking on a dummy for long periods may effect tooth development or speech later on.

Monitors

Normal healthy babies do not need a breathing monitor. Some parents find that using a breathing monitor reassures them. However, there is no evidence that monitors prevent sudden infant death. If you have any worries about your baby,

ask your doctor about the best steps to take.

Immunisation reduces the risk of sudden infant death. For more information about immunisation, visit phs.site/immunisation-and-vaccinations

If your baby is unwell, seek medical advice promptly

Babies often have minor illnesses that you do not need to worry about.

Make sure your baby drinks plenty of fluids and is not too hot. If your baby sleeps a lot, wake them regularly for a drink.

It can be difficult to judge whether an illness is more serious and requires prompt medical attention. See the section on illnesses on page 176 for guidance on when you should get help.

Changing your baby

Babies need their nappies changed fairly often, otherwise they become sore. Unless your baby is sleeping peacefully, always change a wet or dirty nappy and change your baby before or after each feed.

Organise the place where you change your baby so that everything you need is handy (see page 153). The best place to change a nappy is on a changing mat or towel on the

floor, particularly if you have more than one baby. That way, if you take your eye off your baby for a moment to look after another child, your baby cannot fall and hurt themselves.

Try to sit down, so you don't hurt your back. If you are using a changing table, keep an eye on your baby at all times.

How to change a nappy

You need to clean your baby's bottom carefully each time you change a nappy to help prevent soreness and nappy rash.

Step 1

- Take off the nappy. If it's dirty, wipe away the mess from your baby's bottom with white cotton wool.
- Wash your baby's bottom and genitals with cotton wool and warm water and dry thoroughly. For girls, wipe the bottom from front to back, away from the vagina, so that germs will not infect the vagina or bladder. For boys, gently clean the foreskin of the penis (it can be pulled back very gently). Clean under the penis and the scrotum. If the baby's skin is intact you do not need to use any cream.

- If their bottom is red use a cream, such as zinc and castor oil cream which can help by forming a waterproof coating to protect the skin. Cream may prevent the nappy from absorbing urine as well, so use it sparingly. Don't use baby powder as it can cause choking.

Step 2

- If you are using a cloth nappy, place it in a waterproof cover (if needed) and put a nappy liner inside. Lay your baby carefully on the nappy, bring the centre of the nappy between your baby's legs and then fasten the poppers or Velcro at the front. Check that it fits snugly around the waist and legs (If the nappy isn't in a waterproof cover, follow with plastic pants).
- If you are using a disposable nappy, put the side with the sticky tapes under your baby's bottom.
- Fasten the tapes at the front. Be very careful not to get cream on the tabs or they will not stick.

Step 3

- Wash your hands before and after nappy changes.

Nappy hygiene

Disposable nappies

If the nappy is dirty, flush the



contents down the toilet. Roll up the nappy and re-tape it securely. Put it into a plastic bag. Don't put anything but nappies in this bag. Fasten the bag and put it outside in your bin each day.

Cloth nappies

- If the nappy is dirty, flush the contents down the toilet. Biodegradable, flushable nappy liners are available to make it easy.
- Have a lidded bucket ready to store the dirty nappies. You can soak them in a nappy cleanser (follow the instructions on the packet) or just store them here until you have a load ready for washing.
- Wash nappies as soon as possible. Follow the care instructions on your nappies, but a 60°C wash is usually OK. If you did not soak the nappies before, add an antibacterial nappy cleanser to your normal washing detergent (follow the instructions on the packet). Don't use enzyme (bio) washing powders or fabric conditioner as these may irritate your baby's skin – and the conditioner may make the nappy less absorbent.



Make sure you use the correct amount of detergent and rinse thoroughly. Always keep nappy sacks, other plastic bags and wrapping away from babies and buy in a roll if possible.

Nappy rash

Most babies get a sore bottom or have nappy rash at some time, but some have extra-sensitive skin. Nappy rashes are caused by contact between sensitive skin and soiled nappies. If you notice redness or spots, clean your baby very carefully and change their nappies more frequently. Better still, give your baby time without a nappy and let the air get to their skin. Keep a spare nappy handy to mop up any accidents. You will soon see the rash start to get better.

If your baby does have a rash, ask your midwife or health visitor about it. They may advise you to use a protective cream. If the rash seems to be painful and will not go away, see your health visitor or GP.

Babies' poo (stools)

Immediately after birth and for the first few days, your baby is likely to pass a sticky, greenish-black substance. This is called meconium and it is the waste that has collected in your baby's bowels while they were in your womb. As your baby begins to digest milk, the stools will change. They will become more yellow or orange and can be quite bright in colour. Breastfed babies have quite runny stools. Formula-fed babies' stools are firmer and smell more.

Babies vary a lot in how often they pass stools. Some have a bowel movement at or around each feed; some can go for several days without having a movement. Either can be normal, but most breastfed babies produce at least one stool a day for the first six weeks.

When to get help

Most small babies strain and go red in the face, or even cry, when passing a stool. This is normal and doesn't mean they are constipated as long as the stools are soft. If you are worried that your baby may be constipated, mention this to your midwife or health visitor.

What you find in your baby's nappies will probably vary from day to day, and usually there is no need to worry. Ask your doctor, midwife or health visitor if you notice any big changes, such as stools:

- becoming very frequent and watery;
- being very smelly;
- changing colour to become green, white or creamy or if you notice any blood.

See 'Babies with jaundice after two weeks' on page 180.

Putting on a disposable nappy





Washing and bathing

Washing

You don't need to bath your baby every day, but you should wash their face, neck, hands and bottom carefully each day. You can do this on a changing mat. Choose a time when your baby is awake and contented, and make sure the room is warm. You will need a bowl of warm water, some cotton wool, a towel and a fresh nappy. You do not need to use soap on a new baby.

1. Take off your baby's clothes except for the vest and nappy. Wrap your baby in a towel.
2. Gently wipe round each eye, from the nose side outwards. Use a fresh piece of cotton wool for each eye, so you don't transfer any stickiness or infection.
3. Using fresh, moist cotton wool, wipe out each ear – but don't clean inside their ears. Never use cotton buds inside the ear canal.

4. Wash the rest of your baby's face and neck with moist cotton wool and dry gently. Wash and dry your baby's hands in the same way.
5. Take off the nappy and wash your baby's bottom and genitals with fresh cotton wool and warm water. Dry your baby very carefully, including in skin folds, and put on a clean nappy. See page 149 on keeping your baby's umbilical cord clean and dry.

Bathing

Bath your baby two or three times a week, or more often if they enjoy it. Don't bath them straight after a feed or when they are hungry or sleepy. Make sure the room is warm and that you have everything you need ready in advance. Bath seats are not recommended.

1. Check that the water is not too hot. Test it with your wrist or elbow. It should be just comfortably warm.



2. Undress your baby except for their nappy, and wrap them snugly in a towel. Wash your baby's face with cotton wool and water as described above. There is no need to use any soap.
3. Wash your baby's hair with mild unscented baby shampoo, supporting their head over the baby bath or basin. Rinse carefully. You don't need to use shampoo every time.
4. Take the nappy off at the last minute.
5. Put your baby gently into the water. Using one hand for support, gently swish the water to wash your baby without splashing their face. You should never leave your baby alone in the water even



for a few seconds. For boys, gently clean the top of the foreskin of the penis. The foreskin can be pulled back very gently to clean.

6. Lift your baby out and pat them dry with a warm towel. Dry carefully in all the creases. If your baby's skin is dry, gently massage in some baby oil or cream (not aqueous cream). Your baby will probably enjoy this.
7. Never leave the baby unattended on a changing station as they could roll over and fall off it.

If your baby seems frightened of the bath and cries, it will help to talk in a low voice.

Illness

It's sometimes difficult to tell at first when a baby is ill, but you may have a funny feeling that things are not quite right. If you are at all worried, ask for help. You are not fussing.

It's far better to be on the safe side, particularly with a very small baby. Trust your own judgement. You know your baby best.

Very urgent problems

Sometimes there are obvious signs that your baby is not well. **Seek urgent medical attention if your baby:**

- turns blue or very pale;



- has quick, difficult or grunting breathing, or unusual periods of breathing, for example breathing with pauses of over 20 seconds between breaths;
- is very hard to wake, unusually drowsy or doesn't seem to know you;
- develops a rash of red spots that do not fade or lose colour (blanch) when they are pressed (see the 'glass test' on the next page). This may be the rash of meningococcal disease and meningitis, which causes infection in the blood. There may not be any other symptoms.

Your baby may need treatment very quickly. Dial 999 for an ambulance or take your baby to the nearest hospital emergency department.

Problems that could be serious

- Take your baby to your GP if your baby has a hoarse cough with noisy breathing, is wheezing, or cannot

breathe through the nose.

- If your baby is unusually hot, cold or floppy.
- If your baby cries in an unusual way or for an unusually long time or seems to be in pain.
- If you notice any bleeding from the stump of the umbilical cord or from the nose, or any bruising.
- If your baby keeps refusing feeds.
- If your baby keeps vomiting a substantial part of feeds or has frequent watery offensive/smelly diarrhoea. Vomiting and diarrhoea together may mean your baby is losing too much fluid, and this may need prompt treatment.
- If your baby develops jaundice (looks yellow) when they are over a week old, or has jaundice that continues for over two weeks after birth (see page 180).
- If jaundice develops in the first 24 hours after birth urgent medical treatment is required.

If you are worried about your baby:

- Phone your midwife or health visitor for advice. Keep their phone numbers where they can be reached easily.
- Phone your GP who may be able to advise you over the phone or may suggest that you bring your baby along to the surgery. Most GPs will try to see a young baby without an appointment, although it may mean a wait in the surgery.
- If you are really worried about your baby, you should always phone your GP for help immediately, whatever the time of day or night. There will always be a doctor on duty, even if it is not your own GP.

If you have already seen your GP and your baby is not getting better or seems to be getting worse, contact your GP again. If you become very worried and cannot get hold of your GP, dial 999 for an ambulance or take your baby to the nearest hospital emergency department. Minor injuries units are not suitable for assessing and treating sick babies.

For further information see www.nice.org.uk/guidance/ng195 and www.nice.org.uk/guidance/ng254/chapter/Managing-suspected-sepsis



The 'glass test'

The 'glass test' can help you to tell if a rash is a symptom of meningitis. Press the side or bottom of a glass tumbler firmly against the rash. You will be able to see if the rash

fades and loses colour under the pressure (see photo). If it doesn't change colour, contact your GP, phone 999 or take your baby to the emergency department immediately.

Group B streptococcal infection

Group B streptococcal infection is a life-threatening infection in babies. Most babies who are infected show symptoms within 12 hours of birth, but there are some who get it later. The symptoms include:

- being floppy and unresponsive;

- not feeding well;
- grunting;
- high or low temperature;
- fast or slow heart rate;
- fast or slow breathing rate;
- irritability.

These symptoms may be indicative of Group B streptococcal infection or other conditions. If your baby shows any of these symptoms contact your GP immediately. If you cannot get hold of your GP or midwife at once, dial 999 for an ambulance or take your baby to the nearest hospital emergency department. For more information, see www.gbss.org.uk





over with someone. It's always better to ask for help than to worry on your own. Do talk to your midwife or health visitor. As you grow more confident, you will begin to trust your own judgement more. You will be able to decide which action to take to keep your baby safe and well.

You will also want to talk to friends, relations or other mothers in a similar situation. You will meet other mothers when you start taking your baby to the child health clinic or Sure Start. Your health visitor will explain where these are and when you should go.

Your health visitor can tell you about any mother and baby groups in the area.

Getting support

Everyone needs advice or reassurance at some time when they are caring for a

young baby, even if it's just to make sure that they are doing the right thing. Some problems just need talking





About one in eight of all babies will need extra care in hospital, on the ordinary postnatal ward and also in a specialist neonatal area. Having a baby in neonatal care is naturally worrying for parents and every effort should be made to ensure that you receive the information, communication and support you need. Not all hospitals provide neonatal services, so it may be necessary to transfer your baby to another hospital for specialist care.

Why babies need additional care

Babies may need to be admitted to neonatal services for a number of reasons, including:

- They are born early. One in 10 of all babies are born prematurely. Babies born earlier than 34 weeks may need extra help with breathing, feeding and keeping warm.
- They are very small and have a low birth weight.
- They have an infection.
- Their mother has diabetes or has another long-term condition.
- The delivery was very difficult and they need to be kept under close observation for a time.
- They have very marked jaundice (see page 180).
- They are awaiting or recovering from complex surgery.
- They are suffering from drug or alcohol withdrawal, if their mother has been misusing drugs or alcohol during the pregnancy.



babies can have a positive impact on both the baby's and parents' health and wellbeing.

You might hear health professionals call this family centred care or family integrated care (FIC). This is a more advanced form of involving families. FIC means involving the family as much as possible in the daily care and routine of their baby.

Many neonatal units now care for babies and families in this way. This work is supported by Tiny Life, UNICEF UK Baby Friendly Initiative and BLISS

Contact with your baby

New research has found that involving parents as much as possible in the care of their



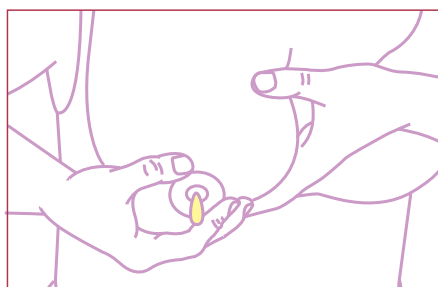
Baby Charter. At first it can be hard to know what to do for your baby on the neonatal unit.

Your baby will really benefit from physical contact with you, even though the environment of the neonatal unit may seem strange and confusing, but staff will guide and support you. Your baby may be in an incubator and on a breathing machine. There may also be tubes and wires attached to their face and body. Ask the nurse to explain what everything is for and to show you how you can be involved with your baby's care. Once your baby is stable, you will be able to hold them. The nurses will show you how to do this.

For further information see www.nice.org.uk/guidance/cg98

Feeding

All babies benefit from receiving their mother's breastmilk. It is more important for sick



or premature babies to get breastmilk. To begin with, your baby may be too small or sick to take their feeds themselves. You may be asked to express some of your breastmilk, which can be given to your baby through a fine tube passed through



their nose or mouth into their stomach. This will not hurt them. Breastmilk has particular benefits, and especially for sick or premature babies, as it is specially enriched with fats and minerals. If your baby is unable to have your breastmilk to begin with, it can be frozen and given to them when they are ready and can be used for mouth care or pain relief. When you go home, you can express milk for the nurses to give while you are away. There is no need to worry about the quality of your milk. Some mothers find that providing breastmilk makes them feel that they are doing something very positive for their baby. See chapter 10 for information on expressing and storing milk.

Incubators

Babies who are very small are nursed in incubators rather than cots to keep them warm. However, you can still have a lot of contact with your baby. Some incubators have open tops. If not, you can put your hands through the holes in the side of the incubator and touch your baby. When your baby is stable, the nurses will be able to help you take your baby out of the incubator and

show you how to have skin-to-skin contact. You should carefully wash and thoroughly dry your hands before touching your baby. You can talk to your baby as well – this can help both of you.

Newborn babies with jaundice

Jaundice in newborn babies is common at around 3–5 days because their livers are immature. For most babies who are getting adequate milk, the jaundice usually goes away by the first week without any special treatments. However jaundiced babies are usually quite sleepy so keep a record of their feeds and consult your midwife. You may need to lift and awaken the baby for the feeds every 3–4 hours. Severely jaundiced babies may be treated with phototherapy. Babies are undressed and put under a very bright light, usually with a soft mask over their eyes. The special light helps to break down the chemical that causes jaundice. It may be possible for your baby to have phototherapy by your bed so that you don't have to be separated. This treatment may continue for several days, with breaks for feeds, before the jaundice clears up. If the jaundice gets



worse, an exchange transfusion of blood may be needed. This is not common. Some babies have jaundice because of liver disease and need a different treatment. Your baby will be given a blood test before phototherapy is started to check for this.

Babies with jaundice after two weeks

Many babies are jaundiced for up to two weeks following birth. This can be as long as three weeks in premature babies. This is common in breastfed babies and usually it is normal and does no harm. It is not a reason to stop breastfeeding. But it's important to see your doctor if your baby is still jaundiced after two weeks. You should see them within a day or two. This is particularly important if your baby's poo (stools) is chalky white. A blood test will

show whether your baby has 'breastmilk' jaundice, which will go away by itself, or jaundice that may need urgent treatment. If jaundice develops in the first 24 hours after birth urgent medical treatment is required.

Babies with additional needs

If your baby has additional needs, you will be coping with a lot of different feelings. You will also need to cope with the feelings of others – your partner, relations and friends – as they come to terms with the fact that your baby has additional needs. More than anything else at this time, you will need to talk to people about how you feel as well as about your baby's health and future.

Your own GP, a neonatologist or paediatrician at your hospital, or your health visitor can all help you. You can also contact your social services department for information about local organisations that may be able to help.

Help and support

Tiny Life is a Northern Ireland premature and vulnerable baby charity, visit www.tinylife.org.uk

Bliss, the neonatal charity, supplies all neonatal services with a free Parent Information Guide, which you should be given on admission.

For more information visit the Bliss website www.bliss.org.uk

Great Expectations offers help and support for parents of a child or young person with Down's syndrome
<https://downsyndromeuk.co.uk/parents/expecting-a-baby>

Getting information

Hospital staff should explain what kind of treatment your baby is being given and why. If they don't, make sure you ask. It is important that you understand what is happening so that you can work together to make sure that your baby gets the best possible care. Some treatments will need your consent and the doctors will discuss this with you.

Some babies will require a referral to an Allied Health Professional (such as a physiotherapist, occupational therapist, SLT or dietitian) who may offer assessment and intervention to meet your baby's needs.

It is natural to feel anxious if your baby requires additional care. Talk over any fears or worries with the hospital staff. Hospitals often have their own counselling or support services, and a number of charities run support and advice services.

The consultant neonatologist or paediatrician should arrange to see you, but you can also ask for an appointment at any time if you wish. The hospital social worker may be able to help with practical problems such as travel costs or help with looking after other children.

16

The loss of your baby



Some women may have to cope with miscarriage, ectopic pregnancy, stillbirth or neonatal death (death shortly after birth). This chapter explains why some of these things may happen.

Help and support

If your baby dies during pregnancy or shortly after birth, you will need both information and support. Each Trust has a bereavement coordinator and bereavement midwife who can support you and also put you in touch with other people and organisations who can help you. More information can also be found on your Trust website by searching for 'bereavement support'.

Talk to the people close to you about how you feel, and to your midwife, doctor or health visitor about what has happened and why. Sometimes it is easier to talk to someone who is not a family member or friend, such as the health professionals mentioned above.

There are also a number of voluntary organisations that

offer support and information. These are often run by bereaved parents. It can be very helpful to talk to another parent who has been through a similar experience.

The following organisations may help:

The **Ectopic Pregnancy Trust** (www.ectopic.org.uk) offers support and information for parents who have had an ectopic pregnancy. They have a helpline on 020 7733 2653 and can put you in touch with other people who have had an ectopic pregnancy.

The Miscarriage Association

(www.miscarriageassociation.org.uk) can give you information and put you in touch with other parents who have experienced a miscarriage. You can call their helpline on 01924 200 799.

Sands (www.sands.org.uk) can put you in touch with other parents who have had a late miscarriage, stillbirth or neonatal death. They also have an online community at www.sands.community/login and a parents' telephone helpline on 0808 164 3332.





Ectopic pregnancy

After fertilisation, the egg should move down into the uterus to develop. Sometimes it gets stuck in the fallopian tube and begins to grow there. This is called an ectopic or tubal pregnancy. Rarely, the egg can become stuck elsewhere, such as the ovary or the cervix. The fertilised egg cannot develop properly and your health may be at serious risk if the pregnancy continues. The egg has to be removed. This can be done through an operation or with medicines.

Ectopic pregnancy can be caused by damage in the fallopian tube, possibly as a result of an infection. Previous abdominal surgery and previous ectopic pregnancy can also increase the risk. The warning signs start soon after a missed period.

These are:

- severe pain on one side, low down in the abdomen;
- vaginal bleeding or a brown watery discharge;
- pain in your shoulders;
- feeling dizzy or faint;

- pain when you have a bowel movement.

If you have any of these symptoms and you might be pregnant – even if you have not had a positive pregnancy test – you should see your doctor immediately.



Some women have no obvious signs or symptoms at all and an ectopic pregnancy may sometimes be mistaken for irritable bowel syndrome, food poisoning or even appendicitis.

Afterwards

You almost certainly will feel a strong sense of loss and it is important to give yourself time to grieve. An ectopic pregnancy involves abdominal surgery or treatment with powerful medicines. It may affect your chances of becoming pregnant again.

It may be helpful to talk to your doctor to discuss the possible

causes and whether your chances of conceiving a baby have been affected.

For further information see www.nice.org.uk/guidance/ng126 and www.rcog.org.uk/for-the-public/browse-our-patient-information/ectopic-pregnancy

Miscarriage

If a pregnancy ends before the 24th week, it is known as a miscarriage. Miscarriages are quite common in the first three months of pregnancy. At least one in six confirmed pregnancies end this way. Many early miscarriages (before 14 weeks) happen because there is something wrong with the development of the baby. There can be other causes, such as hormone or blood-clotting problems. A later miscarriage may be due to an infection, problems in the placenta, or the cervix being weak and opening too early in the pregnancy.

A miscarriage in the first few weeks may start like a period, with spotting or bleeding and mild cramps or backache. The pain and bleeding may get worse and there can be heavy bleeding, blood clots and quite severe cramping pains. With a later miscarriage, you may go through an early labour. If you bleed or begin to have pains at any stage of

pregnancy, you should contact your GP or midwife. You could also contact your local early pregnancy unit. If you are more than six or seven weeks pregnant, you may be referred for an ultrasound scan to see if your baby has a heartbeat and is developing normally. Sometimes the bleeding stops by itself and your pregnancy will carry on quite normally.

Some women find out that their baby has died only when they have a routine scan. If they have had no pain or bleeding, this can come as a terrible shock, especially if the scan shows that the baby died days or weeks before. This is sometimes called a missed or silent miscarriage.

Treatment for miscarriage

Sometimes it is preferable to wait and let the miscarriage happen naturally, but there are three ways of actively managing a miscarriage:

- **Medicine.** You may be offered tablets or pessaries to start the process of miscarriage.
- **Operation.** If you have been pregnant for less than 14 weeks, your doctor may advise an operation called an ERPC (evacuation of retained products of conception). It is done under anaesthetic. The cervix is gently widened and

the contents of your uterus are removed by suction.

- **Induced labour.** If your baby dies after about 14 weeks, you may go into labour. If this doesn't happen, you will be offered tablets that start labour. Although some women would prefer not to go through labour, this is safer for you than an operation to remove the baby. You will be cared for and supported throughout the labour and the birth of your baby.

Afterwards

One early miscarriage is unlikely to affect your chances of having a baby in the future. If you have three or more early miscarriages in a row, you should be referred to a specialist for further investigations. However, sometimes no clear cause can be found.

Both women and men find it difficult to come to terms with a miscarriage at any stage. You will almost certainly feel a sense of loss. You will need time to grieve over the lost baby just as you would over the death of anyone close to you, especially if the miscarriage has happened later in your pregnancy. You may feel shocked, distressed,



angry, or just numb. You may feel guilty, wondering whether your miscarriage was caused by anything you did or did not do. It is important to know that, whatever the cause, miscarriage is never anyone's fault. If a miscarriage is going to happen, there is very little that anyone can do to stop it.

Some people find having something to remember their baby by helps. In an early loss, this may be a copy of a scan picture. If you have a late miscarriage, you may be able to see and hold your baby if you wish. You might also be able to take photographs, footprints and handprints as a keepsake. Some hospitals offer parents a certificate to commemorate their baby. This is done because there is no formal registration of a baby who dies before 24 weeks of pregnancy.

Try to talk about your feelings with your partner and those close to you. You might also want to contact the Miscarriage Association or SANDS (see page 182).

For further information see: www.rcog.org.uk/for-the-public/browse-our-patient-information/early-miscarriage





baby at birth if you want to. It is devastating to experience a stillbirth or neonatal death.

You and your partner are likely to experience a range of emotions that come and go unpredictably. These can include disbelief, anger, guilt and grief. Some women think they can hear their baby crying, and it is not uncommon for mothers to think that they can still feel their baby kicking inside. The grief is usually most intense in the early months after the loss. Some parents find helpful to create memories of their baby, for example they may see and hold their baby and give their baby a name. You may want to have a photograph of your baby and to keep some mementos, such as a lock of hair, hand and footprints or the baby's shawl. All this can help you and your family to remember your baby as a real person and may, in time, help you to live with your loss. You may also find it helpful to talk to your GP, community midwife or health visitor or to other parents who have lost a baby. SANDS can put you in touch with other parents who can offer support and information (see page 182).

Further information is available at www.rcog.org.uk/for-the-public/browse-our-patient-information/when-your-baby-dies-before-birth

www.rcog.org.uk/for-the-public/browse-our-patient-information/recovering-from-surgical-management-of-a-miscarriage

www.rcog.org.uk/for-the-public/browse-our-patient-information/recurrent-miscarriage

Stillbirth and neonatal death

In the UK around 3,000 babies are stillborn every year. This means that the pregnancy has

lasted for 24 weeks or more and the baby is dead when it is born. About 1,300 babies also die shortly after birth.

Sometimes a baby dies in the uterus (an intra-uterine death or IUD) but labour does not start spontaneously. If this happens, you will be given medicines to induce the labour. This is the safest way of delivering the baby. It also means that you and your partner can see and hold the

Following a stillbirth or in the event of a baby dying in the first month of life, a form called a perinatal death notification (PDN) is completed by a health professional. Information is collected about mothers and babies from pregnancy through to birth and the early newborn period. The form, which is anonymised (it contains no information that could identify individuals), is then sent to the NIMACH (Northern Ireland Maternal and Child Health) office which sits within the PHA. NIMACH then send the information to a national perinatal mortality surveillance programme

(MBRRACE-UK) and topic specific confidential enquiries. This work, which is jointly funded by the UK Departments of Health, brings together the information and learning associated with every stillbirth and neonatal death and develops recommendations to improve the care provided to women, babies and families during pregnancy, childbirth and the newborn period.

Further information on the work of MBRRACE-UK/NIMACH can be obtained by contacting the NIMACH office on 028 9536 3481 or at pha.site/mbrpace-uk

Post-mortems

One of the first questions you are likely to ask is why your baby died. A post-mortem examination can help to provide some answers, although sometimes no clear cause is found. A post-mortem may, however, provide other information that could be helpful for future pregnancies and may rule out certain causes. If it is thought that a post-mortem could be helpful, a senior doctor or midwife will discuss this with you and explain the possible benefits.

If you decide to have a full or partial post-mortem, you will

be asked to sign a consent form. When the post-mortem report is available, you will be offered an appointment with a consultant who can explain the results to you and also what these might mean for a future pregnancy.

For those parents who choose to have a post-mortem on their baby, this will be carried out in Alderhay Women's and Children's Trust.

For those parents who choose not to have a post-mortem, other tests including genetic testing and testing your placenta may provide important answers as to why

your baby died.

Multiple births

The loss of one baby from a multiple pregnancy is very difficult for any parent. Grieving for the baby who has died while caring for and celebrating the life of the surviving baby brings very mixed and complex emotions. Often the surviving baby is premature and in a neonatal unit, causing additional concern. For further information and support, contact Twins Trust (www.twinstrust.org). Staff in the neonatal unit will support you through this difficult time.

Saying goodbye to your baby

A funeral or some other way of saying goodbye can be a very important part of coping with your loss, however early it happens.

If your baby dies before 24 weeks, your midwife will provide you with information and the hospital may offer to arrange for a cremation or burial, possibly together with other babies who have died in pregnancy. If you prefer to take your baby home or to make your own arrangements, you can do that. You may need some form of certification from the hospital and they should provide helpful information and contacts. The Miscarriage Association and SANDS (see page 182) can provide further support and information.

If your baby dies after 24 weeks, you will need to register your baby's birth (even if they were stillborn) with the Registrar of Births, Deaths and Marriages. The hospital will offer to arrange a funeral, burial or cremation free of charge, or you may choose to organise this yourself.

The hospital chaplain will be able to help you. Alternatively, you may prefer to contact someone from your own religious community, the Miscarriage Association or SANDS about the kind of funeral you want. You do not have to attend the funeral if you don't want to.

Many hospitals arrange a regular service of remembrance for all babies who die in pregnancy, at birth or in infancy. Again, you can choose to attend if you wish.

Many parents are surprised at how much and how long they grieve after losing a baby. Friends and acquaintances often don't know what to say or how to offer support, and they may expect you to get back to 'normal' long before that is possible. You may find it helpful to contact SANDS or the Miscarriage Association so that you can talk to people who have been through similar experiences and who can offer you support and information. You should be entitled to maternity leave if your baby is stillborn or dies after 24 weeks.

Holding your new baby in your arms, it may be impossible to imagine that you will ever have the energy to go through it all again! But sooner or later, you may decide that you want another child.

This chapter explains how you and your partner can create the best possible circumstances for your next pregnancy.

It takes two

You will increase your chances of getting pregnant if you are in good health – and that applies to men too. A bad diet, smoking, drinking and

unhealthy working conditions can affect the quality of sperm and stop you getting pregnant. You should both try to make your lifestyle as healthy as possible before you try to conceive.

Chapter 5 has advice about diet, smoking, alcohol and exercise, which can help you to conceive.

Folic acid

Women should take 400 micrograms of folic acid from the time they start trying to conceive right up until they are 12 weeks pregnant. You can get these tablets from a supermarket or pharmacist. Eat foods that contain this important vitamin as well.

These include green, leafy vegetables, and breakfast cereals and breads with added folic acid. You will need



a bigger dose of folic acid that requires a prescription if:

- you already have a baby with spina bifida;
- you have coeliac disease;
- you have diabetes or had gestational diabetes in a previous pregnancy.
- you have sickle cell disease;
- you are living with obesity;
- you take anti-epileptic medicines.

Ask your GP for advice as well.

Planning for your pregnancy

www.youtube.com/watch?v=R2VmFqMm6Z8&t=6s

Finding it hard to get pregnant?

It can take several months or more to get pregnant, even if it happened really quickly the first time.



Chapter 1 (page 10) explains when is the best time of the month to have sex if you want to get pregnant. If you are still not pregnant after a few months, talk to your doctor or family planning clinic.

Vitamin D

Women should take a 10 micrograms Vitamin D daily during the autumn and winter months. During the summer months (late March/April to the end of September), most people will usually get enough vitamin D from sunlight, so you may choose not to take a supplement over the summer.

Things to consider

Rubella (German measles)

Rubella in early pregnancy can damage your developing baby. If you were not immune during your last pregnancy, you should have been offered a two-dose measles, mumps and rubella (MMR) immunisation after your baby was born. Before trying for another baby, it is important to check if you are immune by having a blood test. The blood test will measure if you have enough protection (antibodies) against rubella. Women with low or uncertain levels of antibodies can be immunised again.

If you have evidence you have had two MMR vaccines in the past you will not need to have further doses even if your test says you are non-immune.

Your weight

Maintaining a healthy weight can improve your chances of getting pregnant. You may



have put on weight during your last pregnancy and want to go back to your normal size. This is particularly important if you weigh more than 100kg. The best way to lose weight is by following a balanced low-fat diet and taking exercise. It might help to join a slimming class with a friend or your partner to encourage and support you. Speak to your doctor if you need help or advice.

Long-term conditions, medicines and drugs

Some medicines can harm a baby in pregnancy but others are safe.

If either you or your partner has a long-term illness or disability and has to take long-term medication, talk to your doctor about any possible effects on fertility or pregnancy. Check with your doctor, midwife or pharmacist before you take any over the counter medications.

Illegal drugs will affect your ability to conceive and can damage your baby's health.

Diabetes

All women with a history of diabetes (Type 1, Type 2 and gestational) during pregnancy will be advised in



the postnatal period of the importance of planning future pregnancies and ensuring that their diabetes is well managed before they get pregnant. All trusts have pre-pregnancy diabetes clinics in place to assist women with this.

For further information visit www.nice.org.uk/guidance/ng3

Epilepsy

If you have epilepsy, talk to your doctor before you try to get pregnant. Pre-pregnancy clinics for women with epilepsy are available to help you get ready for pregnancy.

For further information visit www.rcog.org.uk/for-the-public/browse-our-patient-information/epilepsy-in-pregnancy

Postnatal depression and postpartum psychosis

If you have previously experienced postnatal depression or postpartum psychosis, talk to your doctor before you try to get pregnant.

Sexually transmitted infections (STIs)

STIs can affect your health and your ability to conceive. If there is any chance that either of you has an STI, it's important to get it diagnosed and treated before you get pregnant. STIs, including HIV, herpes, chlamydia, syphilis, gonorrhoea, hepatitis B and hepatitis C, can be passed on through sex with an infected person, especially if you don't use a condom. Some STIs

can be transmitted during sex without penetration. HIV, hepatitis B and hepatitis C can also be passed on by sharing equipment for injecting drugs.

If you are HIV positive, you can pass the virus on to your baby during pregnancy, at birth or when breastfeeding.

Vaginal birth after a caesarean section

Many women who have had a caesarean section can have a vaginal delivery for their next baby. This depends on why you had a caesarean section the first time. Your obstetrician will be able to advise you. Most women who are advised to try for a vaginal delivery in subsequent pregnancies do have normal deliveries.



18

Your rights and benefits



Make sure that you know your rights and that you claim all the benefits that you are entitled to when you are pregnant. Visit pha.site/benefits or call 0800 232 1271 for further information on what benefits you may be entitled to.

Working out what benefits and rights you are entitled to and making claims can be complicated. There are a number of government departments and voluntary organisations that can help you.

- Your local Jobs and Benefits or Social Security Office can give you advice about benefits. You can find your local Jobs and

Benefits or Social Security Office at pha.site/jobs-benefits-offices

- Law centres and other advice agencies can advise you about your rights at work. To find your local advice agencies, visit www.citizensadvice.org.uk

- The Equality Commission for Northern Ireland can advise you if your problem is to do with sex discrimination, call 028 9050 0600 or visit www.equalityni.org to find out more.

You also have certain rights in the workplace when you are pregnant, such as the right to maternity leave. You can find out more about maternity leave and other rights at pha.site/maternity-rights

Maternity rights do change and different benefits have to be claimed using different forms and from different offices. Get further advice if you are unsure of anything.



Glossary of useful terms

Term	Meaning
Albumin	A protein that can appear in your urine when you are pregnant. It can be a sign of an infection or pre-eclampsia. Your midwife will test your urine for albumin at your antenatal check-ups.
Amniocentesis	A test in which a thin needle is inserted into the uterus through the abdominal wall to take a sample of the fluid surrounding the baby. The fluid is then tested for certain chromosomal and genetic disorders. An amniocentesis is usually carried out between 15 and 18 weeks into your pregnancy. It may be used later in pregnancy to find out if your baby's lungs are mature.
Amniotic sac	The bag of fluid that surrounds and cushions your baby in the uterus. Before or during labour the sac breaks and the fluid drains out. This is called the 'waters breaking'.
Anaesthetics	Medicines that reduce or take away pain. A general anaesthetic means you will be put to sleep.
Antenatal	This literally means 'before birth' and refers to the whole of pregnancy, from conception to birth.
Baby blues	Feeling sad or mildly depressed a few days after your baby is born. The baby blues are very common – eight out of 10 new mothers feel like this. They can be caused by hormone changes, tiredness or discomfort and usually only last a week. More severe depression or anxiety that lasts longer than a week could be postnatal depression (see pages 98 and 163).
Balanced diet	A diet that provides a good balance of nutrients.
Bereavement	The loss of a person. Coping with a bereavement can be particularly difficult if you are pregnant or have just had a baby, and even harder if it is your baby who has died.
Birth plan	A written record of what you would like to happen during pregnancy, labour and childbirth.
Breech birth	When a baby is born bottom rather than head first.
Caesarean section	An operation to deliver a baby by cutting through the mother's abdomen and then into her uterus. If you have a caesarean, you will be given an epidural or general anaesthetic.
Catheter	A thin, flexible, hollow plastic tube that can be used to perform various diagnostic and/or therapeutic procedures. Catheters may be used for the injection of fluids or medications into an area of the body or for drainage, such as from a surgical site, or from the bladder.
Cervix	The neck of the uterus. It is normally almost closed, with just a small opening through which blood passes during monthly periods. During labour, your cervix will dilate (open up) to let your baby move from your uterus into your vagina prior to the birth.
Colostrum	The milk that your breasts produce during the end of pregnancy and in the first few days after your baby is born. It is very concentrated and full of antibodies to protect your baby against infections. Colostrum has a rich, creamy appearance and is sometimes quite yellow in colour.
Conception	The start of a pregnancy, when an egg (ovum) is fertilised and then moves down the fallopian tube to the uterus, where it attaches itself to the uterus lining.
Contraception (also known as birth control)	Contraception prevents or reduces your chances of getting pregnant. See page 161 for the different types of contraception that are available.
Cot death (also known as sudden infant death)	The sudden and unexpected death of an apparently healthy infant during their sleep. For information on what you can do to avoid cot death, go to pages 154 and 169.

Term	Meaning
Down's syndrome	Down's syndrome is a genetic condition, usually due to an extra copy of chromosome 21 in all of the baby's cells. Everyone with Down's syndrome will have some degree of learning disability but most will attend a mainstream school with support and go on to lead fulfilling independent or semi-independent lives. Some babies with Down's syndrome many have recognised health conditions which may require regular monitoring. For more information go to https://downsyndromeuk.co.uk For more information about screening or tests for Down's syndrome, see page 68.
Ectopic pregnancy	An ectopic pregnancy occurs when a fertilised egg begins to grow in the fallopian tube, cervix, ovaries or abdomen, not in the lining of the uterus. The fertilised egg cannot develop properly and has to be removed.
Embryo	The term used for the developing baby in the first eight weeks of pregnancy.
Entonox (also known as 'gas and air')	A form of pain relief offered during labour. It is a mixture of oxygen and gas called nitrous oxide, which is breathed in through a mask or mouthpiece.
Epidural	An anaesthetic that numbs the lower half of the body. It can be very helpful for women who are having a long or particularly painful labour, or who are becoming very distressed. A thin catheter is placed between the vertebrae so that medicine can be delivered to the nerves in the spinal cord.
Episiotomy	A surgical incision made in the area between the vagina and anus (perineum). This is done during the last stages of labour and delivery to expand the opening of the vagina to speed up the birth or to prevent tearing during the birth of the baby.
Fallopian tubes	Branch-like tubes that lead from the ovaries to the uterus. Eggs are released from the ovaries into the fallopian tubes each month. Fertilisation takes place in one of the fallopian tubes.
Fertilisation	Fertilisation takes place if a man's sperm joins with a woman's egg and fertilises it in the fallopian tube.
Fetal alcohol syndrome (FAS)	A syndrome that can cause children to have restricted growth, heart defects and facial abnormalities as well as learning and behavioural disorders. It is caused if your baby is exposed to too much alcohol (via the placenta) when they are in the womb. This condition can be prevented by avoiding alcohol completely during pregnancy.
Fetus	The term used for the developing baby from the eighth week of pregnancy onwards.
Folic acid	One of the B group of vitamins, which is found in foods, including green leafy vegetables, fortified breakfast cereals and brown rice. Folic acid is important for pregnancy as it can help prevent birth defects known as neural tube defects. If you are pregnant or trying to get pregnant, you should take a 400 microgram folic acid tablet every day until you are 12 weeks pregnant. You should consult your doctor and ask for a prescription of the higher dose of folic acid if you have any of the conditions listed on page 187.
Fontanelle	A diamond-shaped patch on the front and top of a baby's head where the skull bones have not yet fused together. During birth, the fontanelle allows the bony plates of the skull to flex, so that the baby's head can pass through the birth canal. The bones usually fuse together and close over by a child's second birthday.
Formula milk	Cows' milk that has been processed and treated so that babies can digest it. It comes in powder or liquid form.
Fundus	The top of the womb.
Haemoglobin (Hb)	Haemoglobin is found in red blood cells and carries oxygen from the lungs to all parts of the body. Pregnant women need to produce more haemoglobin because they produce more blood. If you don't produce enough, you can become anaemic, which will make you feel very tired. Your haemoglobin levels are tested during antenatal check-ups.
Home birth	Giving birth at home, with care provided by a midwife. Talk to your community midwife if you want to consider this option.

Term	Meaning
Induction of labour	A method of artificially or prematurely stimulating labour. Labour can be induced if the pregnancy has gone past the 42nd week or if there are health risks to either the baby or the mother if the pregnancy continues.
Jaundice	The development of a yellow colour on a baby's skin and a yellowness in the whites of their eyes. It is caused by an excess of the pigment bilirubin in the blood. Jaundice is common in newborn babies and usually occurs approximately three days after birth. It can last for up to two weeks after birth or up to three weeks in premature babies. Severe jaundice can be treated by phototherapy, where a baby is placed under a very bright light. Babies who are jaundiced for longer than two weeks should be seen by a doctor as they may need urgent treatment. See page 180 for more information.
Lanugo	Very fine, soft hair that covers your baby at approximately 22 weeks. The lanugo disappears before birth, at full term but may still be present on premature babies.
Mastitis	An infection in the breasts associated with blocked milk ducts. Symptoms include hot, tender and hard breasts and flu-like symptoms. See page 131 for how to treat it.
Maternity team care	A team of midwives, obstetricians, anaesthetists, neonatologists and other specialists who provide care to women who have complex pregnancies.
Meconium	The first stools (bowel movements) that your baby passes. Meconium is made up of what a baby has swallowed during their time in the uterus, including mucus and bile. It is sticky like tar, green/black in colour and has no odour.
Midwife	The midwife is the main provider of care for most pregnant women. Midwives are highly skilled qualified professionals who care for women during normal pregnancy, childbirth and after the birth.
Midwifery-led care	Care for pregnant women where the midwife is the lead professional. Midwifery-led care is suitable for healthy women who have a low risk, uncomplicated pregnancy.
Morning sickness/nausea	Morning sickness affects more than half of all pregnant women. Symptoms include nausea or feeling sick, as well as actually vomiting. Morning sickness can occur at any time of the day, though it occurs most often in the morning because blood sugar levels are low after a night without food. The symptoms usually start after the first month of the pregnancy, peaking in weeks five to seven, and may continue until weeks 14 to 16.
Neonatal care	The care given to sick or premature babies. It takes place in a neonatal unit, which is specially designed and equipped to care for them.
Nuchal translucency scan	An ultrasound scan to help identify whether you are at risk of having a baby with Down's syndrome. The scan is carried out at 11 to 13 weeks of your pregnancy and measures the amount of the nuchal translucency, which is fluid behind the neck of the baby. Babies at risk of Down's syndrome tend to have a higher amount of fluid around their neck. The scan may also help confirm both the accuracy of the pregnancy dates and whether the baby has any other health problems.
Obstetric cholestasis	A potentially dangerous liver disorder. Symptoms include severe generalised itching without a rash, particularly in the last four months of pregnancy.
Obstetrician	A doctor specialising in the care of women during pregnancy and labour and after the birth.
Oedema	Another word for swelling, most often of the feet and hands. It is usually nothing to worry about, but if you have high blood pressure and it gets worse suddenly it can be a sign of pre-eclampsia.
Ovulation	Ovulation occurs when an egg (ovum) is released from one of a woman's ovaries during her monthly menstrual cycle. If the egg is fertilised during this time, she will get pregnant. This is the time of the month when you are most likely to conceive.
Paediatrician	A doctor specialising in the care of babies and children.
Perinatal	The time shortly before and after the birth of a baby.
Perinatal mental health	Mental health problems that develop during pregnancy and that can last for up to one year after childbirth.

Term	Meaning
Placenta	The organ attached to the lining of the uterus, which separates your baby's circulation from your circulation. Oxygen and food from your bloodstream are passed to your baby's bloodstream through the placenta and along the umbilical cord. Waste is also removed this way.
Postnatal	The period beginning immediately after the birth of a baby until they are about six weeks old.
Postnatal care	The professional care provided to you and your baby, from the birth until your baby is about six weeks old. It usually involves home visits by midwives, and health visitors to check that both mother and baby are well. Classes may also be available.
Postnatal depression	Feelings of depression and hopelessness after the birth of a baby. These feelings are more severe than the 'baby blues' (see pages 98 and 163). Postnatal depression affects one in 10 women and can be serious if left untreated.
Pre-eclampsia	A condition that only occurs during pregnancy. Symptoms include high blood pressure, albumin (protein) in urine, bad headaches, vision problems and the sudden swelling of the face, hands and feet. It may develop after the 20th week of pregnancy but can occur earlier. Although most cases are mild and cause no trouble. You should be checked regularly as it can be serious for both mother and baby. For more information, see page 86.
Premature birth	The birth of a baby before the 37th week of pregnancy.
Premature labour	When labour starts before 37 weeks of pregnancy.
Rhesus disease	A woman who is rhesus negative (see below) can carry a baby who is rhesus positive if the baby's father is rhesus positive. This can cause problems in second or later pregnancies. If she gets pregnant with another rhesus positive baby, the immune response will be quicker and much greater. The antibodies produced by the mother can cross the placenta and attach to the D antigen on her baby's red blood cells. This can be harmful to the baby as it may result in a condition called haemolytic disease of the fetus, which can lead to anaemia and jaundice.
Rhesus negative	People with a certain blood type are known as rhesus negative. It means that they do not have a substance known as D antigen on the surface of their red blood cells. This can cause problems in second or later pregnancies (see above).
Rhesus positive	People with a certain blood type are known as rhesus positive. This means that they have a substance known as D antigen on the surface of their red blood cells.
Rubella (German measles)	A virus that can seriously affect unborn babies if the mother gets it during the early weeks of pregnancy. Most women have been immunised against rubella, so they are not at risk. Ask your GP for a blood test if you are planning a pregnancy and think you are not immune to rubella.
Sudden infant death also known as cot death	The sudden and unexpected death of an apparently healthy infant during their sleep. For information on what you can do to avoid sudden infant death, go to pages 154 and 169.
Ultrasound scans (USS)	An imaging technique that uses high-frequency sound waves to create an image of your baby in the uterus. It shows your baby's body and organs as well as the surrounding tissues. Also called sonography, this test is widely used to estimate delivery dates and check that your developing baby is healthy and growing normally.
Umbilical cord	The cord that attaches the baby to the placenta, linking the baby and mother. Blood circulates through the cord, carrying oxygen and food to the baby and carrying waste away again.
Vernix	A sticky white coating that covers a baby when it is in the uterus. It mostly disappears before birth but there may be some left on your baby when they are born, particularly if they are premature.
Vertebrae	Your spine is made up of 33 irregularly shaped bones called vertebrae. Each vertebra has a hole in the middle through which the spinal cord runs.

Useful organisations

Alcoholics Anonymous (AA)

North City Business Centre

2 Duncairn Gardens

Belfast BT15 2GG

028 9035 1222

www.alcoholicsanonymous.ie

Has over 4,000 groups throughout the UK, which are designed to help those with a serious alcohol problem. Through mutual support, sufferers assist one another in coping with their problem. There are no fees for membership and anonymity is carefully preserved.

Antenatal Results and Choices (ARC)

12-15 Crawford Mews

York Street

London W1H 1LX

020 7713 7356

0207 713 7486 (helpline, Mon–Fri 10am–5.30pm)

info@arc-uk.org

www.arc-uk.org

Non-directive support and information for parents throughout antenatal testing, especially when a serious abnormality has been diagnosed and a choice has to be made about the continuation or ending of the pregnancy. Ongoing support given to parents via publications, a helpline, parent contacts, email groups, parents' meetings and newsletters. Support is offered to health professionals by way of training, conferences and publications.

Care Opinion

www.careopinion.org.uk

Care Opinion is a place where you can share your experience of health or care services, and help make them better for everyone.

Cruse Bereavement Support

10 College Green

Belfast

BT7 1LN

028 9043 4600

northern.ireland@cruse.org.uk

Helpline 0808 808 1677

A nationwide service providing emotional support, counselling and information to anyone bereaved by death, regardless of age, race or belief. Also provides information on local groups.

Cry-sis

Helpline 0800 448 0737

Lines open 7 days a week 9am–10pm

info@cry-sis.org.uk

www.cry-sis.org.uk

Offers non-medical, emotional support for families with excessively crying, sleepless and demanding babies.



Domestic and Sexual Abuse Helpline (24 hour)

Helpline 0808 802 1414

www.dsahelpline.org

Email: help@dsahelpline.org

The Domestic and Sexual Abuse Helpline provides information and support to those affected by domestic and sexual abuse across Northern Ireland. It is funded by the Departments of Health, Justice and Communities and aims to offer support, help, signposting and referral to victims, family, friends and professionals.

Healthy Start

www.healthystart.nhs.uk

Helpline 0300 330 7010

Free prepaid card for pregnant women or people who have children under the age of 4, to spend on milk, plain fresh and frozen fruit and vegetables and infant formula milk. You can also get free vitamins.



ICP Support

www.icpsupport.org

Supportline (Tuesday–Friday, 10 am–2 pm)

07939 871929

ICP Support was originally set up in 1991 to provide a support and information line for women who thought they might have intrahepatic cholestasis of pregnancy (ICP) and wanted to know more about it.

La Leche League

028 9581 8118

www.lalecheleagueireland.com

An international, non-profit, non-sectarian organisation which, for over 50 years, has been dedicated to providing education, information and mother-to-mother support and encouragement to women who want to breastfeed. LLL Leaders are mothers who have themselves breastfed for 12 months or longer and have undertaken extensive training to provide telephone counselling and email support, and to run local group meetings.

In Northern Ireland:

028 9581 8118

www.facebook.com/lllnti

Lullaby Trust

CAN Mezzanine

7-14 Great Dover Street

London

SE1 4YR

020 7802 3200

0808 802 6868 (helpline, Mon–Fri

9am–11pm; Sat–Sun 6pm–11pm)

www.lullabytrust.org.uk

Charity working to prevent sudden deaths and promote health. It funds research, supports bereaved families and promotes safe baby care advice.

National Childbirth Trust (NCT)

Helpline 0300 330 0700

enquiries@nct.org.uk

www.nct.org.uk

Supports 1 million mums and dads every year through helplines, courses and a network of local support. With evidence-based information on pregnancy, birth and early parenthood, it can provide support from when you first discover you are pregnant to when your baby turns 2. Visit the website for information on becoming a parent or to find your nearest NCT group.

Parenting NI**42 Dublin Road****Belfast BT2 7HN****Helpline 0808 8010 722****028 9031 0891****www.parentingni.org**

Parenting NI was established as Parents Advice Centre in 1979, the International Year of the Child. It is now a leading parenting support organisation committed to delivering high quality services.

Parenting NI has a regional remit to promote positive parenting by providing support, training and information on family issues and influencing policy, provision and practice at all levels.

SH:24**<https://sh24.org.uk>**

SH:24 is a free online sexual health service, delivered in partnership with the HSC.

SH:24 makes it easier for you to manage your sexual health. It provides free test kits, information and advice – 24 hours a day. It's quick, discreet and completely confidential. You can now also get your contraception including combined, mini or morning after pill for free by post by placing your order at <https://sh24.org.uk>

Tommy's**www.tommys.org**

Tommy's believe that parents need, and deserve, answers when their babies die. Tommy's exists to answer these questions through funding ground-breaking research.

Twins Trust NI**NICVA Buildings****61 Duncairn Gardens****Belfast****BT15 2GB****Twinline 0800 138 0509****Email: Kellymcdonald@twinstrust.org****www.twinstrust.org**

Services include a freephone helpline, Twinline, membership and specialist support groups, including bereavement.

Women's Aid**www.womensaidni.org**

Women's Aid are the lead voluntary organisation in Northern Ireland addressing domestic abuse. They provide specialist services for women, children and young people.

There are eight local Women's Aid groups right across Northern Ireland who will be able to talk to you about support available to you in total confidentiality.

Women's Aid in Northern Ireland:

Provide refuge emergency accommodation to women and their children suffering domestic abuse within the home.

Provide a range of support services in the community to enable women who are leaving an abusive relationship.

Provide a range of support services to children and young people who have experienced domestic abuse.

Work in partnership with relevant agencies to ensure a joined-up response to domestic abuse. You can find your local Women's Aid group by visiting the Women's Aid website.

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