Sickle cell and thalassaemia disorders

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

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

Cystic fibrosis

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

Tay-Sachs disease

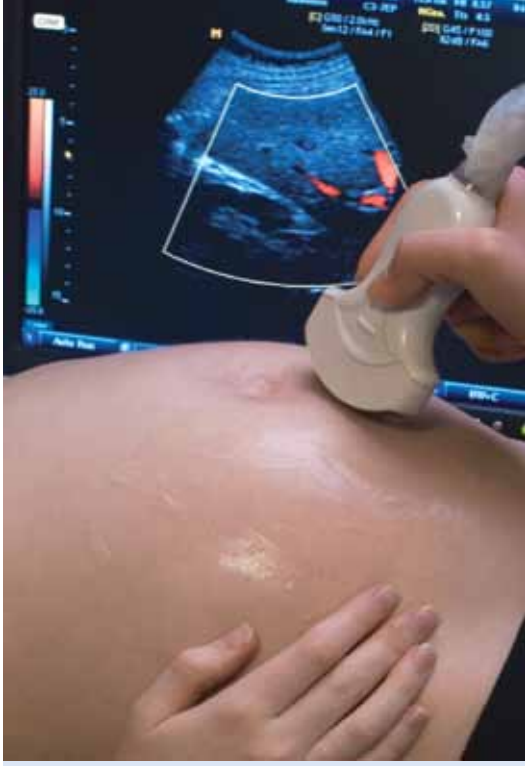
Testing for Tay-Sachs disease should be offered if you or your partner is of Ashkenazi Jewish origin and if you consider yourself or your partner to be at risk.

Cervical cancer

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

Herpes

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



ULTRASOUND SCANS

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

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

What do scans tell us?

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

At the scan

You may be asked to drink a lot of fluid before you have the scan. A full bladder pushes your uterus up and this gives a better picture. You then lie on your back and some jelly is put on your abdomen. An instrument is passed backwards and forwards over your skin and high-frequency sound is beamed through your abdomen to the uterus and pelvis. The sound is reflected back and creates a picture that is shown on a screen. It can be very exciting to see a picture of your own baby moving about inside you.

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

Fetal movement

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

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

TESTS TO DETECT ABNORMALITIES

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

Screening tests can:

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

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

Deciding whether to have tests

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

Haemophilia and muscular dystrophy

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

TESTS FOR DOWN'S SYNDROME AND OTHER GENETIC DISORDERS

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

Combined screening

Combined screening involves a blood test and an ultrasound scan. All women should have dating and nuchal translucency scans between eight and 14 weeks. These scans may be combined. The blood test measures two pregnancy-associated blood chemicals. At the scan, the radiographer measures the thickness of the nuchal translucency at the back of your baby's neck. This information is used to calculate your individual statistical chance of having a baby with Down's syndrome. This nuchal translucency scan can be used in multiple pregnancies. For more information about screening for anomalies, visit www.fetalanomaly.screening.nhs.uk/publicationsandleaflets

Serum screening

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

Screening results

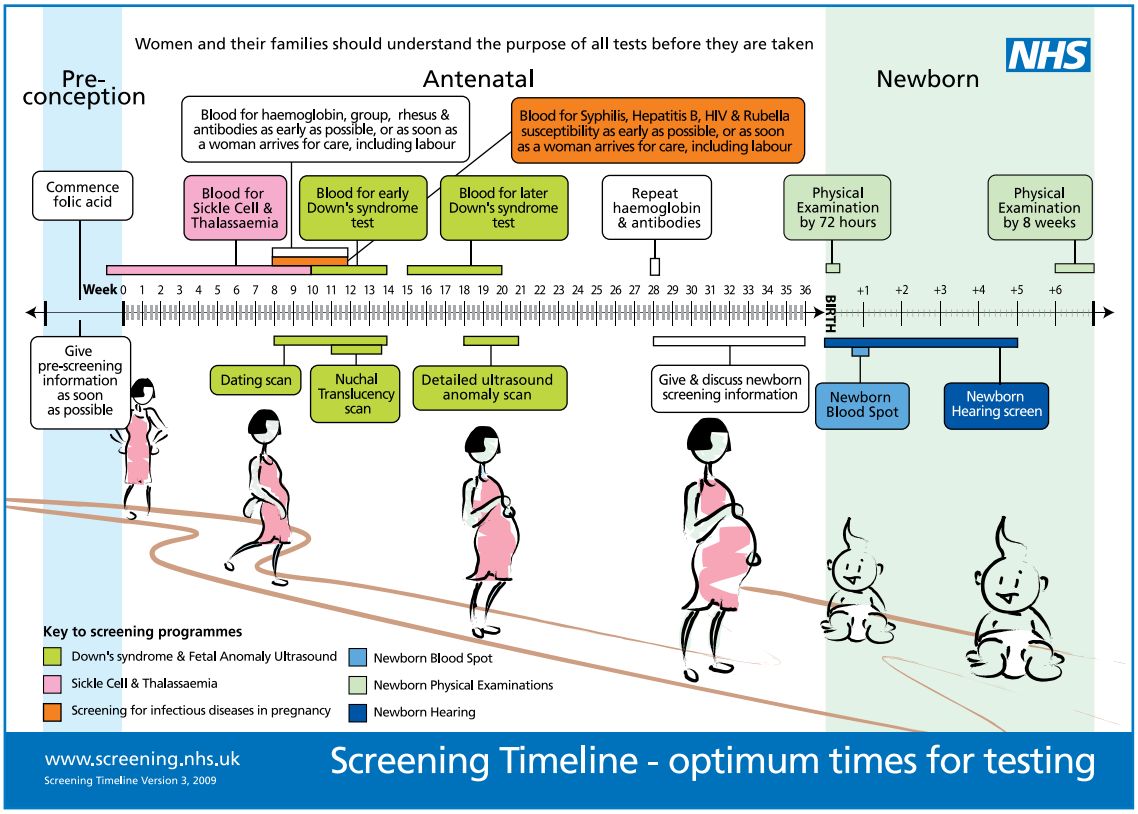
Some maternity services give the result as 'lower risk/screen negative' or 'higher risk/screen positive'.

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

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

More information

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



Amniocentesis

Amniocentesis can be offered from 15 weeks of pregnancy if:

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

What happens

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

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

The risks

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

DIAGNOSTIC TESTS FOR DOWN'S SYNDROME AND OTHER GENETIC DISORDERS

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

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

Chorionic villus sampling (CVS)

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

What happens?

The test takes 10 to 20 minutes and may be a little uncomfortable. Using ultrasound as a guide, a fine needle is passed through the abdomen into the uterus. Sometimes a fine tube is passed through the vagina and cervix into the uterus instead. A tiny piece of the developing placenta, known as chorionic tissue, is taken. The chromosomes in the cells of this tissue are examined. As with amniocentesis, a rapid result can be obtained, but if all the chromosomes are going to be checked the results may take up to two weeks.

The risks

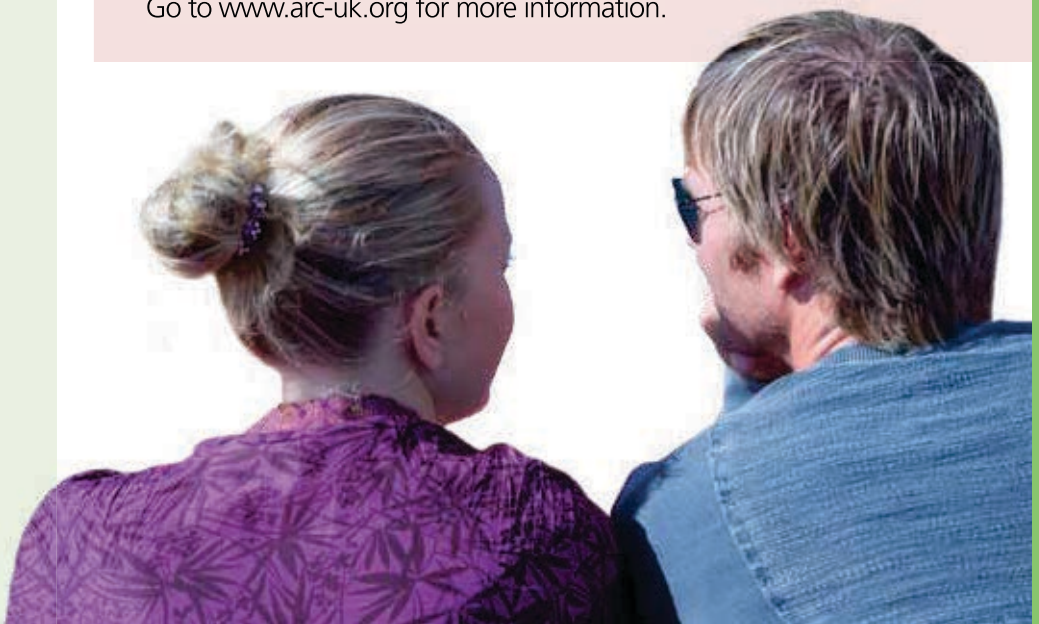
CVS has a 1–2% risk of miscarriage. This is slightly higher than amniocentesis.

IF A TEST DETECTS AN ABNORMALITY

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

Help and support

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



MAKING THE MOST OF ANTENATAL CARE

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

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

Your hand-held antenatal notes

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

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

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

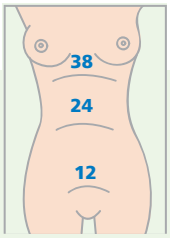
❶ **Date.** This is the date of your antenatal visit.

❷ **Weeks.** This refers to the length of your pregnancy in weeks from the date of your last menstrual period.

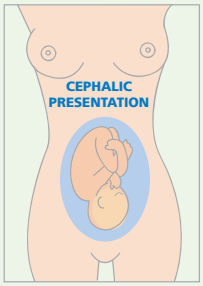
❸ **Weight.** This is your weight.

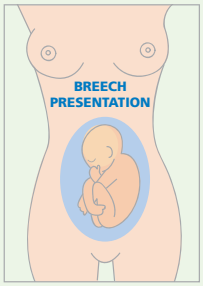
❹ **Urine.** These are the results of your urine tests for protein and sugar. '+' or 'Tr' means a quantity (or trace) has been found. 'Alb' stands for 'albumin', a name for one of the proteins detected in urine. 'Nil' or a tick or 'NAD' all mean the same: nothing abnormal has been discovered. 'Ketones' may be found if you have not eaten recently or have been vomiting.

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

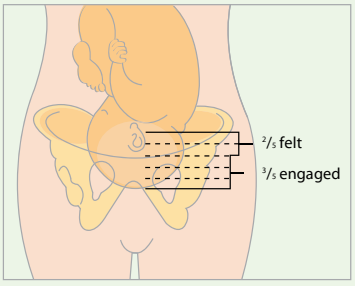


6 Height of fundus. By gently pressing on your abdomen, the midwife or doctor can feel your uterus. Early in pregnancy the top of the uterus, or 'fundus', can be felt low down, below your navel. Towards the end it is well up above your navel, just under your breasts. The figure should be roughly the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





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



8 Relation to brim. At the end of pregnancy, your baby's head (or bottom, or feet if they are in the breech position) will start to move into your pelvis. Professionals 'divide' the baby's head into 'fifths' and describe how far it has moved down into the pelvis by judging how many 'fifths' of the head they can feel above the brim (the bone at the front).

They may say that the head is 'engaged' – this is when 2/5 or less of your baby's head can be felt ('palpated') above the brim. This may not happen until you are in labour. If all of your baby's head can be felt above the brim, this is described as 'free' or '5/5 palpable'.

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

9 Fetal heart (FH). 'FHH' or just 'H' means 'fetal heart heard'. 'FMF' means 'fetal movement felt'.

10 Oedema. This is another word for swelling, often of the feet and hands. Usually it is nothing to worry about, but tell your midwife or doctor if it suddenly gets worse as this may be a sign of pre-eclampsia (see page 67).

11 Hb. This stands for 'haemoglobin'. It is tested in your blood sample to check if you are anaemic.

YOUR ANTENATAL TEAM

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

Many mothers would like to be able to get to know the people who care for them during pregnancy and the birth of their baby. The NHS is working to achieve this but you may still find that you see a number of different carers. The professionals you see should introduce themselves and explain who they are, but if they forget, don't hesitate to ask. It may help to make a note of who you have seen and what they have said in case you need to discuss any point later on.

care from your midwife

The people you are most likely to meet are listed below

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

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

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

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

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

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

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

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

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

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

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

Research

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

Students

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

ANTENATAL EDUCATION

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

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

Choosing an antenatal class

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

The classes

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

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

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

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

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

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

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

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

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

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

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

meet other parents-to-be

5 CONDITIONS AND PROBLEMS IN PREGNANCY

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

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

COMMON MINOR PROBLEMS

Backache

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

How to avoid backache

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

How to ease backache

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

When to get help

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

Constipation

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

How to avoid constipation

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

Cramp

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

How to avoid cramp

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

How to ease cramp

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

Feeling faint

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

How to avoid feeling faint

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

Feeling hot

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

How to avoid feeling hot

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

Headaches

Some pregnant women find they get a lot of headaches.

How to ease headaches

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

When to get help

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

Incontinence

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

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

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

When to get help

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

Help and support

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

Indigestion and heartburn

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

How to avoid indigestion

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

How to avoid heartburn

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

How to ease heartburn

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

Itching

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

How to avoid itching

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

Leaking nipples

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

When to get help

See your midwife or doctor if the milk becomes bloodstained.

Nausea and morning sickness

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

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

How to avoid nausea and morning sickness

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

When to get help

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

Nose bleeds

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

How to stop nose bleeds

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

Passing urine often

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

How to reduce the need to pass urine

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

When to get help

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

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

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

Pelvic joint pain

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

When to get help

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

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

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

coping with the symptoms

Piles

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

How to ease piles

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

Skin and hair changes

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

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

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

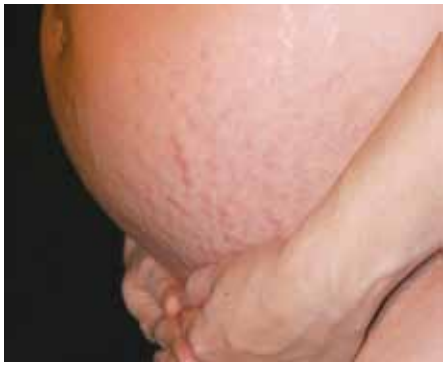
It might be more comfortable to lie on one side with a pillow under your tummy and another between your knees.

Sleep

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

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

Stretch marks



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

Swollen ankles, feet and fingers

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

Suggestions for swollen ankles, feet and fingers

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

put your feet up and rest

Teeth and gums

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

How to keep teeth and gums healthy

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

Tiredness

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

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

free NHS dental treatment

Vaginal discharge

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

When to get help

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

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

Varicose veins

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

If you have varicose veins

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

exercise helps your circulation

Help and support

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

MORE SERIOUS PROBLEMS

High blood pressure and pre-eclampsia

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

The symptoms

Some of the symptoms of pre-eclampsia are:

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

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

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

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

When to get help

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

Placenta praevia

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

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

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

Severe itching and obstetric cholestasis

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

When to get help

You should see your doctor if:

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

Slow-growing babies

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

When to get help

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

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

Seek medical help

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

Vaginal bleeding

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

Bleeding after sex

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

Ectopic pregnancy

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

Bleeding in late pregnancy

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

Help and support

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

Deep vein thrombosis

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

When to get help

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

More information

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

Vasa praevia

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

Problems in early pregnancy

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

6 CHOOSING WHERE TO HAVE YOUR BABY

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

SAFETY

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

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

MAKING AN INFORMED DECISION

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

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

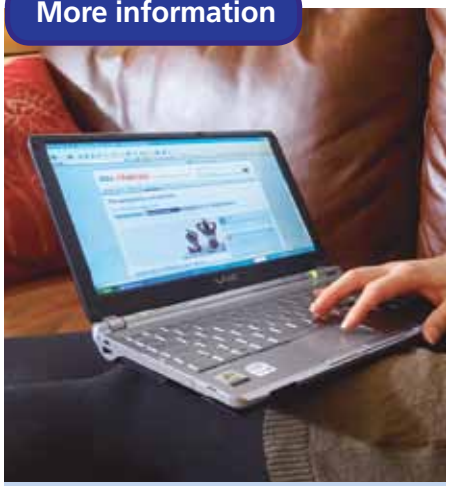
As well as getting information from your midwife, you can get information from:

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

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

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

More information



www.nhs.uk/pregnancyplanner

www.birthchoiceuk.com

www.drfoster.co.uk/Guides/BirthGuide/

www.nct.org.uk/home

HOME BIRTHS

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

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

The advantages of giving birth at home include the following:

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

The things you should consider include the following:

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

Planning a home birth

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

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

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

MIDWIFERY UNITS OR BIRTH CENTRES

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

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

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

The things you should consider include the following:

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

Planning a birth in a midwifery unit or birth centre

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

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

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

the choices that are right for you

BIRTH IN HOSPITAL

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

The advantages of giving birth in hospital include the following:

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

The things you should consider include the following:

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

Planning a hospital birth

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

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

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

BIRTH PLANS

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

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

You will probably want to think about or discuss some things more fully with the baby's father and friends and relatives. And you can change your mind at any time.

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

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

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

What is a midwife?

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

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

What is a supervisor of midwives?

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

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

PALS

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

7 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 person may not be a problem for you, and what is helpful advice for some people may not be right for you. So take from these pages what you find useful.

FEELINGS

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

Hormonal changes and tiredness

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

Help and support

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

Anxiety

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

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

Dreams

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

Ways of coping

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

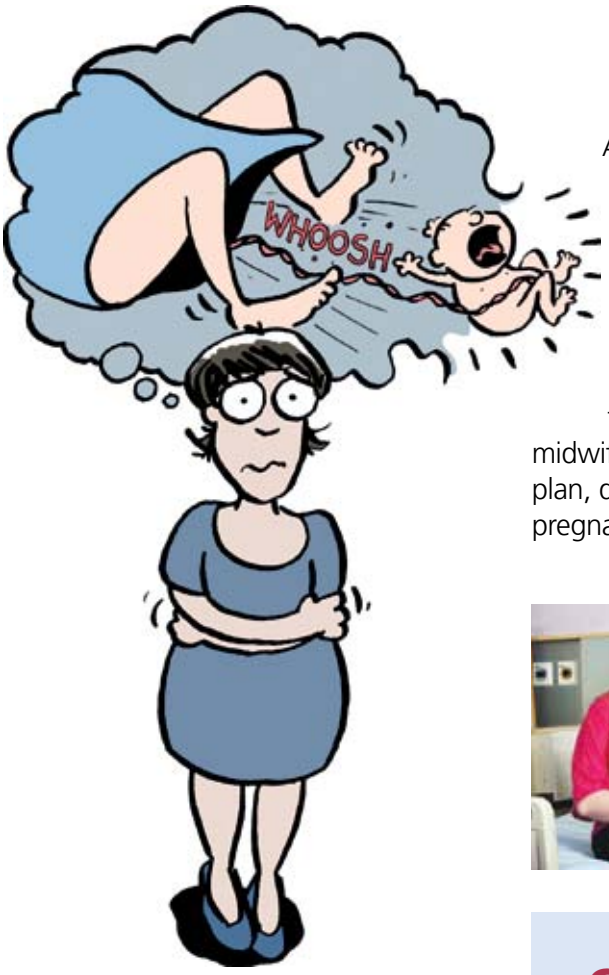
discuss your feelings

DEPRESSION AND MENTAL HEALTH PROBLEMS

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

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

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



WORRYING ABOUT THE BIRTH

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

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

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

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

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

antenatal education will help prepare you

CONCERNS ABOUT DISABILITIES

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

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

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

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

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

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

COUPLES

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

It is quite common for couples to find themselves having arguments every now and then during pregnancy, however much they are looking forward to the baby. Some arguments may be nothing to do with the pregnancy, but others may be because one of you is worried about the future and how you are going to cope. It's important to realise that during pregnancy there are understandable reasons for the odd difficulty between you, and good reasons for feeling closer and more loving.

One practical question you will need to discuss is how you will cope with labour, and whether your partner wants to be there. Many fathers do want to be present at their baby's birth. The chapter on labour and birth (page 85) gives some suggestions for ways in which fathers can help, and what it can mean for them to share this experience.

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

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

SEX IN PREGNANCY

It is perfectly safe to have sex during pregnancy. Your partner's penis cannot penetrate beyond your vagina, and the baby cannot tell what is going on! However, it is normal for your sex drive to change and you should not worry about this, but do talk about it with your partner.

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

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

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

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

Help and support

thecoupleconnection.net

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

SINGLE PARENTS

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

Don't feel that, just because you don't have a partner, you have to go to antenatal visits and cope with labour on your own. You have as much right as anyone else to take whoever you like – a friend, sister, or perhaps your mum. Involve your 'labour partner' in antenatal classes if you can, and let them know what you want from them. Ask your midwife if there are antenatal classes in your area that are run especially for single women.

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

Help and support

One Parent Families/Gingerbread

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

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

Lone Parent Helpline

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

FAMILY AND FRIENDS

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

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

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

More information

Families Information Service

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

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

WORK

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

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

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

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

AFTER THE BIRTH

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

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

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

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

MOOD CHANGES THAT CAN DEVELOP AFTER THE BIRTH OF A BABY

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

The baby blues

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

How does it affect you?

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

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

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

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

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

Postnatal depression

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

How does it affect you?

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

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

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

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

Postnatal post traumatic stress disorder and birth trauma

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

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

How does it affect you?

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

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

Puerperal psychosis

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

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

How does it affect you?

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

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

DOMESTIC ABUSE

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

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

Help and support

Domestic abuse

If you are in immediate danger, call 999.

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

Refuge
www.refuge.org.uk

Women's Aid
www.womensaid.org.uk

there is help available

Benefits and advice if your partner has died

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

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

Read Chapter 17 for advice about the following:

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

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

BEREAVEMENT

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

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

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

If your partner dies

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

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

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

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

8 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 two weeks before your due date.

Packing your bag

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

- Something loose and comfortable to wear during labour. It should not restrict you from moving around or make you too hot. You may need about three changes of clothes.
- Two or three comfortable and supportive bras, including nursing bras if you are planning to breastfeed. Remember, your breasts will be much larger than usual.
- About 24 super-absorbent sanitary towels.
- Your wash bag with toothbrush, hairbrush, flannel, etc.

- Towels.
- Things that can help you pass the time and relax, e.g. books, magazines, MP3 player.
- A sponge or water spray to cool you down.
- Front-opening nightdresses if you are going to breastfeed.
- Dressing gown and slippers.
- Five or six pairs of pants.
- A loose, comfortable outfit to wear after you have given birth and to come home in.
- Clothes (including a hat) and nappies for the baby.
- A shawl or blanket to wrap the baby in.

Transport

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

Home births

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

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

Mobile phones

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

If labour starts early

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

Stocking up

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

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

Important numbers

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

You need to include the following:

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

THE SIGNS OF LABOUR

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

Regular contractions

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

Other signs of labour

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

Pain relief in labour

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

has the time come?

TYPES OF PAIN RELIEF

Self-help

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

- Learn about labour. This can make you feel more in control and less frightened about what is going to happen. Read books like this one, talk to your midwife or doctor and attend antenatal classes if they are available in your area.
- Learn how to relax and stay calm. Try breathing deeply.
- Keep moving. Your position can make a difference. Try kneeling, walking around or rocking back and forwards.
- Have a partner, friend or relative to support you during labour. If you don't have anyone, don't worry – your midwife will give you all the support you need.
- Ask your partner to massage you (although you may find that you don't want to be touched).
- Have a bath.

Hydrotherapy

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

'Gas and air' (Entonox)

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

How it works

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

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

Side effects

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

staying calm will help

TENS

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

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

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

How it works

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

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

Side effects

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

Intramuscular injections of pain-relieving drugs

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

How it works

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

Side effects

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

Epidural analgesia

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

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

How it works

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

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

Side effects

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

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

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

Alternative methods of pain relief

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

Keep active

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

WHEN TO GO TO HOSPITAL OR YOUR MIDWIFERY UNIT

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

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

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

Home birth

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

ARRIVING AT THE HOSPITAL OR MIDWIFERY UNIT

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

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

Examination by the midwife

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

- take your pulse, temperature and blood pressure and check your urine

- feel your abdomen to check the baby's position and record or listen to your baby's heart, and
- probably do an internal examination to find out how much your cervix has opened. Tell her if a contraction is coming so that she can wait until it has passed. She will then be able to tell you how far your labour has progressed. If you would prefer not to have an internal examination you don't have to have one.

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

Water births

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

Delivery rooms

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

Bath or shower

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

WHAT HAPPENS IN LABOUR

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

The first stage of labour – dilation

The dilation of the cervix

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

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

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

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

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

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

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

Fetal heart monitoring

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

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

- Your baby's heartbeat and your contractions may also be followed electronically through a monitor linked to a machine called a CTG. The monitor will be strapped to your abdomen on a belt.
- Alternatively, a clip can be put on your baby's head to monitor the heart rate. The clip is put on during a vaginal examination and your waters will be broken if they have not already done so. Ask your midwife or doctor to explain why they feel that the clip is necessary for your baby.

Speeding up labour

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

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

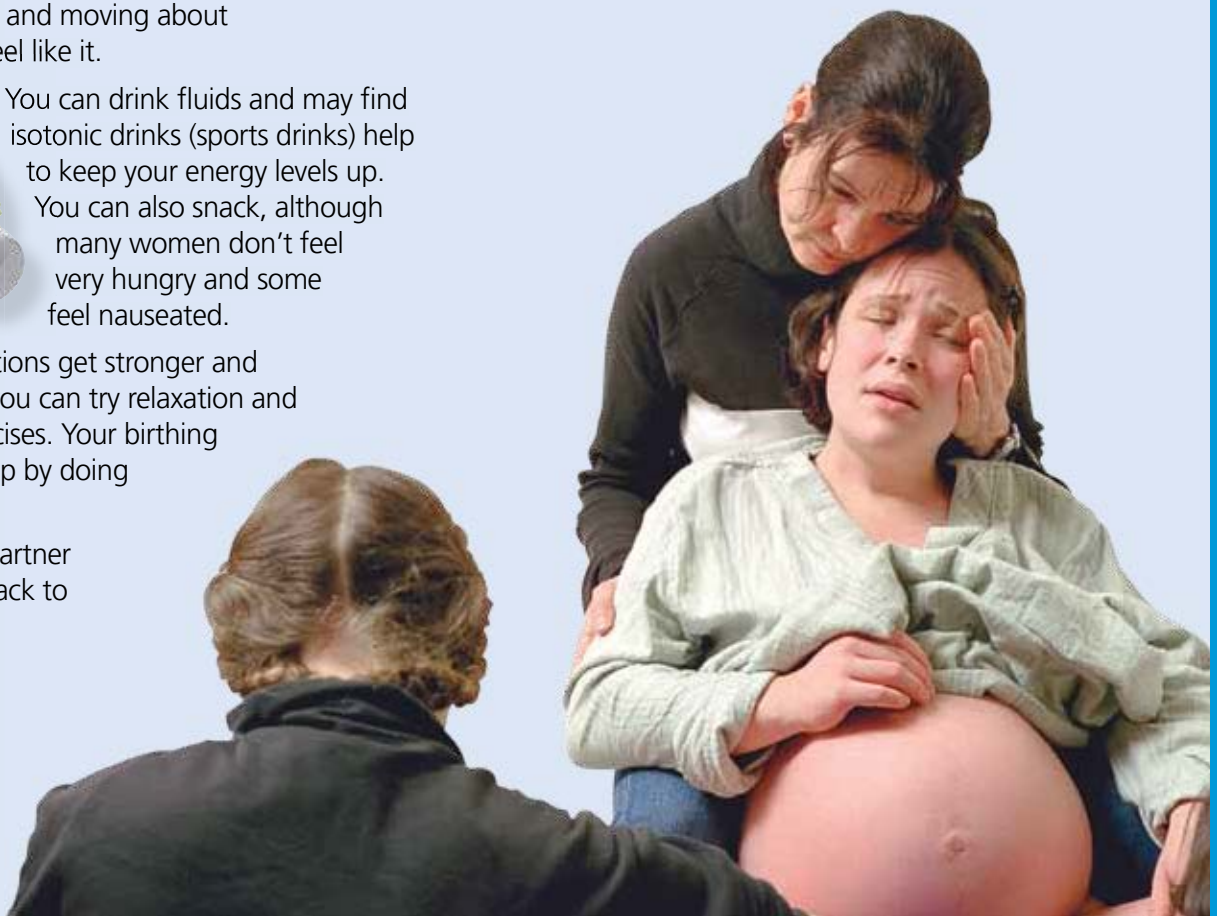
- Your waters will be broken (if this has not already happened) during a vaginal examination. This is often enough to get things moving.
- If this doesn't speed up labour, you may be given a drip containing a hormone, which is fed into a vein into your arm to encourage contractions. You may want some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

support and encouragement

Coping at the beginning

- You can be up and moving about if you feel like it.

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



The second stage of labour – the baby's birth

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

Find a position

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

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

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

Pushing

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

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

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

The birth

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

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

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

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

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

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

Skin-to-skin contact

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

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

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

The third stage of labour – the placenta

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

The injection contains a drug called Syntocinon, which makes the uterus contract and helps to prevent the heavy bleeding which some women experience.

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

skin to skin

After the birth

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

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

Vitamin K

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

Stitches

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

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

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

SPECIAL CASES

Labour that starts too early (premature labour)

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

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

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

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

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

Overdue pregnancies

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

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

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