

Pregnancy & Childbirth



A Goal Oriented Guide to Prenatal Care

Version 4.0 March 2019

Congratulations on Your Pregnancy

*The Department of Defense and the Department of Veterans Affairs are proud to welcome you to our Obstetrical Services. We will do everything possible to help you receive the best prenatal care for you and your baby. That's why we have implemented **Goal-Oriented Prenatal Care**. If you have any complications in your pregnancy, you may need additional visits and testing. Visits and testing outlined here form the basis of care for all pregnant women.*

With goal-oriented care, we design each visit to cover precise goals that are most appropriate to that specific time in your pregnancy. So no matter where you are located you will receive all critical aspects of prenatal care at the appropriate time. We have eliminated practices that do not have sound scientific backing (such as taking urine at each visit and early pregnancy cervical checks) and have added practices that have been shown to help promote a healthy pregnancy. With this approach, you will know what to expect and when to expect it. When possible, we encourage you to involve your baby's father or support person in your care.

*This book will guide you each step of the way through your pregnancy. **Please bring it to every visit.** We have divided the contents by visits with additional material in the Resource Section. Each visit section will include what to expect at your visit, signs to report, patient education, and a space to record related information. We encourage you to read each visit section carefully prior to each appointment. Please ask your healthcare provider if you have any questions or concerns. In this way, you will be well prepared for each step in this very special journey!*

Thank you for allowing us to take this journey with you!

Important Information	
Hospital Name	
Healthcare Provider	
Important Telephone Numbers	
OB Clinic	
Labor & Delivery (L&D)	
Labor & Delivery Triage Line	
Emergency Department	
My Childcare Provider	

Appointment List			
DATE	TIME	PROVIDER	LOCATION

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Visit Information

This section provides detailed information for each visit. Each visit section includes what to expect in your pregnancy, what to expect at your visit, and general pregnancy education. We suggest you be cautious about information and advice you may receive from family members, friends, the Internet or other outside sources. While most of these sources are well-meaning and may provide important support, bad advice and inaccurate information are common. Please make sure to discuss your specific concerns with your provider.

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Suggested Additional Reading (available in your clinic):

- Prenatal Fitness and Exercise

WEB SITE INFORMATION: Links to non-federal organizations in this book are provided solely as a service to our users and are not an all inclusive list of non-federal organizations. Links do not constitute an endorsement of any organization by the Department of Defense or the Department of Veterans Affairs and none should be inferred. The Department of Defense and the Department of Veterans Affairs are not responsible for the content of the individual organizations web pages found via these links.

General Pregnancy and Childbirth

<http://www.nlm.nih.gov/medlineplus>

<http://www.healthfinder.gov>

<http://marchofdimes.com>

<http://www.childbirth.org>

<http://www.text4baby.org> (text messages about baby)

<http://www.dodparenting.org> (Parent Review)

Baby/Child Care

<http://www.aap.org>

<http://www.dodparenting.org> (Parent Review)

Breastfeeding

<http://www.lalecheleague.org>

General

<http://www.militaryonesource.com>

The Birth of a Mother

In this book, you are asked questions focused on how you feel about your pregnancy and your relationship with your mother, or the primary person who raised you, and your partner. There is space provided to record your thoughts. As you go through your pregnancy and adapt to being the mother of a new baby, it is important that you realize you are being “born” or reborn into your role as a mother to this baby. Even if this is not your first baby, the transition to being a mother is a process that involves feelings, behaviors, attitudes, and character developed from life experiences and expectations.

While responses to being a mother may come from life experiences, maternal attitudes and behaviors change in relation to the age, condition, and situation of one’s child. Each mother-child relationship, each pregnancy, each delivery, and each childbirth experience are different for each woman. This is true even if you already have children. Each pregnancy, labor, and delivery is unique.

Supportive sharing from significant persons, especially your family, balances the process of becoming a mother. The support you receive from your mother, or other key support person, and your partner assists you in the changes you go through to become a mother. For you and your partner, mutual sharing provides the best foundation for adapting to your roles as new parents. The ability to see yourself as a mother and expand on the idea that the new child will impact your dreams and fantasies is a building process that occurs throughout pregnancy. It happens best with the support and help of your partner. Some of the questions raised in this book are to help include your partner in this important process.

The ability to imagine and think about being a mother depends on your life experiences. Good “mothering” role models, whether your own mother or another loving person you respect, will help you be confident and identify with being a mother. Many women feel a tremendous sense of relief in having a female friend or mentor with whom they can share feelings about their pregnancies. Regardless of the relationship you have with your partner, you may feel unable to express certain feelings or fears with him or her. This is normal. Women often say that they recognize their husband or partner “kind of understands”, but worry about discussing their fears, thoughts, hopes and dreams. Sometimes it is helpful to have a friend other than your partner to discuss your hopes, dreams and fears with.

Keep in mind that it is natural to have doubts and conflicts about this immense role change. This usually happens every time you have a baby. Becoming a mother affects your sense of self. If you are expecting your first child, you are truly between roles. Often there is fear of the impact the baby will have on marriage, family, and career. Generally, a vision of your image as a mother becomes clearer as pregnancy continues. The questions throughout this book are to help you define your idea of motherhood. Being able to picture or express your idea of motherhood takes place by rehearsing or imagining yourself in the role of a mother. It is normal to dream of yourself as a mother.

This process helps you identify the characteristics of a good mother. The ongoing process of the “birth of a mother” requires you to accept the loss of a former part of yourself. It is important to recognize your new role, with all its responsibilities, has many rewards. In other words, any losses you might have are balanced by rewards you will receive.

Preparing for any role change requires a desire to learn. During the process of becoming a mother, you will seek out information or models of your new role. Various confidants, whether your mother, a close friend, or your partner can all help provide information and act as role models. Watching other mothers with their children and attending birthing and prenatal classes are sources of information to help you through this process.

At many military installations, the DoD provides assistance through the New Parent Support Program. This program employs nurses, social workers and other individuals who can provide you access to many education programs. They can provide you written or video educational information and sometimes they can even come to your home to help you adapt to your role of becoming a new mother. For women veterans receiving services through the Department of Veterans Affairs, each facility has a Women Veterans Program Manager who can assist you with finding the resources you need during your pregnancy and after delivery.

This book will provide you with a lot of valuable information and should help answer many of your questions but it is no substitute for a wise and supportive mentor. Some places have support groups for women whose spouses are deployed. Other places have groups where experienced women volunteer to provide guidance to new mothers. We encourage you to take advantage of these kinds of opportunities. We wish you the very best in your own birth as a mother!

Visit Summary Information

Goal-oriented visits:

6–8 Week Visit Goal: Exchange information and identify existing risk factors that may impact your pregnancy

To Do:

1. Read the visit information and any additional related topics prior to your visit. Write down any questions you may have.
2. Ask your family about any medical problems that exist in your family members such as diabetes, cancer, hypertension, and genetic problems.
3. Fill out questionnaire, if provided prior to your appointment, in preparation for this visit.
4. Suggested reading in Resource Section: Common Discomforts and Annoyances of Pregnancy, Travel and Pregnancy, Tobacco, Alcohol and Drug Use in Pregnancy, Specific Genetic Testing, Nutrition, Dental Care, and Genetic Screening. Think about whether you wish to have blood tests to screen for birth defects.

10–12 Week Visit Goal: Determine current health status and work toward a healthy pregnancy

To Do:

1. Read the visit information and any additional related topics prior to your visit. Write down any questions you may have.
2. Wear clothing easy to change out of for a physical exam.
3. Suggested reading in Resource Section: Common Discomforts and Annoyances of Pregnancy, Genetic Screening, Breastfeeding, Exercise, Immunizations, and Sexually Transmitted and Other Infections.
4. Review Prenatal Fitness and Exercise brochure.

16–20 Week Visit Goal: Work toward a comfortable and safe pregnancy

To Do:

1. Read the visit information and any additional related topics prior to your visit. Write down any questions you may have.
2. After visit, schedule your appointment for an ultrasound if not already scheduled.
3. Suggested reading in Resource Section: Breastfeeding and Testing and Monitoring during Pregnancy.

24-Week Visit Goal: Prevent preterm labor for a safe and healthy baby

To Do:

1. Read the visit information and any additional related information prior to your visit. Write down any questions or concerns you may have.
2. Suggested reading in Resource Section: Preterm Labor and Fetal Movement Counting Chart. Check out available prenatal classes at your hospital.

28-Week Visit Goal: Monitor your baby and your progress and learn to count fetal movements

To Do:

1. Read the visit information and any additional related topics prior to your visit. Write down any questions or concerns you may have.
2. Follow instructions given to you for your one hour glucose beverage test.
3. Suggested reading in Resource Section: Fetal Movement Count Chart, Testing and Monitoring during Pregnancy, and True versus False Labor.
4. Fill out Fetal Movement Chart and bring with you to visit.

32-Week Visit Goal: Prepare for your baby's arrival

To Do:

1. Read the visit information and any additional related topics prior to your visit. Write down any questions or concerns you may have.
2. Fill out Fetal Movement Chart and bring with you to visit.
3. Suggested reading in Resource Section: Labor and Delivery Basics, Labor and Delivery Procedures, Family Planning, Birth Planning, Breastfeeding, and Bottle Feeding.

36-Week Visit Goal: Begin preparations for your hospital experience

To Do:

1. Read the visit information and any additional related topics prior to your visit. Write down any questions or concerns you may have.
2. Fill out Fetal Movement Chart and bring with you to visit.
3. Suggested reading in Resource Section: Labor and Delivery Basics, Labor and Delivery Procedures, Birth Plan, Promoting Safety in Childbirth, Baby Supplies for First Week, and Safety Tips for Babies.

38–41 Week Visit Goal: Preparing for birth and baby's arrival at home

To Do:

1. Read the visit information and any additional related topics prior to your visit. Write down any questions or concerns you may have.
2. Fill out Fetal Movement Chart and bring with you to visit.
3. Suggested reading in Resource Section: Labor and Delivery Basics, Labor and Delivery Procedures, Birth Plan, Promoting Safety in Childbirth, Baby Supplies for First Week, Safety Tips for Babies, Breastfeeding, and Bottle Feeding.

Post Delivery Visit 6-8 Weeks after Delivery: Determine health status and promote adjustment to being a mother

To Do:

1. Read the visit information and any additional related topics prior to your visit. Write down any questions or concerns you may have.
2. Think about family planning needs if that has not already been decided.
3. Call the clinic to confirm whether or not you may bring baby with you for this appointment.

Keeping You and Your Baby Safe

The VA and DoD have created Guidelines for Pregnancy that form the basis for the care outlined in this book. We have created the Resource Section to provide you further information that will help in your pregnancy. It is important that you be a partner with the providers in your pregnancy care. To help with this we have a few tips and recommendations for you.

The information in this book is helpful but it is not a substitute for your obstetric care provider. He or she will have specific information about you and will be able to help tailor your prenatal care for your personal circumstances. These are guidelines and the best care will sometimes mean doing things different than or in addition to what is outlined here.

Help keep track of your key pregnancy information. The VA/DoD Pregnancy Passport contains most of the information that is essential for good prenatal care. Take it to your visits and keep it with you at all times. This will help if your records are misplaced or computer systems are down. It will also be useful if you have an emergency and need to get care away from your hospital or clinic.

Help us assure that your due date is well established by 20 weeks of pregnancy. It is very hard to establish a firm due date after mid-pregnancy. Firm due dates are always estimates but the due date affects many of the decisions that could need to be made for your care. If there is any uncertainty in your due date your provider will usually order an ultrasound to help establish the due date.

Remember, your due date is an estimate. Normal pregnancies usually end between 37 and 42 weeks by you going into labor all on your own. In a normal pregnancy, the baby and placenta help prevent you from going into labor too soon. Usually, when the baby is mature, the baby will stop preventing labor and allow it to happen.

Try not to be too anxious to deliver before it happens on its own. There are many reasons why your provider might recommend giving birth before your due date. Sometimes it is critical for you or the baby's health to be delivered early. There will always be a good medical reason if it is recommended you give birth before 39 weeks. Be sure you understand why this recommendation is being made. If your cervix is not ripe, labor induction can be long and hard and can increase your chances of a cesarean delivery especially if this is your first baby. Even babies born at 37 to 38 weeks can have problems from prematurity such as difficulty breathing and eating or jaundice.

If you have questions or concerns, ask or arrange to go to the hospital to be seen. This book can give you answers to many questions. Your provider will also answer your questions and address your concerns. It is important that you help us take care of you by making sure we understand your needs.

6-8 Week Visit

Prenatal Information Sheet

6-8 Week Visit



Goal: Exchange information and identify existing risk factors that may impact the pregnancy

Prenatal Information Sheet: 6–8 Week Visit

Goal: Exchange information and identify existing risk factors that may impact the pregnancy

Your baby's growth

- Your baby (embryo) is probably an inch long and likely weighs 1/30 of an ounce.
- Your baby's face and body are fairly well formed.
- Your baby's bones have appeared. Internal organs are beginning to work and the baby's heart has been beating since the third week.
- The placenta is attached to the uterine (womb) wall on the mother's side and the umbilical cord going to the baby on the other. The placenta acts as an "almost" perfect filtering system between mother's blood and baby's blood. The placenta has a fetal (baby) circulation side and a maternal circulation side. A membrane barrier separates these sides. The placenta and umbilical cord provide the way for nutrients (food and oxygen) to get to your baby and for waste products to be removed. Unfortunately, it also allows some harmful substances, such as alcohol and drugs, if in the mother's blood, to get to the baby.



Your baby's growth

Your body's changes

- Your uterus has grown from the size of a pear to the size of a large orange.
- You are probably beginning to notice changes in your body as a result of your pregnancy.
- Your breasts may become larger and tender.
- The area around your nipples may darken.
- You may have to go to the bathroom more frequently to urinate.
- You may have "morning sickness" that may last beyond the morning.
- Your bowel habits may change. You may be more constipated.



Your body's changes

Your family's changes

- The hormone changes that affect your body may also affect your emotions, causing mood swings.
- Your partner may have concerns about your health, the baby, and your family's financial state.
- Coping with the discomforts of pregnancy may change household and work routines.
- You and your partner both need time to adjust and accept your upcoming role as new or repeat parents.
- It is important to share these feelings with someone you trust.
- Talk with your spouse/partner regarding any feelings about the pregnancy.



Your family's changes



Thoughts & feelings

Your thoughts and feelings

- You may have some new feelings - maybe you stopped doing things you enjoy or felt sad some days in the past couple weeks.
- Accept how you are feeling, even if it is that you are very tired, and remember that these changes are temporary.
- Discuss your feelings with someone you trust and your healthcare provider, especially if you have been very sad or depressed.
- If you have experienced depression at another point in your life, you are at much higher risk for pregnancy-related depression. In fact, one in three mothers with a history of Major Depressive Disorder will experience depression during or after pregnancy. Please discuss any history of depression, thoughts of hurting yourself or others, or any mental health concerns with your provider as soon as possible.
- In early pregnancy you may find that your desire for sexual intercourse changes especially if you have nausea, vomiting, fatigue and/or breast tenderness. Since the amniotic sac protects and cushions the fetus, intercourse normally does not hurt the developing baby or cause a miscarriage. Ask your healthcare provider if you have concerns.
- Hormone changes and weight gain can make it easy to become frustrated with yourself and others. Physical discomforts, like not sleeping well, nausea and fatigue, can make it hard to deal with the demands of life even when you are not pregnant! If you are already a parent, your challenge may be even greater.
- Pregnancy is both exciting and scary. Adapting to a new pregnancy as a Veteran transitioning to civilian life, as an Active Duty member or as a military spouse can be challenging. For pregnant spouses of deployed military members or for pregnant active duty service members, there may be anxiety about the timing of the pregnancy and birth. Planning an upcoming Permanent Change of Station (PCS)/move can be especially challenging when you are pregnant. A strong support system helps decrease anxiety that may come with pregnancy and military/veteran transitions.



Signs to report immediately

Signs to report immediately

- When in doubt, call the clinic or your healthcare provider or go to the Emergency Department!
- Bright red vaginal bleeding or painful cramping.
- Persistent severe headaches.
- Fever at or over 100.4° F or 38° C.
- Persistent nausea and vomiting.
- Thoughts of hurting yourself or others, or any mental health concerns.

Today's visit (typical topics)

- Fill out the questionnaire, if received prior to this visit, about any history that is relevant to this pregnancy.
- You will be screened for potential risk factors such as:
 - Social risks: alcohol/drug/tobacco/intimate partner violence.
 - Medical risks: immunization status, exposure to sexually transmitted infections, current health status, and family history of specific diseases.
 - Nutritional risks: weight and dietary intake.
 - Obstetrical risks: problems in previous pregnancies and risks for preterm labor.
 - Mental health concerns.
- If you are struggling with nausea and vomiting, refer to Common Discomforts & Annoyances of Pregnancy in the Resource Section for things you can do. Now is the time to think about avoiding too much weight gain. For tips about weight gain, refer to Nutrition in Pregnancy in the Resource Section.
- Receive and discuss information on exercise, benefits of breastfeeding, and other health related behaviors.
- Discuss initial information regarding options for screening for birth defects including chromosomal abnormalities. More detailed counseling will be arranged at later visits. See Genetic Screening in Resource Section.
- Receive needed immunizations and information on ways to decrease chance of getting various diseases.
- Have recommended blood work and urine screen completed.
- Discuss your anticipated due date which may change when more information is known and further testing is done. Knowing your last menstrual cycle date will help determine your due date.
- Often, an early ultrasound will be ordered to confirm or more accurately determine your due date.



Today's visit

Normal is same as pre-pregnant BP or slightly less than pre-pregnant BP

My BP:

Your blood pressure

- We will measure blood pressure (BP) at every prenatal visit. Rapidly increasing or abnormally high blood pressure can be a sign of Gestational Hypertension.
- High blood pressure can cause serious complications such as a decrease in the blood and oxygen supply to the baby and mother.



Your blood pressure

My weight:

Your weight

- Your weight will be checked at each visit. If you are over or underweight, you may be referred to a Registered Dietitian for additional information.



Your weight



Your weight

Your weight

- Whether you are underweight (BMI < 18.5), normal weight (BMI 18.5 – 24.9), overweight (BMI 25.0 – 29.9), or obese (BMI ≥ 30.0), you should discuss your optimal weight gain with your healthcare provider.
- Estimate your pre-pregnancy Body Mass Index (BMI) and track your weight gain on pages 136 and 137 of this book.
- Total weight gain should be about 25–35 pounds unless you are over or underweight. Your weight gain is not all fat. It is mostly water in your body and the weight of the growing baby.
- Normal pregnancy weight gain:
(if pre-pregnant BMI is normal)

breast	1.0 - 1.5 lbs.
blood	3.0 - 4.5 lbs.
extra water	4.0 - 6.0 lbs.
uterus	2.5 - 3.0 lbs.
placenta/amniotic fluid	3.5 lbs.
baby	7.0 - 8.0 lbs.
fat stores	4.0 - 6.5 lbs.

TOTAL 25 - 35 lbs.

- Gaining the right amount of weight by eating the right type of food is an extremely important part of a healthy pregnancy.



Your exercise routine

Your exercise routine

- For healthy pregnant women who have not been advised differently, regular mild to moderate exercise sessions, three or more times per week, for at least 20 minutes each, with a goal of 150 minutes per week, helps to keep you fit and feeling better during a time when your body is changing.
- Consider including aerobic exercise, strength training, or a combination of both in your program.
- Check with your healthcare provider before you begin an exercise program or before you begin a new type of exercise.



Consider breastfeeding

Breastfeeding - a great start

- Now is the time to think about how you want to feed your baby.

	<p>Breastfeeding - a great start</p> <ul style="list-style-type: none"> • Breastfeeding for at least your baby's first 12 months of life is recommended. • Breastfeeding is not only best for the baby, it is also best for your health. Breastfeeding can improve your health by helping you lose pregnancy weight and lower the level of bad cholesterol. On average, women who breastfeed live longer and healthier lives compared to women who do not breastfeed. • See Breastfeeding in Resource Section for further information. 	
	<p>Take only medications approved by your healthcare provider</p> <ul style="list-style-type: none"> • Discuss any prescription medication with your provider. • Over-the-counter drugs considered safe for common discomforts include: <ul style="list-style-type: none"> – Headaches: Tylenol®, Tylenol PM®, Datril® – Cold: Tylenol®, saline nose spray/rinses, Robitussin® (no alcohol), Benadryl® – Allergies: Claritin®, Zyrtec®, Allegra® – Constipation: Metamucil®, Fiber-All®, Miralax®, Milk of Magnesia® – Indigestion: Tums®, Rolaids®, Maalox®, Mylanta II®, Simethicone – Heartburn: Zantac®, Pepcid®, Prilosec® – Hemorrhoids: Preparation H®, Anusol® – Nausea/Vomiting: Vitamin B6, Emetrol®, Unisom®, ginger, sea sickness bands 	
	<p>Drugs to avoid</p> <ul style="list-style-type: none"> • Aspirin®, Motrin®/Ibuprofen, Tetracycline, Accutane® • Limit caffeine. For more information, see page 134, Caffeine, in the Resources section of this book. 	



**Consider
breastfeeding**



**Take only
medications
approved by
your provider**



**Drugs
to avoid**



**Drugs
to avoid**

Drugs to avoid

- Alcohol, tobacco, and any illicit drugs are harmful to your baby; avoidance helps to decrease risks. There is no known amount of alcohol that is safe to drink while pregnant. All drinks with alcohol can hurt an unborn baby.

NOTE: If you are using any drugs or substances that may be harmful to your baby, ask about strategies to quit and approaches to lifestyle behavior changes.



**Work and
household
activities**

Work and household activities




- AVOID:
 - Cat litter.
 - X-rays (may be necessary after discussion with your OB healthcare provider).
NOTE: Dental x-rays with proper shielding are safe.
 - Use of dry cleaning solutions.
 - Children's sandboxes (cats may use as a litter box).
 - Working around radiation or radioisotopes.
 - Working with lead or mercury.
 - Gardening without gloves.
- If in doubt about your potential exposures, ask your health care provider.



**Contact with
certain diseases
or
infections**

Avoiding infections

- Practice behaviors that prevent infection: Wash your hands often, especially after using the toilet or changing a diaper, before food preparation, and before and after you eat.
- Cover your cough and encourage your family members to do the same.
- Avoid contact with people who have known infectious conditions, such as a cold, the flu or a childhood disease such as chicken pox.
- It is important that you be open with your healthcare provider regarding exposure to any Sexually Transmitted Infections (STIs). Sexually Transmitted Infections (STIs) are viruses, bacteria, or parasites that pose risks of injury or death to your baby. These STIs include:
 - HIV(AIDS)
 - Gonorrhea
 - Syphilis
 - Chlamydia
 - Genital Herpes
 - Genital warts

	<p>Immunization status</p> <ul style="list-style-type: none"> • Your immunizations should be up-to-date. We will review your immunization and/or past exposure history for the following: <ul style="list-style-type: none"> – Varicella (Chicken Pox) – Rubella (German Measles) – Hepatitis B – Tetanus (Lockjaw) – Pertussis (Whooping Cough) – Diphtheria – Influenza (Flu) (seasonal-related) • No live virus vaccines are recommended during pregnancy. • Flu vaccines are safe to receive during pregnancy. Please make sure yours is up-to-date for your pregnancy and delivery. • While the influenza vaccine is recommended and safe during pregnancy, the flu mist is a live vaccine so should not be given during pregnancy. • Receive immunizations as needed. • For more information about immunizations in pregnancy, visit the Centers for Disease Control and Preventions web page on maternal vaccines at: https://www.cdc.gov/vaccines/pregnancy/pregnant-women/index.html. • You can avoid many infections by following good hand washing practices. 	 <p>Immunization status</p>
	<p>Screening for birth defects</p> <ul style="list-style-type: none"> • After counseling with your provider, decide which tests, if any, should be scheduled to assess for risk of birth defects. This may include an ultrasound. See Genetic Screening in Resource Section. 	 <p>Serum Screening Options</p>
	<p>Intimate Partner Violence</p> <ul style="list-style-type: none"> • Intimate partner violence often increases during pregnancy. Please do not hesitate to seek help from your healthcare provider, counselor, or a close friend if you are experiencing physical, sexual, or emotional abuse from your intimate partner or anyone else. 	 <p>Domestic abuse screen</p>



**Domestic abuse
screen**

Intimate Partner Violence

- Let your healthcare provider know if, within the past year, or since you have been pregnant, a current or former intimate partner (boyfriend, girlfriend, wife, husband, sexual partner, etc.) has physically hurt you, insulted or talked down to you, threatened you with harm, screamed or cursed at you, or forced you to have sexual activity.
- National Domestic Abuse Hotline:
1-800-799-7233



Summary of visit

Summary of visit

Due date: _____ Date of next visit: _____

Date for lab work/other medical tests: _____

Date for any other scheduled appointments: _____



Your next visit

Your next visit

At your 10-12 week visit we will:

- Measure your uterine growth, blood pressure, and weight, and listen to the fetal heart tone (may not be heard this early in pregnancy) and discuss any concerns/questions you may have.
- Complete a head-to-toe physical and pelvic exam, Sexually Transmitted Infection (STI) screening and possibly a Pap smear.
- Discuss lab test results from first visit and have additional labs, if needed.
- Discuss lifestyle changes if needed.
- Provide further education on Cystic Fibrosis Carrier risk and discuss your options to be screened with a blood test if not done at first visit.
- You should plan on at least 30 minutes for this visit.
- You should bring: any copies of your outpatient medical record and your immunization record for your provider to review and complete your medical history.

**ALWAYS
BRING YOUR
PURPLE BOOK
AND
PREGNANCY
PASSPORT
TO
EVERY VISIT**

My reaction when I learned I was pregnant:

My partner's reaction to my pregnancy:

Goals for my pregnancy:

Questions for my next visit:

Notes:

10–12 Week Visit Prenatal Information Sheet

10-12 Week Visit



Goal: Determine your current health status
and work toward a healthy pregnancy

Prenatal Information Sheet: 10–12 Week Visit

Goal: Determine your current health status and work toward a healthy pregnancy

Your baby's growth

- Your baby is now about 2.5 to 3.0 inches long and likely weighs about 0.5 ounces. The head is about twice the size of the body.
- During this time, your baby's body and organ tissues grow rapidly.
- The eyes and ears are moving into normal positions.
- Intestines move from the umbilical cord into the stomach area.
- We may be able to hear your baby's heartbeat with a Doppler.



Your baby's growth

Your body's changes

- Your uterus is now the size of a grapefruit.
- We may be able to feel the upper edge of your uterus (the fundus) a little bit above your pubic bone.
- Wear comfortable clothing that provides room to grow.
- Morning sickness often diminishes by the end of this month.
- If you haven't already started, slowly add healthier food choices and change unhealthy eating habits.
- Your teeth and gums are affected by pregnancy, just as other tissues in your body. Routine dental care is important to maintaining your dental health. Check when your last dental cleaning was and schedule an appointment with your dental provider if it has been more than six months. Dental x-rays with the proper precautions are not harmful during pregnancy.



Your body's changes

Your family's changes

- You may be moody, irritable, tearful, disorganized, have trouble concentrating, or have irrational thoughts. These feelings are normal. It may be helpful to talk about them with your family.
- Your sexual desire may increase or decrease - both are normal.



Your family's changes

Your thoughts and feelings

- You may find you are more moody or "stressed out" than you have been in the past. This is in part due to hormonal changes as your body adjusts to pregnancy. Just planning for your baby's arrival can be challenging.
- Most expectant mothers have concerns, whether it is body changes/discomforts, their health or the baby's, fear of labor or changes to their personal or work situation.



Thoughts & feelings



**Thoughts
&
feelings**

Your thoughts and feelings

- Discuss your feelings with someone you trust and healthcare provider, especially if you have been depressed.
- Discuss any concerns about past traumatic events with your healthcare provider. There are options to help you cope with this if it becomes a problem.



**Signs to report
immediately**

Signs to report immediately

- When in doubt, call the clinic or your healthcare provider or the Emergency Department!
- Bright red vaginal bleeding, or painful cramping.
- Persistent severe headaches, severe nausea, and vomiting.
- Fever at or over 100.4° F or 38° C.
- Inability to keep liquids down (due to nausea and/or vomiting) resulting in a reduced amount of urine.
- Thoughts of hurting yourself or others, or any mental health concerns.



Today's visit

Today's visit (typical topics)

- Review your medical and mental health history with your healthcare provider.
- You may receive a complete head-to-toe physical and pelvic exam that includes screening for sexually transmitted infections (STI) and may include a Pap smear.
- Review and discuss initial lab results.
- Identify and discuss with your healthcare provider any additional visits, labs, or tests you may need.
- Discuss with your provider information regarding options for screening for birth defects including chromosomal abnormalities. See Genetic Screening in Resource Section.
 - If you have chosen to undergo first trimester screening for birth defects, with a first trimester result, your provider will review any tests completed.
 - If you have chosen a testing strategy with results in the first trimester but have not yet had testing, and you are still within the appropriate gestational age, testing will be arranged.












**Your blood
pressure**




Your blood pressure

- Blood pressure is measured at every prenatal visit because high blood pressure can cause serious complications for baby and mother if not controlled.

My BP:

<p>My weight:</p> <p>_____</p> <p>Total weight change:</p> <p>_____</p> <p>My optimal weight gain:</p> <p>_____</p>	<p>Your weight and nutrition</p> <ul style="list-style-type: none"> • Weight gain now is usually two to four pounds. Monitor/review your weight gain regularly. • Your baby is likely to be healthier if you eat nutritious foods. • Try small, frequent meals to provide needed nutrition and to decrease nausea and vomiting. • Choose your calories wisely—make sure each one is good for both the baby and you. • If you are currently taking a multivitamin, you may continue taking it. Discuss your decision with your provider. • If you are taking specific nutritional supplements (such as vitamins) or if you are on a special diet, you should discuss with your provider the need for ongoing supplementation or additional nutritional consultation. • Whether you are underweight (BMI < 18.5), normal weight (BMI 18.5 - 24.9), overweight (BMI 25.0 - 29.9), or obese (BMI ≥ 30.0), you should discuss your optimal weight gain with your healthcare provider. • Estimate your pre-pregnancy BMI and track your weight gain on pages 136 and 137 of this book. 	 <p>Your weight</p>
<p>Reference: Prenatal Fitness and Exercise</p>	<p>Your exercise routine</p> <ul style="list-style-type: none"> • You may find it more difficult to “catch your breath” even when walking up stairs. Take it slowly. If you have a concern, discuss it with your provider. • It is best to never exercise to the point of exhaustion or breathlessness. This is a sign that your body cannot get the oxygen supply it needs, which affects the oxygen supply to the baby as well. • Certain activities should be avoided. For further information, see Exercise in the Resource Section. • Additional information for active duty service members can be found on pages 95 through 101 of this book. 	 <p>Your exercise</p>
<p>Breastfeeding - a great start</p> <ul style="list-style-type: none"> • Get to know other breastfeeding moms and get involved in community breastfeeding groups, such as La Leche League. • Human breast milk contains more than 100 protective ingredients not found in a cow’s milk-based formula. Breast milk can’t be duplicated. 		
		 <p>Consider breastfeeding</p>

 <p>Consider breastfeeding</p>	<p>Breastfeeding - a great start</p> <ul style="list-style-type: none"> • Learn as much about breastfeeding as you can ahead of time. • I plan to _____ feed my baby. I want to do this for _____ months. 	
 <p>Fetal heart rate</p>	<p>Fetal heart rate</p> <ul style="list-style-type: none"> • You may be able to hear your baby's heartbeat at this visit with a Doppler. 	<p>Fetal heart rate:</p> <p>_____</p>
 <p>Uterine size</p>	<p>Uterine size</p> <ul style="list-style-type: none"> • At 10 – 12 weeks your uterus is at the top of your pubic bone. 	<p>Uterine size:</p> <p>_____</p>
 <p>Initial lab results</p>	<p>Initial lab results</p> <ul style="list-style-type: none"> • If any of your test results are abnormal, your provider will discuss life-style changes, treatments, and possible outcomes. 	
 <p>Blood type testing</p>	<p>Blood type testing</p> <ul style="list-style-type: none"> • Blood typing and antibody testing will be done to tell if your blood is Rh (D) negative or positive. • If you are found to be Rh (D) negative: <ul style="list-style-type: none"> – You will receive a D-immunoglobulin (RhoGAM®) injection at 28 weeks to prevent your blood from building up antibodies that can harm your baby. – Additional RhoGAM® injections are usually given if you have certain procedures, such as amniocentesis, or if you are experiencing vaginal bleeding during the pregnancy. – The RhoGAM® injection is repeated after delivery if baby's blood is Rh positive. 	
 <p>Rubella and Varicella results</p>	<p>Rubella and Varicella results</p> <ul style="list-style-type: none"> • If screening shows no immunity (tests negative), we will discuss precautions to protect against these infections. 	

	<p>Asymptomatic Bacteriuria (ASB) Screen</p> <ul style="list-style-type: none"> • ASB is an increased growth of bacteria in the urine that can only be found through laboratory analysis of a urine sample. There are no symptoms, but ASB can result in a serious kidney infection if left untreated. • Antibiotic treatment may be prescribed. It is important to take as directed and finish the whole prescription or the bacteria can return. • To reduce the chance of getting ASB, wear cotton panties and wipe from front to back. 	 <p>Asymptomatic Bacteriuria (ASB) screen</p>
	<p>Cystic Fibrosis (CF) Carrier Screen</p> <ul style="list-style-type: none"> • This test is optional. The chances of having CF vary with ethnic groups. See Specific Genetic Testing in the Resource Section for further information. • We offer this test to determine if you are a carrier for CF and your baby's chances of having the disease. If you test positive, then the next step is to test the baby's father. • If you and your partner are carriers, your unborn baby will have a 1 out of 4 (25%) chance of having CF. • You will be given additional information and the option for further counseling. • This information allows couples to decide on their options. 	 <p>Cystic Fibrosis (CF) carrier screen</p>
	<p>Summary of visit</p> <p>Due date: _____ Date of next visit: _____</p> <p>Date for lab work/other medical tests: _____</p> <p>Date for dental cleaning if needed: _____</p> <p>Date for any other scheduled appointments: _____</p> <p>_____</p>	 <p>Summary of visit</p>



Your next visit

Your next visit

At your 16 – 20 week visit we will:

- Measure your uterine growth, blood pressure, weight, listen to your baby's heart rate, and discuss concerns/questions you may have.
- Follow-up on results from birth defect and fetal abnormality screening tests if you elected to do any.
- Discuss the potential benefit, limitation and safety of prenatal obstetric ultrasound.

ALWAYS BRING
YOUR
PURPLE BOOK
AND
PREGNANCY
PASSPORT
TO EVERY VISIT

Differences I have noticed recently in my body:

How pregnancy has impacted my relationship with my partner:

Questions for my next visit:

[illegible]

16–20 Week Visit Prenatal Information Sheet



16–20 Week Visit

Goal: Work toward a more comfortable
and safer pregnancy

Prenatal Information Sheet: 16–20 Week Visit

Goal: Work toward a more comfortable and safer pregnancy

Your baby's growth

- Your baby (fetus) is now about 4.4 to 5.5 inches long and may weigh about 4 ounces.
- Fine hair, called “lanugo,” is growing on your baby’s head and is starting to cover the body. Fingernails are well-formed.
- The arms and legs are moving and you may start feeling this movement. This movement is called “quickening.” You may not feel movement every day at this point, but the movements will become stronger and more frequent as your pregnancy progresses.



**Your baby's
growth**

Your body's changes

- Your uterus is about the size of a cantaloupe.
- Your center of gravity changes as your uterus grows. This change may affect your balance.
- There is an increase in the mobility of your joints that can affect your posture and cause discomfort in your lower back. As your uterus grows, the round ligaments supporting the uterus can stretch and pull. This ligament pain feels like a sharp pulling sensation on either or both sides of the lower abdomen.
- You may have difficulty sleeping.
- You may have some head stuffiness or frequent nose bleeds. These symptoms may occur because of changes in your circulatory system due to hormonal changes.
- Constipation may be a problem. Refer to Common Discomforts & Annoyances of Pregnancy in the Resource Section for things you can do.
- You may notice a whitish vaginal discharge.
- You may feel Braxton-Hicks contractions that are usually painless, irregular uterine contractions or tightening of the uterus beginning as early as your sixth week of pregnancy.
- Most women, especially in their first pregnancy, will not feel Braxton-Hicks contractions until after 20 weeks.



**Your body's
changes**



Your family's changes

Your family's changes

- Open communication is important to developing a strong relationship that will be the foundation for your family. This is especially important if military operations or transitions require family separation.
- Now is the time to begin discussing birth control with your partner and healthcare provider. There are many effective birth control options available for you after baby's birth.
- Keep in mind that breastfeeding alone may not prevent a pregnancy. Many birth control methods can be used safely while breastfeeding if you want to prevent/delay another pregnancy.



Thoughts & feelings

Your thoughts and feelings




- You may still feel somewhat emotional at times. This will likely continue through your pregnancy as you and your partner prepare for changes now and after baby arrives. You will likely feel more rested which will help you be more positive. As much as you are excited about planning for your baby's birth, you may be worried about how you will adjust to motherhood, labor and delivery, expenses, work and the changes that are coming.
- Pregnant women deal with many changes. Hormone changes and weight gain may make you more likely to become frustrated with yourself and others. Physical discomforts such as not sleeping well, aches, pain, nausea or heartburn may add to your frustration.
- Discuss your feelings with someone you trust and your healthcare provider especially if you have been sad or depressed, or had thoughts of hurting yourself or others.
- Consider taking time to talk to your mother or mothers who you admire to help you identify important characteristics of a mother.



Signs to report immediately

Signs to report immediately

- When in doubt, call the clinic, your healthcare provider or Labor and Delivery!
- Bright red vaginal bleeding.
- Gush of fluid from the vagina.
- Severe nausea and vomiting:
 - Inability to keep fluids down.
 - You are producing only a small amount of dark urine or no urine at all.
- Fever at or over 100.4° F or 38° C.
- Thoughts of hurting yourself or others, or any mental health concerns.

	<p>Today's visit (typical topics)</p> <ul style="list-style-type: none"> • We will measure your uterine growth, blood pressure, weight, listen to baby's heart rate, and discuss any concerns/questions you may have. • If you have chosen to undergo screening for birth defects, your provider will review any test results. Your chosen strategy may necessitate that additional blood be drawn or an ultrasound be arranged after this visit. • Your provider will discuss with you the risks, benefits, and indications for an obstetrical ultrasound. If an ultrasound is indicated, it will be ordered but not usually done during this visit. • Discuss how to identify differences in preterm labor versus false labor. • Some women who have a history of preterm delivery, will be offered progesterone treatment at this visit. Your provider will talk to you about whether this or other treatment is recommended for you. 	 <p>Today's visit</p>
<p>My weight:</p> <hr/> <p>Total weight change:</p> <hr/>	<p>Your weight</p> <ul style="list-style-type: none"> • The usual weight gain is approximately one pound a week during the rest of the pregnancy. • Water contributes to 62% of the weight gain, fat is about 30% and protein is about 8%. • Slow and steady weight gain is best. • Use your chart to monitor your rate of weight gain. Follow the recommendations your provider made at your first visit. • No amount of alcohol is safe for your baby. 	 <p>Your weight</p>
<p>Reference: Prenatal Fitness and Exercise</p>	<p>Your exercise routine</p> <ul style="list-style-type: none"> • Stay off your back while exercising from now on. • Mental, emotional and social benefits of exercise include: <ul style="list-style-type: none"> – Helping to prevent depression. – Promoting relaxation and restful sleep. – Encouraging concentration and improving problem solving. – Helping prepare for childbirth and parenting. – Helping prevent excess weight gain. – Improving self-esteem and well-being. 	 <p>Your exercise</p>



**Consider
breastfeeding**

Breastfeeding - a great start

- Some advantages to baby include:
 - Easier digestion of breast milk.
 - No allergy problems to breast milk.
 - Less likely to cause overweight babies.
 - Less constipation for baby.
 - Easier on baby's kidneys.
 - Fewer illnesses in the first year of life.
 - Less chance of SIDS (Sudden Infant Death Syndrome).
 - Close infant contact with mom.



Fetal heart rate

Fetal heart rate

- Usually your baby's heartbeat is easier to locate and hear at this time in your pregnancy.

Fetal heart
rate:



Fundal height

Uterine size/Fundal height

- At 16 weeks, your uterus is usually midway between the belly button and the pubic bone or 16 cm above the pubic bone.
- The fundal height is the distance between the pubic bone and the top of the uterus.
- Beginning at 20 weeks, the fundal height in centimeters will be about equal to the number of weeks you are pregnant.

Fundal height:



**Serum Screening
Options**

Screening for birth defects

- If you have not done so already, after counseling with your provider, decide which other tests, if any, should be scheduled to assess for risk of birth defects. This may include an ultrasound. See Genetic Screening in Resource Section.



**Your blood
pressure**

Your blood pressure

- Blood pressure is measured at every prenatal visit. High blood pressure can cause serious complications for baby and mother if left unchecked.

My BP:

Ultrasound





Ultrasound

- An anatomy ultrasound will be ordered but not usually performed at this visit.
- An obstetrical ultrasound exam uses sound waves to “see” your baby in the womb. This exam provides information about your baby’s health and well-being.
- The result of an ultrasound can be exciting and reassuring, or it can detect abnormalities in your pregnancy that are not anticipated. Ultrasound exams provide much information about your pregnancy, but cannot detect all birth defects. An ultrasound provides information about your baby’s health and well-being inside the womb such as:
 - Gestational age and size.
 - The number of babies.
 - Rate of growth.
 - Placenta position.
 - Baby’s heart rate.
 - Amount of amniotic fluid.
 - Some birth defects.
 - Gender, if readily visible.

NOTE: Gender identification is not 100% accurate nor is it usually medically necessary. It is not routinely noted in the ultrasound report. Lengthy or repeated ultrasound exams, just to assess gender, are not indicated.

- Ultrasound use, when medically indicated, has not been shown to produce any harm.
If there is a medical indication for 3D/4D ultrasound, your provider will perform or order the procedure.
- Typically a trained technician will perform the ultrasound exams. The technician is not authorized to discuss the findings with you at the time of your exam. Your provider will discuss the result of this exam with you after this visit.
- On the day of your ultrasound, wear clothes that allow your abdomen to be exposed easily.

 <p>Summary of visit</p>	<p>Summary of visit</p> <p>Due date: _____ Date of next visit: _____</p> <p>Date for lab work/other medical tests: _____</p> <p>Date for any other scheduled appointments: _____</p>	
 <p>Your next visit</p>	<p>Your next visit</p> <p>At your 24 week visit we will:</p> <ul style="list-style-type: none"> • Measure your uterine growth, blood pressure, weight, listen to your baby's heart rate, and discuss any concerns/questions you may have. • Discuss signs and symptoms of preterm labor. • Discuss the importance of the test for gestational diabetes and how this test is done at your 28 week visit for most women, but will be done earlier if you have a history of gestational diabetes. 	<p>ALWAYS BRING YOUR PURPLE BOOK AND PREGNANCY PASSPORT TO EVERY VISIT</p>

What do you feel is the role of a mother?

What concerns do you have about becoming a mother?

Things I will need to know to breastfeed:

Questions for my next visit:

[illegible]

24 Week Visit Prenatal Information Sheet



Goal: Prevent preterm labor for a safe
and healthy baby

Prenatal Information Sheet: 24 Week Visit

Goal: Prevent preterm labor for a safe and healthy baby

Your baby's growth

- Your baby is now about 8.4 inches long and weighs about 1.2 pounds.
- Your baby is resting and growing inside your uterus, inside of a sac filled with amniotic fluid. This sac provides the perfect environment for your baby. Movement is easy and the fluid serves as a cushion for the fetus against injury. The fluid in the sac also regulates the temperature. The fluid level should now begin to increase steadily.



Your baby's growth

Your body's changes

- Your uterus is now an inch or two above the belly button and is about the size of a small soccer ball.
- You may feel occasional tightening of your abdomen (Braxton-Hicks), which is normal.
- You may develop varicose veins, increased heartburn, and skin changes due to the fluctuation in hormones.
- If you have any of the signs of preterm labor, such as cramping or contractions that do not go away within an hour of rest and hydration, call your provider immediately.



Your body's changes

Your family's changes

- Talk to your family about ways to help each other adjust to the many changes you are all facing. Encourage their involvement by inviting them to your clinic visits. Jointly plan for the future and share the many emotions, fears, and joys you are all going through. The more your family is involved now, the easier they will bond with the new baby and participate in his/her care.
- If the father of the baby is not available, find someone you trust and who is willing to be your support person.



Your family's changes

Who will be my support person? _____

Your thoughts and feelings

- You may still feel somewhat emotional at times. This will likely continue through your pregnancy as you and your partner prepare for changes now and after baby arrives. As much as you are excited about planning for your baby's birth, you may be worried about how you will adjust to motherhood, labor and delivery, expenses, work and the changes that are coming.
- Discuss your feelings with someone you trust, and your healthcare provider, especially if you have been sad or depressed, or had thoughts of hurting yourself or others.



Thoughts & feelings



Signs to report immediately

Signs to report immediately

- When in doubt, call the clinic, your healthcare provider or Labor and Delivery!
- Bright red vaginal bleeding.
- Gush of fluid from the vagina.
- Four or more painful cramping contractions within an hour (after resting, hydrating and emptying bladder).
- Severe nausea and vomiting:
 - Inability to keep fluids down.
 - Producing small amount of dark urine or no urine at all.
- Persistent headache (unrelieved by taking Tylenol®).
- Loss of vision.
- Sudden weight gain.
- Rapid swelling of hands and face.
- Constant right upper belly pain.
- Fever at or over 100.4° F or 38° C.
- Thoughts of hurting yourself or others, or any mental health concerns.



Today's visit

Today's visit (typical topics)






- We will measure your uterine growth, blood pressure, weight, listen to your baby's heart rate, and discuss any concerns or questions you may have.
- Schedule lab tests.
- Sign up for breastfeeding and other prenatal classes.
- Check to see if you are having any preterm contractions.
- Learn the signs of preterm labor and what to do if it occurs.
- If you had a cesarean delivery for a prior birth, discuss your birth options for this pregnancy. See Cesarean Delivery in Resource Section for further information.
- If you are considering surgical sterilization ("tying your tubes") you should discuss this with your provider now. Some states require several weeks between a signed consent and surgery.



Your weight:

Your weight

- Your weight gain will average close to one pound per week.
- Many common discomforts of pregnancy (constipation, nausea, heartburn) can be reduced through a change in diet.
- Record your weight on the Weight Chart in the Resource Section.

<p>Your total weight change:</p> <p>_____</p>	<p>Your weight</p> <ul style="list-style-type: none"> • How am I doing with my weight gain? • What can I do to improve my diet and exercise? 	 <p>Your weight</p>
<p>Reference: Prenatal Fitness and Exercise</p>	<p>Your exercise routine</p> <ul style="list-style-type: none"> • We recommend you drink a full glass of water for every 30 minutes of exercise you do. • For healthy pregnant women who have not been advised differently, regular mild to moderate exercise is recommended. • Always check with your healthcare provider before beginning a new exercise program. 	 <p>Your exercise</p>
	<p>Breastfeeding - a great start</p> <ul style="list-style-type: none"> • Some advantages of breastfeeding to you include: <ul style="list-style-type: none"> – Burns about the same number of calories as one hour of exercise and allows you to use some of the extra fat you have stored during your pregnancy. – Helps your uterus get back to its normal size faster. – Saves time, money and extra trips to the store for formula and supplies. – There are no special foods you have to eat; however, you should eat a well-balanced diet, and limit alcohol and caffeine. • For further information see Breastfeeding in Resource Section. 	 <p>Consider breast-feeding</p>
<p>Fetal heart rate:</p> <p>_____</p>	<p>Fetal heart rate</p> <ul style="list-style-type: none"> • Baby's heartbeat is getting much easier to hear. 	 <p>Fetal heart rate</p>
<p>Fundal height:</p> <p>_____</p>	<p>Fundal height</p> <ul style="list-style-type: none"> • Fundal height is about 24 cm or two inches above the belly button. 	 <p>Fundal height</p>



Your blood pressure

Your blood pressure

My BP: _____

- Blood pressure is measured at every prenatal visit. High blood pressure can cause serious complications for baby and mother if left untreated.



Preterm labor guidelines

Preterm labor

- Your baby needs to continue to grow inside you for the full term of your pregnancy. Labor earlier than three weeks before your due date can lead to a premature (preemie) baby with many associated risks. Even 37 to 38-week babies can have difficulties.
- As always, when in doubt call your healthcare provider or Labor and Delivery.
- **Report any of the following symptoms to your health care provider:**
 - Low, dull backache
 - Four or more uterine contractions per hour. Uterine contractions may feel like:
 - Menstrual cramps.
 - Sensation of “baby rolling up in a ball.”
 - Abdominal cramping (may also have diarrhea).
 - Increased uterine activity compared to previous patterns.
 - Increased pelvic pressure (may be with thigh cramps).
 - Sensation that “something feels different” (e.g., agitation, flu-like syndrome, and sensation that baby has “dropped”).
- **If you experience any of the above symptoms you should:**
 - Stop what you are doing and empty your bladder.
 - Drink three to four glasses of water.
 - Lie down on your side for one hour and place your hands on your abdomen and feel for tightening/hardening and relaxing of your uterus.
 - Count how many contractions you have in an hour.
 - If you have more than four contractions for more than one hour call either the clinic or Labor & Delivery immediately.
- **You should report immediately:**
 - Change in vaginal discharge such as change in color of mucus, leaking of clear fluid, spotting or bleeding.

Gestational Diabetes (GD) testing

- Gestational diabetes is high sugar levels in your blood during your pregnancy. It usually goes away after delivery. If your results are high, this does not mean you have diabetes, it just means further testing is needed.
- You will have a blood test for gestational diabetes. This blood test will tell how your body is responding to your sugar levels.
- To prepare for the test at your next visit, eat your usual dinner the night before the test and your normal breakfast the day of the test.
- At the lab, you will be given a very sweet drink (glucose beverage) that has a specific amount of sugar in it. A sample of your blood will be drawn one hour after you drink the glucose beverage.
- During the hour between drinking the glucose beverage and having your blood drawn, do not eat or drink anything, including gum or candy, because it may affect the test results. You may drink plain water during this time while you are waiting.
- The 1-hour glucose tolerance test is conducted between 24 and 28 weeks; an additional 3-hour test may be ordered if the results of the 1-hour test are not normal.



**Gestational
Diabetes
(GD) testing**

Summary of visit

Due date: _____ Date of next visit: _____

Date for lab work/other medical tests: _____

Date for any other scheduled appointments: _____



**Summary
of visit**

Your next visit

At your 28 week visit we will:

- Measure your uterine growth, blood pressure, weight, listen to your baby's heart rate, and discuss any concerns or questions you may have.
- Provide instructions on counting fetal movement.
- Provide RhoGAM® if your blood type is Rh negative (D-) and you are not sensitized.
- If you have not done so already, you will be tested for gestational diabetes, and possibly other labs. For planning purposes, be prepared to wait one hour to complete the gestational diabetes testing. If your healthcare provider has ordered a second blood test for gestational diabetes, be prepared to wait three hours to complete the test.
- Sign up for breastfeeding and other available classes.



Your next visit

**ALWAYS
BRING YOUR
PURPLE BOOK
AND
PREGNANCY
PASSPORT
TO EVERY VISIT**

Activities or traditions you remember from your childhood that you would like to continue in your family:

Think about what your baby will look like. Write your thoughts here:

Questions for my next visit:

[illegible]

[illegible]

28 Week Visit Prenatal Information Sheet

28 Week Visit



Goal: Monitor baby and your progress and
learn to count fetal movements

Prenatal Information Sheet: 28 Week Visit

Goal: Monitor baby and your progress and learn to count fetal movements

Your baby's growth

- Your baby's weight has probably doubled since your last visit! Your baby weighs about 2.5 lbs. and is about 10 inches long.
- The baby starts to lose the lanugo (fine hair), especially from the face. The baby has a large amount of cheesy-like substance (vernix) covering the body that protects the skin while the baby is living in the amniotic fluid. This vernix decreases on the skin as the baby grows.
- Your baby's eyebrows and eyelashes may be present now.
- The brain tissue also increases during this time.
- Now that you are 28 weeks, you should be feeling your baby move (kicks, rolls, twists, turns, and jabs) on a regular basis.



Your baby's growth

Your body's changes

- You've probably gained about 18 pounds.
- You may also start experiencing some swelling, and/or numbness or pain in your hands and wrists (Carpal Tunnel Syndrome). Avoid sleeping on your hands or bending your wrists for long periods of time. Discuss persistent pain, numbness or weakness with your provider.



Your body's changes

Your family's changes

- Everyone needs help with child care whether on a full, part-time, or occasional basis. Consider your needs.
- Active duty moms should be prepared to list their child care providers upon return to work/duty.
- If you will be returning to work after baby's birth, now is the time to explore the various child care options in your community.



Your family's changes

Your thoughts and feelings

- Stress may begin to surface. If it seems uncontrollable, talk to your provider about this.
- Remember to give yourself a break! You may need to adjust the expectations you have for yourself at this time. Focus on what is important to you and your family. Sometimes going for a walk or doing something you enjoy will help you prioritize what is important or help you relax.
- About 15% of women experience depression during pregnancy or after delivery. Discuss any concerns with your provider.
- Discuss your feelings with someone you trust, and your healthcare provider, especially if you have been very sad or depressed.



Thoughts & feelings



Signs to report immediately

Signs to report immediately

- When in doubt, call the clinic, your healthcare provider or Labor and Delivery!
- Bright red bleeding or gush of fluid from the vagina.
- The baby is not moving as much as you expect.
- Four or more painful cramping contractions within an hour (after resting, hydrating, and emptying bladder).
- Severe nausea and vomiting:
 - Inability to keep fluids down.
 - Producing small amount of dark urine or no urine at all.
- Persistent headache (unrelieved by taking Tylenol®).
- Loss of vision.
- Sudden weight gain.
- Rapid swelling of hands and face.
- Constant right upper belly pain (not related to baby movement).
- Fever at or over 100.4° F or 38° C.
- Thoughts of hurting yourself or others, or any mental health concerns.



Today's visit

Today's visit (typical topics)

- We will measure your uterine growth, blood pressure, and weight, listen to your baby's heart rate, and discuss any concerns or questions you may have.
- Check for preterm labor.
- Review signs of preterm labor and what to do if they occur.
- You will receive blood test for gestational diabetes.
- You will learn how to do Fetal Movement Counts.
- Discuss Intimate Partner Violence.
- Discuss and be screened for depression in pregnancy.
- If you are Rh negative, you will have an additional blood test before receiving RhoGAM® injection.
- Register for Breastfeeding class, Childbirth classes and Labor & Delivery tour.
- A post-delivery depression screening will be completed (see page 153 for more information).








Your weight

Your weight and nutrition

- Try to eat a variety of foods.
- If needed, extra nutrients such as iron, vitamins B-6 and B-12, and calcium may be prescribed.
- Record your weight on the weight chart in the Resource Section.
- For further information see Nutrition in Resource section.

Your weight:

Your total weight change:

Reference: Prenatal Fitness and Exercise	Your exercise routine <ul style="list-style-type: none"> • Now that your uterus is getting larger, you need to avoid exercises that require a lot of balance, to prevent a fall. • Make sure the calories you eat are nutritious for both you and your baby and that you stay well hydrated. 	 Your exercise
	Breastfeeding - a great start <ul style="list-style-type: none"> • Classes on breastfeeding will: <ul style="list-style-type: none"> – Help answer many questions. – Give you confidence in your ability to breast-feed. – Introduce you to other breastfeeding moms. – Reassure you that what you are doing is best for both you, your baby and your family. 	 Consider breastfeeding
	Intimate Partner Violence <ul style="list-style-type: none"> • Intimate Partner Violence (IPV) often increases during pregnancy. Please do not hesitate to seek help from your healthcare provider, counselor or a close friend if you are experiencing physical, sexual, emotional, or verbal abuse from your partner or anyone. • Let your provider know if within the last year, or since you have been pregnant, a current or former intimate partner (e.g., boyfriend, girlfriend, wife, husband, sexual partner) has physically hurt you, insulted or talked down to you, threatened you with harm, screamed or cursed at you, or forced you to have sexual activity. • National Domestic Abuse Hotline: 1-800-799-7233 	 Domestic abuse screen
Fetal heart rate: _____	Fetal heart rate <ul style="list-style-type: none"> • This measurement will be done at each visit to monitor your baby's well-being. 	 Fetal heart rate
Fundal height: _____	Fundal height <ul style="list-style-type: none"> • The top of your uterus measures about 28 cm from your pubic bone. 	 Fundal height



Your blood pressure

Your blood pressure

My BP: _____

- Blood pressure is measured at every prenatal visit. High blood pressure can cause serious complications for baby and mother if left untreated.



Fetal movement count

Fetal movement count

Fetal Movement Count

- One very reassuring way to determine the baby's overall health and wellness is to record your baby's movements daily.
- By now, you probably know when your baby is most active. This may be before or after a meal, early in the morning, or at night when you go to bed. Each baby is unique.
- You should count your baby's movements whenever he or she is most active. This count should occur about the same time each day. After 10 times, you can stop counting for the day. You will need to record the time it takes for your baby to move 10 times. See Fetal Movement Counting Chart in Resource Section.
- You should be able to feel at least 10 movements within two hours.
- If you do not get 10 movements within two hours, you should call or go to Labor & Delivery immediately with your baby's movement chart. **Don't wait until the next day or next appointment.**



Preterm labor guidelines

Preterm labor

- Your baby needs to continue to grow inside you for the full term of your pregnancy. Labor earlier than three weeks before your due date can lead to a premature (preemie) baby with many associated risks.
- As always, when in doubt call your healthcare provider or Labor and Delivery.
- **Report any of the following symptoms to your healthcare provider:**
 - Low, dull backache.
 - Four or more uterine contractions per hour. Uterine contractions may feel like:
 - Menstrual cramps.
 - Sensation of the "baby rolling up in a ball."
 - Abdominal cramping (may also have diarrhea).
 - Increased uterine activity compared to previous patterns.

Preterm labor

- Increased pelvic pressure (may be with thigh cramps).
- Sensation that “something feels different” (e.g., agitation, flu-like syndrome, and sensation that baby has “dropped”).

• If you experience any of the above symptoms you should:

- Stop what you are doing and empty your bladder.
- Drink three to four glasses of water.
- Lie down on your side for one hour and place your hands on your abdomen and feel for tightening/hardening and relaxing of your uterus.
- Count how many contractions you have in an hour.
- If you have more than four contractions for more than one hour call either the clinic or Labor & Delivery immediately.

• You should report immediately:

- Change in vaginal discharge such as change in color of mucus, leaking of clear fluid, spotting or bleeding.



Preterm labor
guidelines

Gestational Diabetes (GD) testing

High blood sugar puts your baby at risk for complications.

- High blood sugar usually develops towards the middle of your pregnancy.
- Risk factors include: being over age 25, overweight, family history of diabetes, ethnic background (Hispanic, African American, Native American, Asian), previous delivery of a baby weighing over nine pounds.
- This test will determine if you have a normal response to a sugar load (a beverage containing a specific amount of sugar).
- If your blood sugar levels are high, further testing will be ordered.
- Often this condition can be controlled through special diet.



Gestational
Diabetes
(GD) testing

Rh (D) negative (Anti-D) prophylaxis

- Earlier in your pregnancy, you had a test to identify your Rh (D) status.
- Rh (D) negative women will have an additional blood test (antibody screen) and will usually receive a RhoGAM® injection at this appointment.
- This injection will be repeated after delivery if baby is Rh positive.



Rh prophylaxis



Summary of visit

Date of next visit: _____

Date for lab work/other medical tests: _____

Summary of visit

Date of Breastfeeding Class: _____

Date of Childbirth Class: _____

Date of Other Classes: _____



Your next visit

At your 32 week visit we will:

- Measure your uterine growth, blood pressure, weight, listen to your baby's heart rate, review fetal movement record, and discuss any concerns/questions you may have.
- You will sign up for expectant parent classes (if not done already).
- You may review preterm labor signs.

Your next visit

ALWAYS BRING
YOUR
PURPLE BOOK
AND
PREGNANCY
PASSPORT
TO EVERY VISIT

Review the goals you noted for yourself early in your pregnancy. Is there something you need to do to meet your goals? What?

Differences I have noticed recently:

How has the pregnancy effected your family/relationships?

Other things I need to do/get ready in the next four weeks:

Questions for my next visit:

[illegible]

32 Week Visit Prenatal Information Sheet

32 Week Visit



Goal: Prepare for your baby's arrival

Prenatal Information Sheet: 32 Week Visit

Goal: Prepare for your baby's arrival

Your baby's growth

- Your baby weighs almost four pounds, and the length is 18-19 inches!
- Organ systems are now adequately developed.
- Most likely, your baby is in the "head down" position so you may feel most of his/her kicks and jabs under your ribs.
- If your baby is in the breech or "butt down" or transverse (sideways) position you may feel the movements in different areas.



**Your
baby's
growth**

Your body's changes

- The top of your uterus is about four to five inches above your belly button by now.
- You may also notice that your back and pelvic area may feel different. The bones in your pelvis are moving and shifting to make room for the baby's head to pass through.
- As this happens, the ligaments around the pelvis also stretch, which can cause some discomfort in the hip joints, back, and front of the pelvis.



**Your body's
changes**

Your family's changes

- You and your partner may become more anxious as the "big day" approaches.
- You may become more irritable and find that this can put a strain on your relationship.
- You'll probably find that it is harder to do all the things that you are used to doing, such as sleeping and moving quickly. When possible, schedule rest periods and avoid quick movements.
- Make sure you have a plan for getting to the hospital no matter when you need to go! This plan needs to include transportation, child and pet care options, and phone numbers.



**Your family's
changes**

Your thoughts and feelings

- You may still feel somewhat emotional at times. You may feel increasingly fatigued which will impact how you respond to the people around you.
- Signs of pregnancy-related depression may include: loss of interest in activities you enjoy, feelings of guilt or hopelessness, changes in appetite or sleep patterns, or thoughts of harming yourself or others. If you experience any of these symptoms, please contact your provider immediately.
- Discuss your feelings with someone you trust, and your healthcare provider, especially if you have been very sad or depressed.



**Thoughts
&
feelings**



Signs to report immediately

Signs to report immediately

- When in doubt, call the clinic, your provider or Labor and Delivery!
- Bright red bleeding or gush of fluid from the vagina.
- The baby is not moving as much as you expect.
- Four or more painful cramping contractions within an hour (after resting, hydrating, and emptying bladder).
- Severe nausea and vomiting:
 - Inability to keep fluids down.
 - Producing a small amount of dark urine or no urine at all.
- Persistent headache (unrelieved by taking Tylenol®).
- Loss of vision.
- Sudden weight gain.
- Rapid swelling of hands and face.
- Constant right upper belly pain (not related to baby movement).
- Fever at or over 100.4° F or 38° C.
- Thoughts of hurting yourself or others, or any mental health concerns.



Today's visit

Today's visit (typical topics)

- We will measure your uterine growth, blood pressure, and weight, listen to your baby's heart rate, check your baby's position, review the fetal movement record, and discuss any concerns/questions you may have.
- Check for preterm labor.
- Discuss birth control options for after you deliver.
- Receive a domestic abuse screening.
- Sign up for classes such as Breastfeeding, Childbirth, Labor and Delivery, Postpartum and Newborn tour if not done yet.



Your weight

Your weight and nutrition

- Continue to monitor/record your weight gain.
- Pregnancy increases your requirements for iron, calcium, folate, protein, and water.
- Make sure to read food labels carefully.
- Try to limit simple sugars (honey, maple syrup, white, and brown sugars).

My weight:







Total weight change:



Your exercise

Your exercise routine

- You can continue to exercise right up to delivery and this may even help the delivery go more easily. Discuss your exercise routine with your provider.
- Don't exercise on an empty stomach and make sure you replace any fluids lost during exercise.

Reference: Prenatal Fitness and Exercise	Your exercise routine <ul style="list-style-type: none"> • Avoid exercising in very hot and/or humid weather. • You may need to modify the intensity of your exercise routine according to your symptoms. Now is not the time to exercise to exhaustion or fatigue. 	 Your exercise
	Breastfeeding - a great start <ul style="list-style-type: none"> • Breastfeeding for at least your baby's first 12 months of life is recommended. • If you have any doubts or concerns about breastfeeding, let your provider know. We have many excellent resources to help you feel more comfortable and confident with breastfeeding. 	 Consider breastfeeding
Fetal heart rate: _____	Fetal heart rate <ul style="list-style-type: none"> • This measurement will be done at each visit to monitor your baby's well-being. 	 Fetal heart rate
Fundal height: _____	Fundal height <ul style="list-style-type: none"> • The top of your uterus is 32 cm above your pubic bone or four to five inches above your belly button. 	 Fundal height
My BP: _____	Your blood pressure <ul style="list-style-type: none"> • Blood pressure is measured at every prenatal visit because high blood pressure can cause serious complications for baby and mother if not controlled. It can also be a sign of pre-eclampsia. 	 Your blood pressure
Fetal Movement Count: _____	Fetal movement count <ul style="list-style-type: none"> • Review fetal movement count record. 	 Fetal movement count



Family
planning

Family planning

- Even though it may seem early to discuss birth control when you are still pregnant, now is an excellent time to plan for what you and your partner will use for birth control after baby arrives.
- You can get pregnant the first time you have sexual intercourse following delivery. Prior to discharge from the hospital, your provider will discuss birth control with you. See Family Planning in Resource Section.
- Talk with your provider about plans for your next pregnancy.



Preparing for
baby's arrival

Preparing for baby's arrival

- Most women go through the “nesting” phase a week or two before delivery. You’ll probably clean everything in sight, so take it as a blessing in disguise.
- Plan, cook, and freeze some meals ahead of time. Keep a stock of basic staples, so you won’t have to go to the store for basic food items.
- If friends offer to help, suggest that they cook a meal or two for you and your family.
- Baby’s living area: Whether baby has his or her own room, or is sharing a room with a sibling or with you, be sure the area is clean and safe. Wash your baby’s new sheets, blankets, and clothes in a mild detergent (or, if your machine has this feature, run them through an extra rinse) before you bring baby home.
- Learn about the proper installation and use of car seats and booster seats at: <https://www.nhtsa.gov/equipment/car-seats-and-booster-seats>.
- After the baby comes home, you will have many new duties, a lot less sleep, and a lot less energy. So plan ahead.



Preterm labor
guidelines

Preterm labor

- Your baby needs to continue to grow inside you for the full term of your pregnancy. Labor earlier than three weeks before your due date can lead to a premature (preemie) baby with many associated risks.
- As always, when in doubt call your healthcare provider or Labor and Delivery.
- **Report any of the following symptoms to your health care provider:**
 - Low, dull backache.
 - Four or more uterine contractions per hour. Uterine contractions may feel like:
 - Menstrual cramps.
 - Sensation of the “baby rolling up in a ball.”
 - Abdominal cramping (may have diarrhea).
 - Increased uterine activity compared to previous patterns.

Preterm labor

- Increased pelvic pressure (may be with thigh cramps).
- Sensation that “something feels different” (e.g., agitation, flu-like syndrome, and sensation that baby has “dropped”).

• If you experience any of the above symptoms you should:

- Stop what you are doing and empty your bladder.
- Drink three to four glasses of water.
- Lie down on your side for one hour and place your hands on your abdomen and feel for tightening/hardening and relaxing of your uterus.
- Count how many contractions you have in an hour.
- If you have more than four contractions for more than one hour call either the clinic or Labor & Delivery immediately.

• You should report immediately:

- Change in vaginal discharge such as change in color of mucus, leaking of clear fluid, spotting or bleeding.

Summary of visit

Date of next visit: _____

Date for lab work/other medical tests:



Summary of visit

Your next visit

At your 36 week visit we will:

- Measure your uterine growth, blood pressure, weight, listen to the baby’s heart rate, check your baby’s position, review the fetal movement record, and discuss concerns/questions you may have.
- Discuss any specific desires you have for your labor and delivery. See Birth Plan in Resource Section.
- Do a Group B Streptococcus (GBS) test.



Your next visit

ALWAYS
BRING YOUR
PURPLE BOOK
AND
PREGNANCY
PASSPORT
TO EVERY
VISIT

Right now, I am concerned/worried about:

My spouse/partner is concerned/worried about:

Preparation for labor:

Who will be in the labor/birth room with you?

Questions/concerns since taking classes:

Plan for pain relief during labor:

I am planning to use _____ method of family planning to prevent/delay another pregnancy.

Questions for my next visit:

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

36 Week Visit Prenatal Information Sheet



36 Week Visit

Goal: Begin preparations for your hospital
experience

Prenatal Information Sheet: 36 Week Visit

Goal: Begin preparations for your hospital experience

Your baby's growth

- Your baby probably weighs around 6 pounds now and is about 20 inches in length.
- Most likely, your baby is in the "head down" position. However, some babies settle into the head down position only a few days before delivery. If baby is in the breech (or butt down) position, your provider will discuss options to turn the baby to head down position.



**Your
baby's
growth**

Your body's changes

- Easier breathing after the baby "drops" or moves down into pelvis. Some babies don't "drop" until after labor begins.
- More frequent urination after the baby "drops" down.
- Increased backache and heaviness.
- Pelvic and buttock discomfort.
- Increased swelling of the ankles and feet and occasionally the hands.
- More frequent and more intense Braxton-Hicks (non-painful) contractions.



**Your body's
changes**

Your family's changes

- More excitement and anxiety but also more impatience and restlessness as the delivery date nears are common – for both you and your partner. Many parents feel a renewed desire this month to tie up loose ends at work or home, organize the home, or catch up on social obligations. While you may think you have more energy now than in the last two months, don't overdo it. Involve your partner in carrying out needed tasks.
- Apprehension about the baby's health and labor and delivery is common.
- Share your concerns about the changes you anticipate with your partner and those around you.



**Your family's
changes**



Thoughts
&
feelings

Your thoughts and feelings

- Some women find that as the due date approaches they become very anxious about labor and delivery or their ability to care for a newborn. You may experience mood swings, anxiety, or be very short-tempered and emotional in these last few weeks of your pregnancy. These feelings are common.
- If at any time you believe you are close to hurting yourself or someone else, contact your provider immediately. If you cannot reach your provider, seek help at the hospital Emergency Department.
- Discuss your feelings with someone you trust, and your healthcare provider, especially if you have been very sad or depressed in the last couple of weeks.



Signs to report
immediately

Signs to report immediately







- When in doubt, call the clinic, your healthcare provider or Labor and Delivery!
- Bright red bleeding or gush of fluid from the vagina.
- The baby is not moving as much as you expect.
- Four or more painful cramping contractions within an hour (after resting and emptying bladder).
- Severe nausea and vomiting:
 - Inability to keep fluids down.
 - Producing a small amount of dark urine or no urine at all.
- Persistent headache (unrelieved by taking Tylenol®).
- Loss of vision.
- Sudden weight gain.
- Rapid swelling of hands and face.
- Constant right upper belly pain (not related to baby movement).
- Fever at or over 100.4° F or 38° C.
- Thoughts of hurting yourself or others, or any mental health concerns.



Today's visit

Today's visit (typical topics)

- We will measure your uterine growth, blood pressure, weight, listen to baby's heart rate, review the fetal movement record, check baby's position, do a test for Group B Streptococcus (GBS) and discuss any concerns/questions you may have.
- Discuss any specific plans you have for your birth experience.
- You will complete necessary forms from your healthcare provider and take them to the Admissions Office.
- **Homework** - Prior to going into labor and being admitted to the hospital, make sure you have made arrangements for childcare and pet care.

<p>My weight:</p> <p>_____</p> <p>Total weight change:</p> <p>_____</p>	<p>Your weight and nutrition</p> <ul style="list-style-type: none"> • When making your choices from each food group, pick those that are low in fat and high in fiber and iron. • With your enlarging uterus, you may need to eat smaller, more frequent meals. • Track your weight gain in the Resource Section of this book. 	 <p>Your weight</p>
<p>Reference: Prenatal Fitness and Exercise</p>	<p>Your exercise routine</p> <ul style="list-style-type: none"> • Regular exercise helps you keep fit during your pregnancy and feeling better during a time when your body is changing. • Avoid overheating by drinking adequate amounts of fluids and wearing appropriate clothing. 	 <p>Your exercise</p>
	<p>Breastfeeding - a great start</p> <ul style="list-style-type: none"> • Breast milk is the ideal food for a baby and is easily digested. 	 <p>Consider breastfeeding</p>
<p>Fetal heart rate:</p> <p>_____</p>	<p>Fetal heart rate</p> <ul style="list-style-type: none"> • This measurement will be done at each visit to monitor your baby's well-being. 	 <p>Fetal heart rate</p>
<p>Fundal height:</p> <p>_____</p>	<p>Fundal height</p> <ul style="list-style-type: none"> • This measurement will be done at each visit to monitor the progress of your pregnancy. 	 <p>Fundal height</p>
<p>My BP:</p> <p>_____</p>	<p>Your blood pressure</p> <ul style="list-style-type: none"> • Blood pressure is measured at every prenatal visit because high blood pressure can cause serious complications for baby and mother if not controlled. It can also be a sign of pre-eclampsia. 	 <p>Your blood pressure</p>



**Fetal movement
count**

Fetal movement count

- Review fetal movement count record.

Fetal
Movement
Count:



**Fetal
presentation**

Fetal presentation

- The location of the baby's heartbeat in the lower half of your abdomen is a clue to your baby being in the head down position.
- If the baby's position is not head-down, your healthcare provider will discuss with you what may need to occur.



**Group B
Streptococcus**

Group B Streptococcus (GBS)

- GBS, bacteria commonly found in the vagina or rectum, can sometimes be passed on to the baby during labor and delivery.
- Testing will determine if you have GBS.
- Your provider will swab the vaginal and rectal area and send the specimen to the lab.
- Once completed, test results will be discussed with you at your next visit.
- If the test is positive, you will receive antibiotics during labor. See GBS in Resource Section for further information.



Birth plan

Birth plan

- It is anticipated that most women will have spontaneous onset of labor and deliver vaginally. However, induction of labor with medications may be required if you have premature rupture of membranes and labor did not start spontaneously, or if you developed medical problems that required delivery.
- At times, operative delivery is required (forceps, vacuum, or cesarean section) to assist in the delivery of your baby. Your provider will discuss with you if operative delivery is required.
- If you have a birth plan or any special requests, please let your nurse or healthcare provider know and we will do whatever we can to accommodate you and your family while also providing an optimal and healthy outcome. Please keep in mind that not all birth techniques are considered safe and some may not be a covered benefit. Although your health care team will try to honor your wishes, ultimately your safety and your baby's safety come first.

Preparing for baby's arrival

- Pack two bags, one for you and one for the baby. The baby's bag can stay in the car until after the baby is born. This way your partner will have less to carry while helping you to Labor & Delivery.
- Bring things to make you comfortable: washcloths, extra socks, lip balm, hair items, and basic toiletries. If you wear contact lenses, be sure to bring your case and a pair of glasses.
- Bring several pair of your oldest panties as you'll be bleeding quite a bit for a few days after you give birth.
- Remember your phone and your charger for calls to friends and family, and for taking pictures and video after the birth!
- If breastfeeding, be sure to bring a nursing bra or two.
- Feel free to bring your own nightgowns or pajamas, slippers, and robe, but we can also provide these items for your use while in the hospital.
- You will need your own clothes to go home. Make sure they are comfortable (stretch pants or sweats are ideal), and, yes, you may still be wearing maternity clothes for a while.
- For baby: bring an outfit to wear home, a blanket, and a car seat. You won't need these until the day of discharge. Now is a good time to install the car seat in your car and have the installation inspected by a certified car seat technician.
- Feel free to bring your favorite music and a portable music player. Your tastes/preferences may change as you move through the different stages of labor, so you may want a variety of music options.



Preparing
for
baby's arrival

Preterm/Labor signs

- Technically, this is the last week you need to report preterm labor symptoms. Most providers will not attempt to stop labor at this time in your pregnancy. If your baby is born prior to 39 weeks, it may require an extended stay in a special nursery for monitoring of temperature, heart rate, and breathing.
- Go to Labor & Delivery if you're having:
 - More than six contractions per hour that do not ease up with drinking three to four glasses of water, emptying your bladder, and lying on your side for an hour.
 - Leaking of clear fluid, spotting or bleeding.
 - Or other preterm labor symptoms previously discussed.
 - For further information, see Labor and Deliver Basics in Resource Section.



Preterm
labor guidelines



Summary of visit

Date of next visit: _____

Date for lab work/other medical tests: _____

Summary of visit _____



Your next visit

At your 38-41 week visit we will:

- Measure your uterine growth, blood pressure, and weight, listen to your baby's heart rate, review the fetal movement record, assess baby's position, and discuss any concerns/questions you may have.
- Discuss results of Group B Streptococcus (GBS) culture.
- Offer to complete a vaginal exam to check for any changes in the cervix.

Your next visit

ALWAYS BRING
YOUR
PURPLE BOOK
AND
PREGNANCY
PASSPORT
TO EVERY VISIT

Questions to ask at next visit:

Things to do before baby arrives:

[illegible]

38–41 Week Visit Prenatal Information Sheet



Goal: Preparing for the delivery and
baby's arrival at home

Prenatal Information Sheet: 38–41 Week Visit

Goal: Preparing for the delivery and baby's arrival at home

Your baby's growth

- Your baby probably weighs around 7 pounds now and is about 21 inches in total length.
- Most likely, your baby is in the “head down into the pelvis” position, but some babies won’t drop into position until a few days before delivery or until labor begins.
- We know babies are usually mature enough to do very well on the outside beginning at 39 weeks. Many are ready at 37 to 38 weeks. We also know babies continue to grow well within mom up to 42 weeks. If you have not delivered by 41 weeks, we will begin testing to ensure the placenta is functioning well.
- If you are still pregnant, labor will be induced sometime during your 41st week. Keep in mind that a majority of pregnancies are anywhere from 37 to 42 weeks long.



**Your baby's
growth**

Your body's changes

- While baby's type of movement may change as he or she takes up more room in the uterus, it is still important to count and report any decrease in the number of movements.
- Baby is getting big and you are getting tired. Avoid over-exhaustion; take frequent breaks and prop your feet up.
- If you have trouble sleeping, try a warm bath before bed, a soothing massage, pillows between your legs, or sleeping on your side.
- You will be seen by your provider more frequently as your due date nears to promote a safe delivery for both you and your baby.



**Your body's
changes**

Your family's changes

- Keep in mind that you can deliver anytime from today until 42 weeks of pregnancy. Few babies are born on their due date.
- You and your family may become more frightened and/or frustrated if you have not delivered. Tips on conquering these fears and frustrations include:
 - Talking them over with your partner, friends, or provider.
 - Using relaxation techniques such as deep breathing, music, quiet walks, afternoon naps, and quiet time alone.
- Enjoy this time with your family and try to rest up for the big event.
- Review your labor and delivery plans/wishes and coping techniques with your support person and provider.



**Your family's
changes**



**Thoughts
&
feelings**

Your thoughts and feelings

- Some women find that as the due date approaches they become very anxious about labor and delivery or their ability to care for a newborn. You may experience mood swings, anxiety, or be very short-tempered and emotional in these last few weeks of your pregnancy. These feelings are common.
- It is important to notice how you are feeling and coping. Do not hesitate to ask loved ones or professionals for assistance.
- Discuss your feelings with someone you trust, and your healthcare provider, especially if you have been very sad or depressed in the last couple weeks.



**Signs to report
immediately**

Signs to report immediately

- When in doubt, call the clinic, your healthcare provider or Labor and Delivery!
- Bright red bleeding or gush of fluid from the vagina.
- The baby is not moving as much as you expect.
- Any nausea and vomiting.
- Producing a small amount of dark urine or no urine at all.
- Persistent headache (unrelieved by taking Tylenol®).
- Four or more painful cramping contractions within an hour (after resting, drinking water and emptying bladder).
- Loss of vision.
- Sudden weight gain.
- Rapid swelling of hands and face.
- Constant right upper belly pain (not related to baby movement).
- Fever at or over 100.4° F or 38° C.
- Thoughts of hurting yourself or others, or any mental health concerns.






Today's visit

Today's visit (typical topics)

- We will measure your uterine growth, blood pressure, weight, listen to your baby's heart rate, review the fetal movement record, assess baby's position, and discuss any concerns/questions you may have.
- With a vaginal exam, your provider may check for any cervical opening or thinning.
- Discuss Group B Streptococcus (GBS) results.

You may:

- Sign up for any missed expectant parent or prenatal classes and L&D tours.
- Make sure all necessary forms are completed and are at the Admissions Office.

My BP/date: <hr/>	Your blood pressure <ul style="list-style-type: none"> It is still important to report to your healthcare provider any severe headache, loss of vision, sudden weight gain, or rapid swelling of hands and face. 	 Your blood pressure										
My weight/date: <hr/>	Your weight and nutrition <ul style="list-style-type: none"> Recommendations for total weight gain during pregnancy depend on pre-pregnancy Body Mass Index (BMI). Your weight gain is not all fat. It is mostly water in your body and the weight of the growing baby. Estimate your pre-pregnancy BMI and track your weight gain on pages 136 and 137 of this book. The following table provides more information regarding recommended weight gain for women carrying one baby. Ask your healthcare provider about weight gain recommendations if you are pregnant with twins. <table border="1" data-bbox="349 811 1065 1001"> <thead> <tr> <th>Pre-pregnancy Weight (BMI in kg/m²)</th> <th>Recommended Weight Gain</th> </tr> </thead> <tbody> <tr> <td>Underweight (BMI <18.5)</td> <td>28 – 40 lbs</td> </tr> <tr> <td>Normal Weight (BMI 18.5 – 24.9)</td> <td>25 – 35 lbs</td> </tr> <tr> <td>Overweight (BMI 25.0 – 29.9)</td> <td>15 – 25 lbs</td> </tr> <tr> <td>Obese (BMI ≥30.0)</td> <td>11 – 20 lbs</td> </tr> </tbody> </table> <p>Abbreviations: BMI - Body Weight Index; kg - kilograms(s); lbs - pounds; m - meters</p> <ul style="list-style-type: none"> Weight gain generally slows down or ceases towards the end of your pregnancy. 	Pre-pregnancy Weight (BMI in kg/m ²)	Recommended Weight Gain	Underweight (BMI <18.5)	28 – 40 lbs	Normal Weight (BMI 18.5 – 24.9)	25 – 35 lbs	Overweight (BMI 25.0 – 29.9)	15 – 25 lbs	Obese (BMI ≥30.0)	11 – 20 lbs	 Your weight
Pre-pregnancy Weight (BMI in kg/m ²)	Recommended Weight Gain											
Underweight (BMI <18.5)	28 – 40 lbs											
Normal Weight (BMI 18.5 – 24.9)	25 – 35 lbs											
Overweight (BMI 25.0 – 29.9)	15 – 25 lbs											
Obese (BMI ≥30.0)	11 – 20 lbs											
Reference: Prenatal Fitness and Exercise	Your exercise routine <ul style="list-style-type: none"> Continue your exercises but modify intensity to avoid fatigue. Don't forget to finish your exercise with an adequate cool down and relaxation period. See Exercise in Resource Section for further information. 	 Your exercise										



Consider
breastfeeding

Breastfeeding - a great start

- Breastfeeding for even a few weeks has long term health benefits for the baby and mom.
- Drinking plenty of water will help maintain your milk supply.
- Breastfeeding is not for every mother. Your decision will depend on lifestyle, desire, time and support.



Fetal heart rate

Fetal heart rate

- This measurement will be done at each visit to monitor your baby's well-being.

Fetal heart
rate/date:



Fundal height

Fundal height

- Measure uterine growth, and check to see if baby is dropping into the pelvis. You may feel this "drop" as an increase in frequency of urination and easier breathing.



Fetal movement
count

Fetal movement count

- See Fetal Movement Count record. Complete Fetal Movement Count daily.



Weekly cervical
sweeping

Cervical sweeping

- Towards the end of pregnancy, the cervix will start to prepare itself for going into labor. This preparation or "ripening" results in cervical softening (effacement) and opening (dilatation). The part of the membranes that was over the cervical opening can now usually be felt by a vaginal exam.
- If indicated, your provider may examine your cervix at this visit. Some providers may offer you cervical sweeping. This is done by your provider inserting a gloved finger between the membranes and the inner wall of the cervix. The finger is then swept in a circular motion around the inner cervix to separate the membranes from the cervical wall.
- Most women will find this process uncomfortable. Some women, but not many, will get some contractions and some vaginal spotting as a result of this procedure. Some (but not many) will actually go into labor!

Cervical Exam

Date: _____

_____cm

_____%

_____station



Cervical Exam

Date: _____

_____cm

_____%

_____station

	<p>Postdate pregnancy plan</p> <ul style="list-style-type: none"> • If you have not delivered by the end of your 40th week, you will begin a postdate pregnancy plan. • This plan may include: <ul style="list-style-type: none"> – Non-stress tests twice a week. – Weekly ultrasound measurement of amniotic fluid levels. – Continued daily fetal movement recording. – Induction should be offered to women who reach 41 weeks. 	 <p>Postdate pregnancy plan</p>
	<p>Labor and Delivery</p> <ul style="list-style-type: none"> • Hopefully, by now, you have toured the Labor & Delivery area, are pre-admitted, have transportation and child/pet care arranged, and have your phone and charger in your bag. • Expect to be a little nervous. The big event is about to happen! • Prior to admission, you will probably be given a vaginal exam to determine where you are in labor. Your vital signs will be taken and the baby will be monitored. • If you are in active labor or your bag of water broke or you need close observation, you will be admitted and taken to a labor room where your baby's heart rate and your contractions will be monitored by an external fetal monitor (same monitor as used for the non-stress test you may have had). You will have your blood drawn and possibly an IV started at this time. • Now you and your partner get to put all that practice to work! Remember each contraction puts you one contraction closer to holding your baby. • If you have any special requests, such as having your partner cut the cord, or you want to breast feed immediately after delivery, let the staff know now. Don't forget your phone and charger for your baby's very first pictures. • Right after the baby is born is a good time to put your baby to breast. Getting your baby and you skin-to-skin is great for both of you. This serves two functions: helps you bond with your new baby and decreases your blood loss by contracting your uterus. • Your placenta usually delivers within 30 minutes after the baby is born. You may be too occupied with baby to take much notice. 	 <p>When you are admitted</p>



Postpartum (after the delivery)

Postpartum (after the delivery)

- Even though you have worked hard and long to bring about this birth, most mothers are too excited to sleep. Enjoy this time but sleep when you can. Getting enough rest will decrease your irritability, help you feel better, and help in your recovery.
- The staff will be checking on both you and your baby frequently during this postpartum period. These checks are done to ensure both of you are doing well.
- If your baby is a male, you will need to decide on whether or not to have him circumcised. This procedure may be done prior to hospital discharge. While there may be health benefits, at present, there is not enough medical evidence to recommend routine circumcision. Circumcision is a personal decision based on cultural, health, and religious beliefs.
- If you are having any problems caring for your newborn, let the staff know immediately. They are there to help you feel more comfortable and secure in your new role.
- The nursing staff will go over the basics of self and infant care. Ask questions and make sure you understand the information you are given.



Going home

Going home

- **Appointments:** At the time of discharge, you will be given information regarding follow-up appointments to be made for you and your baby.
- **Car seat:** Before leaving the hospital, your car seat will be evaluated and instructions given. The safest place for a newborn car seat is in the middle of the back seat facing the rear. Learn more about the proper use of car seats and booster seats at <https://www.nhtsa.gov/equipment/car-seats-and-booster-seats>.
- **Family Planning:** If you need a prescription for birth control, get it before leaving the hospital.
- **Immunizations:**
 - If your chicken pox and rubella titers indicate you have not had these diseases you will be given the vaccines to prevent these diseases in the future.
 - If you have not received the flu vaccine, you may receive it prior to hospital discharge.
 - If you are less than 26 years old, we recommend that you receive the series of three immunizations of the Human Papilloma Virus (HPV) vaccine. If you have not had it, the first dose is given after your delivery before discharge from the hospital, with follow-up repeat immunizations at two months and at six months after the first immunization.

- **DEERS:** If you or your spouse is active duty military, you must stop by the Military Personnel Office or the nearest DEERS office to enroll your baby in DEERS soon after discharge. At this time you should receive the forms to enroll your baby in TRICARE. Complete these forms and forward them to your local TRICARE office.



Going home

- **VHA Directive 1330.01(2):** Health Care Services for Women Veterans – Additional information regarding VA coverage for a woman veteran's newborn can be found on page 102.
- **Shaken Baby Syndrome:** Going home with a newborn is an exciting but challenging time. Babies cry for many reasons: when they are hungry, feel uncomfortable, have pain, or when they just want to be held. At times, no matter what you do, the baby will not stop crying. This can be very frustrating for parents and caregivers. It is important that no one ever shakes your infant for any reason. If you or your partner are having trouble calming your infant, put your baby in the crib, take a deep breath and call for help from a friend or contact your baby's provider as soon as possible to receive help with this. Additional help may be obtained from the local New Parent Support Program, telephone number: _____
- **Intimate Partner Violence:** IPV may increase during the postpartum period as the family adjusts to the changes of adding a baby. Please do not hesitate to seek help from your healthcare provider, counselor or a close friend if you are experiencing physical, sexual, or emotional abuse. The National Domestic Violence Hotline Advocates are available 24/7 at 1-800-799-SAFE (7233) in more than 200 languages. All calls are free and confidential.
- **Postpartum:** Many new mothers experience the "baby blues". This is a very common reaction during the first few days after delivery. The "baby blues" may include crying, worrying, sadness, anxiety, mood swings, difficulty sleeping and not feeling like yourself.

"Baby blues" is not the same as postpartum depression and does not require medical attention. With time, patience, and the support of family and friends, "baby blues" will usually disappear within a few days. If "baby blues" persist or worsen it may be a sign of a bigger problem. You should contact your provider prior to your scheduled postpartum visit.



Post delivery appointments

Post-delivery appointment for newborn

- At the baby's first appointments, your baby will be measured, weighed, and receive a complete physical exam.
- Parenting concerns such as feeding, bowel movements, sleep, and number of wet diapers will be discussed.
- Be sure to write down questions you have and bring them with you to this visit.
- If you, your baby, or your family are having problems adjusting, be sure to let your health care provider know.



Additional signs to report

Additional signs to report

- **Prior to your six-week check-up, call your healthcare provider if you experience:**
 - Fever greater than 100.4° F or 38° C.
 - Burning with urination.
 - Increased pain near your vagina or surgical site.
 - Foul smelling vaginal discharge, or discharge from your C-section incision.
 - Swollen, painful, hot, red area on your leg or breast.
 - Extended periods of hopelessness or depression (more than two to three days a week).
 - Thoughts of hurting yourself or others, or any mental health concerns.



Your next visit

Your post-delivery appointment

Prior to when you leave the hospital, you will be instructed to schedule a post-delivery appointment for 6-8 weeks after you gave birth.

- You will receive a complete physical exam, possibly including a Pap smear.
- During this visit, your healthcare provider will review the following with you:
 - Family planning
 - Your adjustment to parenthood
 - Signs of postpartum depression
- You may receive an HPV immunization.

Your post delivery appointment

- If you are especially sad or “blue” in the weeks after the birth of your baby, contact your provider to discuss this prior to this visit. Many new mothers get the baby “blues” for a few days after delivery but it usually doesn’t last very long. Postpartum depression is more intense and lasts longer. With postpartum depression, signs and symptoms such as overwhelming fatigue, insomnia, loss of appetite, lack of joy in life or thoughts of harming yourself or your baby may actually interfere with your ability for care for yourself and your baby.



Your next visit

Do you think you will be like your mother or different when you consider what kind of parent you will be?

How do you visualize yourself as a mother (warm, caring, strict, etc.)?

Write a few words to describe how you feel as a new mother:

This image shows a blank sheet of white paper with horizontal blue lines, similar to notebook paper. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

6-8 Weeks After Delivery Information Sheet



Goal: Determine health status and promote adjustment to being a mother and parent

Post Delivery Information Sheet: 6-8 Weeks after Delivery

Goal: Determine health status and promote adjustment to being a mother and parent

Your body's changes

- As soon as the baby is born your uterus starts to get smaller. By the time of your postpartum check it should be almost back to the size it was when you became pregnant.
- You should gradually return to your pre-delivery weight. Combining a healthy diet with exercise will help you lose weight and get safely back in shape after delivery.
- It is difficult to predict when you will ovulate after delivery. (This is why it is very important that you always use birth control whenever you have sex if you do not plan to become pregnant.)



**Your body's
changes**

Your family's changes

- Your baby is here! What an exciting and challenging time for everyone as you each adjust to the changes of a growing family.
- You and your partner may both have moments when you feel anxious or sad. You may both worry about money, your relationship or the future – not to mention being good parents. Make time to talk with one another about your concerns. Involve your partner in your activities and look for other ways to maintain a relationship. Set aside some time for the two of you to spend alone together.
- Your partner may feel “left out” because of all the attention you are giving to the baby. Remember to involve your partner in activities to help care for the baby.



**Your family's
changes**

Your thoughts and feelings

- You may find you have less interest than you expected in having sexual intercourse with your partner. There are several reasons for this. One is that the demands of a baby leave you exhausted. Additionally, your body is still adjusting to changing hormone levels and the birthing process.
- Discuss your feelings with someone you trust and your healthcare provider, especially if you have been very sad or depressed.
- Remember to make time for yourself. If you are feeling especially tired or stressed leave your baby with someone you trust and take time to do something relaxing such as going for a walk, going for a pedicure or just taking a long bath.



**Thoughts
&
feelings**



Consider breastfeeding

Breastfeeding - a great start

- The American Academy of Pediatrics, the American College of Nurse-Midwives, the American College of OB/GYN, and the American Dietetic Association all strongly recommend breastfeeding for at least your baby's first 12 months of life.
- Consider exploring community breastfeeding groups such as La Leche League. This is an excellent opportunity to get to know other breastfeeding mothers.
- Discuss any breastfeeding concerns with your provider at this visit.
- See Breastfeeding in Resource Section for further information.



Today's visit

Today's visit (typical topics)

- A complete physical exam with a pelvic and breast examination will be done to see if your body has returned to normal.
- Pre-existing medical conditions will be reviewed to help you determine a follow-up plan.
- If you had gestational diabetes in your pregnancy, additional lab work will be ordered.
- Your birth control method will be reviewed and revised as needed.
- A post-delivery depression screening will be completed (see page 153 for more information).
- Receive a domestic abuse screening.
- If you have not already completed the HPV vaccination series, and you want to be vaccinated, your next immunization will be given.
- If you are going back to work or need a release from your healthcare provider to return to duty, be sure to let them know during this visit.
- This is likely the last time you will see your healthcare provider for a year or so. Do not hesitate to ask any questions you have about your recovery or concerns you have.
- Your newborn is usually welcomed to accompany you to this visit. Check with your clinic. If you are bringing your newborn, bring a carriage or car seat for him/her to use during the exam.

My baby's name:

Date/Time of birth:

Weight/Length:

My labor was - as expected / different than expected:

My support person/coach was:

Others present at delivery:

Things I want to remember:

Prenatal Information Resources

Resources



YOUR PREGNANCY IN THE ARMY

Information for Active Duty Service Members

Congratulations!

Whether you are pregnant for the first time or are an experienced mother, and whether your pregnancy was expected or a bit of a surprise, we want your pregnancy to be healthy, happy and successful. Pregnancy for anyone, let alone women on active duty in the military, can be a challenging experience. The Army has joined our sister services to create a plan of care, based on the best available current medical evidence, that will maximize your chances of a successful pregnancy. Our goal is to provide you with the care and education you need to take home a healthy baby and be optimally prepared to care for your new addition. After all, your baby will be a new member to our Army family.

The plan of care and educational materials that are associated with these pregnancy guidelines as well as the requirements/limitations listed on your pregnancy profile will serve as a framework for your care during your pregnancy. There may be occasion to deviate from these guidelines due to your specific circumstances, potential pregnancy complications, local practices, and new medical information. Please remember these are guidelines and are not a substitute for specific recommendations made by a qualified provider.

Maternity uniforms

You will be provided two sets of maternity uniforms. At most posts, you will need to take a memorandum from your Commander requesting the issue and a copy of your pregnancy profile showing your due date to the Central Issuing Facility (CIF) or the unit supply room. These uniforms will be turned in upon your return from convalescent leave. Check with your command to inquire about specifics.

Pregnancy profile

Upon confirmation of your pregnancy (by examination or a lab test), you will be provided a physical profile which lasts until the end of your pregnancy. Activities that are acceptable during pregnancy are specifically noted in the profile and include: specific stretching, aerobic conditioning at own pace, and lifting up to 20 pounds. Limitations specific to your duty will be indicated in your profile.

You are exempt from regular physical training (PT) and Army Physical Fitness Testing (APFT) / weight standards for the remainder of your pregnancy and for 180 days past delivery. After receiving medical clearance from your provider, Commanders will enroll Soldiers in the Army Pregnancy/Post-Partum physical training (PPPT) program. This will help you maintain health and fitness and prepare you for your APFT.

It is critical that you maintain a copy of your current profile with you at all times. When you receive your profile, make an appointment to meet with your Commander to complete your pregnancy counseling. This is also a good time to start thinking about your family care plan.

Convalescent leave

- Maternity Convalescent Leave – is six weeks (42 days) of non-chargeable leave that is given to a female Soldier by her physician after she gives birth and before she is discharged from the hospital. Maternity Convalescent Leave begins on the on the first full day after the Soldier leaves the hospital.
- Primary Caregiver Leave – is six weeks (42 days) non-chargeable leave for the service member who gives birth or to the parent (Soldier) who is designated with the primary responsibility for caring for the child or children following a birth. If the parent (Female Soldier) gives birth is also designated as the Primary Caregiver, maternity convalescent leave must be completed before the Primary Caregiver Leave may begin.
- Secondary Caregiver leave – is 21 days of non-chargeable leave for the parent (Soldier) not designated with the primary responsibility of caring for the infant following birth.

Postpartum profile

Prior to beginning convalescent leave, all postpartum soldiers will also be issued a postpartum profile. The temporary profile will be for 45 days and it begins on the day of child birth and allows for Physical Training (PT) at the Soldier's own pace. If a Soldier decides to return early from convalescent leave, the temporary profile remains in effect for the entire 45 days. Participation in a postpartum PT program is highly encouraged to assist you in returning to the required fitness standards and to help transition you back to unit PT.

Army Physical Fitness Test (APFT)

You are exempt from the Army Physical Fitness test (APFT) during pregnancy and for 180 days following delivery. At the end of 180 days, you will take a record APFT. Your unit may have you take diagnostic APFT in preparation for the record test.

Both parents active duty

Both parents will need to update their Service members' Group Life Insurance and DD93, Record of Emergency Data. Also, both parents will need to let their unit command know of the new family member. Only the sponsor needs to enroll the baby in DEERS and TRICARE. Notify the Personnel Administration Center (PAC) of your new family member.

Congratulations again on the exciting road ahead of you!

References

U.S. Army Public Health Command, Directorate Health Promotion and Wellness (2010). *U.S. Army Pregnancy Postpartum Physical Training Program Implementation Guide* (TG 255A).

<https://phc.amedd.army.mil/topics/healthyliving/wh/Pages/Women'sHealthPortal-Pregnancy.aspx>

Comment: Search on Pregnancy Postpartum Physical Training (P3T)

Site provides a succinct summary of the information contained in the specific references listed below.

AR 40-501 *Standards of Medical Fitness*, Pregnancy and Postpartum Profiles

AR 614-30 *Assignments, Details, and Transfers*, Overseas Service in Pregnancy

AR 600-8-10 *Leaves and Passes*, Convalescent Leave After Pregnancy and Childbirth

Army Directive 2019-05 (Army Military Parental Leave Program)

<http://www.apd.army.mil>

Comment: Navigate through Official Documents, Army Administrative Publications

Site details considerations in pregnancy.

DoD Directive 1308.1 *DoD Physical Fitness and Body Fat Program*

YOUR PREGNANCY IN THE NAVY/MARINE CORPS

Information for Active Duty Service Members

Congratulations!

Whether you are pregnant for the first time or are an experienced mother, and whether your pregnancy was expected or a bit of a surprise, we want your pregnancy to be healthy, happy and successful. Pregnancy for anyone, let alone women on active duty in the military, can be a challenging experience. The Navy has joined our sister services to create a plan of care, based on the best available current medical evidence, that will maximize your chances of a successful pregnancy. Our goal is to provide you with the care and education you need to take home a healthy baby and be optimally prepared to care for your new addition. After all, your baby will be a new member to our Navy/Marine Corps family.

The plan of care and educational materials that are associated with these pregnancy guidelines as well as the requirements/limitations listed on your pregnancy profile will serve as a framework for your care during your pregnancy. There may be occasion to deviate from these guidelines due to your specific circumstances, potential pregnancy complications, local practices, and new medical information. Please remember that these are guidelines and are not a substitute for specific recommendations made by a qualified obstetrical health care provider.

Maternity Uniforms

The certified maternity uniform is mandatory for all pregnant servicewomen in the Navy when the regular uniforms no longer fit. The outer garments (sweater, raincoat, overcoat, peacoat and reefer) may be worn unbuttoned when it no longer fits properly. You are expected to wear regular uniforms upon returning from convalescent leave; however, your Commanding Officer (CO) may approve the maternity uniforms for up to six months from the date of delivery. Enlisted servicewomen will be given a clothing allowance upon presenting the pregnancy notification to Personnel Support Detachment (PSD).

Statement of Pregnancy

You will be provided with a Pregnancy Notification Form for use in notifying your CO. This form will identify your Estimated Due Date (EDD), the 20th week of pregnancy, and the 28th week of pregnancy. These dates are used by your command for planning purposes. The OPNAVIST 6000.1 Series and MARINE CORPS ORDER 5000.12 Series provide guidance and detailed information regarding assignments and rest periods in relation to a servicewoman's pregnancy time line.

Limitations

Few restrictions are required in an uncomplicated pregnancy of a physically fit servicewoman working in a safe environment. You are exempt from standing at parade rest or attention for longer than 15 minutes; lying in a prone position for a prolonged period; working in one position for prolonged periods; and performing prolonged work at heights.

You are also exempt from participating in weapons training; swimming qualifications; drown proofing; diving; lifting greater than 25 pounds; exposure to excessive heat or vibration; and any other physical training requirements that may adversely affect the health of the servicewoman/fetus.

During the last three months of pregnancy (weeks 28 and beyond) you will be allowed to rest 20 minutes every four hours and limited to a 40-hour work week (pregnancy does not preclude watch standing but all hours will count as part of the 40-hour work week). You may request a waiver to extend your hours beyond 40 hours if your health care provider concurs.

Physical Readiness Program (PRP)

You are exempt from the PRP during pregnancy and for six months following delivery. However, if you have an uncomplicated pregnancy you are encouraged to perform an individualized exercise program that incorporates regular to moderate exercise for 30 – 45 minutes, three or more times a week. An exercise program should be gradually resumed six weeks after an uncomplicated vaginal delivery or cesarean delivery.

Military Parental Leave Program (MPLP)

The Navy Parental Leave Program policy applies to all active duty Sailors. Reserve Sailors who were performing active duties, or mobilized more than 12 continuous months, and are the parents of a qualifying birth are also eligible.

The three family leave categories under the MPLP are:

- Maternity Convalescent Leave is a six-week (42 days), non-chargeable leave period for the Sailor who gives birth, commencing the first full day after a Sailor is released from the hospital following a birth.
- Primary Caregiver Leave is a six-week (42 days) non-chargeable leave period for the parent who gives birth or is designated with primary responsibility for caring for the child or children following a birth. If the parent who gives birth is designated as the Primary Caregiver, then then Maternity Convalescent Leave must complete before the Primary Caregiver Leave begins.
- Secondary Caregiver leave is a two-week (14 days) non-chargeable leave period for the parent not designated with primary responsibility for caring for the child following a birth.

Details about the leave periods are described in MILPERSMSAN 1050-415, Parental Leave Program.

Useful policy references

OPNAVINST 6000.1 Series: Guidelines Concerning Pregnant Servicewomen

MARINE CORPS ORDER 5000.12 Series: Marine Corps Policy on Pregnancy and Parenthood

MARINE CORPS ORDER P6100.12 Series: Marine Corps Physical Fitness Test and Body Composition Program Manual

OPNAVINST 6110.1 Series: Physical Readiness Program

OPNAVINST 1740.4 Series: U.S. Navy Family Care Policy

MARINE CORPS ORDER 1730.13 Series: Family Care Plans

NAVMEDCOMINST 6320.3 Series: Medical and Dental Care for Eligible Persons at Navy Medical Department Facilities

MILPERSMSAN 1050-415, Parental Leave Program.

References

<https://www.med.navy.mil/Pages/default.aspx>

<https://www.hqmc.marines.mil/>

<http://www.bupers.navy.mil/>

YOUR PREGNANCY IN THE AIR FORCE

Information for Active Duty Service Members

Congratulations!

Whether you are pregnant for the first time or are an experienced mother, and whether your pregnancy was expected or a bit of a surprise, we want your pregnancy to be healthy, happy and successful. Pregnancy for anyone, let alone women on active duty in the military, can be a challenging experience. The Air Force has joined our sister services to create a plan of care, based on the best available current medical evidence, that will maximize your chances of a successful pregnancy. Our goal is to provide you with the care and education you need to take home a healthy baby and be optimally prepared to care for your new family member. After all, your baby will be a new member to our Air Force family.

The plan of care and educational materials that are associated with these pregnancy guidelines as well as the requirements/limitations listed on your pregnancy profile will serve as a framework for your care during your pregnancy. There may be occasion to deviate from these guidelines due to your specific circumstances, potential pregnancy complications, local practices, and new medical information. Please remember that these are guidelines and are not a substitute for specific recommendations made by a qualified obstetrical health care provider.

Maternity Uniforms

Enlisted personnel will receive a lump sum maternity uniforms allowance. You must take your profile, signed by your Commander to the orderly room. The staff will forward this to Finance and you should receive your payment within one month. We advise you do this early in your pregnancy so that you receive your payment and purchase uniforms before you grow out of your regular uniforms. This payment is enough to purchase one maternity blues set, ABU set and dress blues set. Visit your Airman's Attic on base for spare sets of maternity uniforms.

Profile

Within 24 hours of notification of your positive pregnancy test, you are required to go to Force Health Management (FHM) for initiation of your pregnancy profile and Occupational Health Assessment. The pregnancy profile outlines some requirements and limitations regarding your activity during your pregnancy. You will receive a memorandum from FHM that will serve as a temporary profile until the Profile Reviewing Officer has validated your profile. As an Air Force service member, it is your responsibility to notify your supervisor regarding your pregnancy soon after pregnancy is diagnosed (AFI 48-123). Your supervisor, commander and Unit Deployment Manager will receive a copy of your profile via e-mail immediately upon validation.

Limitations

The pregnancy profile limits requirements for physical training, body weight requirements and environmental exposures. During your pregnancy and for six months following delivery, you are not worldwide qualified and must be removed from mobility status.

Physical Training (PT)

Although you are not required to perform formal physical training or weigh-ins, we strongly encourage you to eat a healthy diet and perform moderate exercise during your pregnancy. Most facilities offer programs on appropriate exercise, health diet, tobacco cessation, labor and delivery, new mom classes and other programs, specifically for pregnant women. We encourage you to take advantage of these programs as well as some of the many other activities and resources that are available to you during your pregnancy.

Convalescent Leave

Maternity convalescent leave is six weeks (42 days), primary caregiver leave is six weeks (42 days), and secondary caregiver leave is three weeks (21 days). Every birth mother will have convalescent leave. Caregiver leave is given in addition to the convalescent leave.

Details about the leave periods are described in Air Force Guidance Memorandum 2018-01 to AFI 36-3003, Military Leave Program, and AFI 36-3003, Military Leave Program.

Congratulations again on the exciting road ahead of you!

References

Air Force Guidance Memorandum 2018-02 (AFGM2018-02) to AFI 44-102

AFI 44-102 Medical Care Management
(Section 4D. Medical Care Related to Pregnancy)

AFI 10-203, Duty Limiting Conditions
(Section 3.5. Pregnancy-related Duty Limitations)

AFI 36-2905 Fitness Program
(Section 5.2.4. Pregnancy)

Air Force Guidance Memorandum 2018-01 to AFI 36-3003

Air Force Instruction 36-3003, Military Leave Program.

<http://www.operationalmedicine.org/ed2/Instructions/Instructions.htm>

DEPARTMENT OF VETERANS AFFAIRS (VA)

Maternity Care Benefits for Eligible Veterans

Congratulations!

Whether you are pregnant for the first time or are an experienced mother, we want your pregnancy to be healthy, happy and successful. Many people are unaware the Veterans Health Administration (VHA) is authorized to provide comprehensive pregnancy and postpartum care to eligible women Veterans. If eligible, maternity benefits begin with the confirmation of pregnancy and continue through the final post-partum visit, usually at six to eight weeks after the delivery or when you are medically released from obstetric care.

Most VA Medical Centers do not have obstetrical services “in-house”. Obstetrical (OB) care is covered by the VA through the Office of Community Care and provided by authorized maternity care providers in the community. Community care is routinely used to provide maternity care within a reasonable distance of your home. The VA covers pregnancy related care and delivery services. This includes, but is not limited to coverage for required laboratory and ultrasound tests in pregnancy. You will receive an Authorization for Care letter with details of your maternity coverage. You should carry this with you to every visit as proof of coverage. This will help to avoid errors in billing. If an error does occur and you receive a bill, contact your Office of Community Care.

Once your pregnancy is confirmed, your VA provider and Maternity Care Coordinator (MCC) or designee will discuss with you all aspects of maternity care that will be covered. Every facility has an Office of Community Care. Personnel at your local Community Care office can help explain the process to the OB provider you choose. They will also be able to determine if the OB provider of your choice will accept VA payment terms. In some cases you may be asked to choose another OB provider. It is important for you to make your OB appointment as soon as possible. The earlier you start prenatal care, the better for you and your baby.

Please discuss coverage for newborn services with your facility Maternity Care Coordinator (MCC) or designee. These individuals and the Office of Community Care can assist you with information regarding current newborn health coverage. Newborn care is furnished for not more than 7 days after the birth of a child. Newborn care includes but is not limited to inpatient care, outpatient care, medications, immunizations, circumcision, well-baby office visits, neonatal intensive care, and other appropriate post-delivery services.

SPECIALTY CARE WHILE PREGNANT: During the pregnancy, if medical concerns come up and your OB provider thinks you need to see another specialist or need additional procedures, the OB provider can refer you to a Community specialist by submitting a Request for Service Form. Depending on the urgency, of the procedure, the request should be telephoned, faxed or e-mailed securely to the Office of Community Care. This will allow the OB doctor and hospital to be paid for the services performed. It is important to present your VA Authorization for Care letter at all of your specialty care visits.

Make sure that when you see your OB provider you get their emergency contact information and you know where to go for emergencies. Since most VA Medical Centers do not have obstetrical services “in-house”, you should go to the hospital your OB provider recommends if you have a pregnancy related emergency.

FOLLOWING UP DURING AND AFTER YOUR PREGNANCY: Keep in contact with your local Maternity Care Coordinator or designee during your pregnancy. Make sure you have a follow-up appointment with your VA provider after the birth of your baby (within three to six months). Request a copy of your Obstetric records from your OB provider to be sent to your local VA facility.

My Maternity Care Coordinator or designee is

Maternity Care Coordinator or designee Telephone Number

Office of Community Care Contact Person

Office of Community Care Telephone Number

Partners and Pregnancy

Most **partners** feel both excited and anxious about the upcoming changes in their lives. You can help your partner by being understanding of the changes a pregnant woman may experience and by being **prepared and supportive**. Your support contributes to a healthy pregnancy and often helps make labor and delivery easier.

Emotional Aspects of Pregnancy

Pregnancy can be an emotional journey for both you and your partner. You may feel isolated as she focuses on her changing body and emotions. It will be helpful if you attend prenatal visits together. Also, read materials about pregnancy and parenthood with her.

Pregnancy and Sex

Sexual intercourse is permitted during the entire pregnancy unless your partner's provider has told her otherwise. The baby is cushioned within the "womb" and there is no way to harm the baby during normal sexual relations. However, there may be times when your partner may not feel comfortable having intercourse. Remember to be patient and supportive of her feelings.

Partner's Checklist before Delivery

- Did you take a tour of the hospital?
- Did you and your partner attend prenatal classes?
- Is the hospital pre-admission paperwork completed?
- Do you know your partner's wishes regarding pain relief during labor?
- Do you want to cut the umbilical cord?
- Do you have a car seat for baby? Do you know how to install it in your vehicle?
- Do you have cash/change ready for late night vending machine trips?
- Do you have a bag packed? (Things you may want to help you and her through labor.) Be sure to add your camera or phone.
- Do you have a list of people to contact after the birth?

How to Help During Labor and Delivery

Remember, you are the "coach" during labor and delivery. Being supportive and staying calm is important.

- During early labor, you can help your partner by going for a walk, listening to music, or watching a movie with her.
- The "coach" can time contractions from the beginning of one contraction to the beginning of the next contraction.
- Offer a massage or apply pressure to her back if that relaxes her.
- Help her to focus on something when she is having a contraction and remind her to breathe. Slow deep breathing can be very relaxing. Breathe with her.
- Stay calm with a relaxing tone in your voice.
- Encourage her during the pushing stage.

Military Parental Leave

If you are on active duty, discuss parental leave policies with your supervisor. As a primary or secondary caregiver, you may be eligible for non-chargeable leave following the birth of your child.

The Postpartum Period

Typically, women will stay in the hospital for one to two days. Have the car seat installed so you are ready to take your new baby home when your partner is discharged from the hospital.

If mother is breastfeeding, some partners may feel left out of the bonding process. You can help her by changing the diaper before bringing the baby to her to nurse. After the feeding, you can burp the baby and rock the baby to sleep. Breastfeeding does allow an active role for both the woman and her partner. Some partners may enjoy bathing the baby.

Sexual Intercourse after Delivery

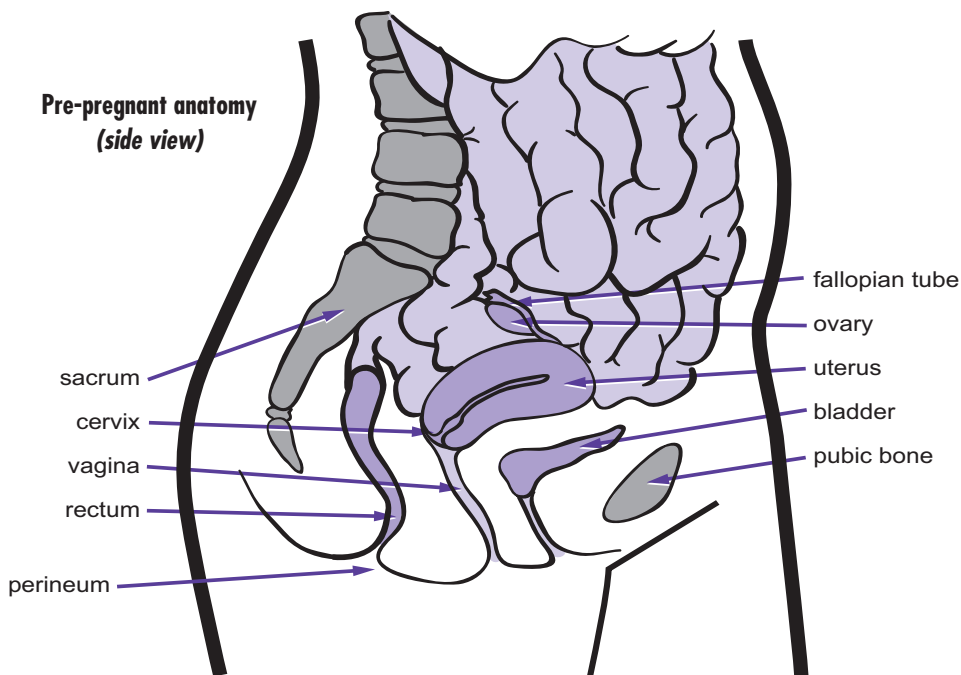
There is no set time frame before a woman can have sex again after giving birth. Some health care providers recommend waiting four to six weeks. You and your partner should discuss with her health care provider when to resume normal sexual relations.

When your partner does feel ready to have sex again, remember to go slow and listen to her. Even if a woman is not having a period or is breast-feeding, she can ovulate. You should use some type of birth control when you start having sex again, if pregnancy is a concern for you and your partner. For additional information about birth control, visit CDC site: <https://www.cdc.gov/reproductivehealth/contraception/index.htm>.

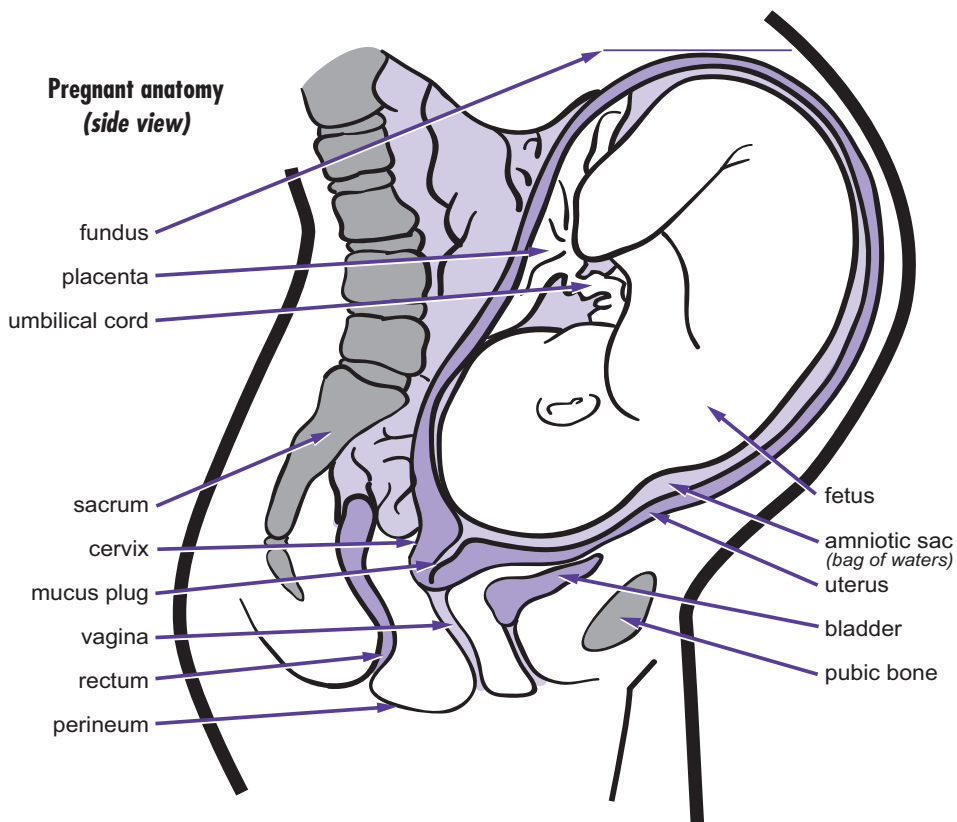
References

2009 National Defense Authorization Act

**Pre-pregnant anatomy
(side view)**



**Pregnant anatomy
(side view)**



Notes:

This image shows a single sheet of white paper with horizontal blue lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Common Discomforts & Annoyances of Pregnancy

All these discomforts/annoyances are a common part of pregnancy and usually end eventually. Try the hints given below. If you don't get relief, talk to your provider or nurse about other possible measures to try.

Discomfort	When	What you can do to help	Notify provider if:
Ankle/foot swelling	Second trimester until delivery	<ul style="list-style-type: none"> • While sitting, prop your feet up (even a few inches up helps) and do not cross your legs. • Continue drinking lots of fluids (at least 8 glasses daily). • Wear comfortable shoes or sandals and avoid high heels. • Consider support hosiery. 	<ul style="list-style-type: none"> • Redness in legs • Increasing pain/redness in calves
Breast tenderness	Begins early and continues	<ul style="list-style-type: none"> • Wear well fitted, good support or athletic bra day and night. • Soak in a warm bath. 	<ul style="list-style-type: none"> • Redness in breast • Fever
Breast leakage	May begin second trimester	<ul style="list-style-type: none"> • Wear pads in bra. • Avoid harsh soaps or creams. 	<ul style="list-style-type: none"> • Red/pinkish discharge from breasts • Fever
Bleeding gums	Entire pregnancy	<ul style="list-style-type: none"> • Use a very soft tooth brush. • Get routine dental care. • Gently brush teeth at least twice daily. • Floss daily. • Use good dental hygiene. 	<ul style="list-style-type: none"> • More than slight bleeding from gums • Pain in teeth • Pus from gums
Constipation	Entire pregnancy	<ul style="list-style-type: none"> • Eat foods high in fiber (bran, green leafy vegetables, whole grain cereals/breads, fruits) daily. • Drink at least 8 - 10 glasses of fluids daily. • If approved by your provider, exercise daily (this will help move food through the bowel). • Walk after meals. • Do not take stool softeners, laxatives, or enemas unless you talk with your provider. 	<ul style="list-style-type: none"> • Blood in stool • Abdominal pain • No bowel movements over extended period of time

Discomfort	When	What you can do to help	Notify provider if:
Contractions (Braxton Hicks)	After 20th week	<ul style="list-style-type: none"> • Know this is part of your uterus getting “ready” for labor. • Empty bladder and drink 2 - 3 glasses of water. • Lie down on your side with hands on belly. • Keep track of how often these occur. 	<ul style="list-style-type: none"> • Regular contractions that do not go away • Painful contractions • No improvement in symptoms • History of preterm labor
Dizziness	As your uterus enlarges	<ul style="list-style-type: none"> • Move slowly when getting up from lying down or sitting. • Eat small, frequent meals and healthy snacks with protein to avoid low blood sugar. • Drink lots of fluids especially if exercising or in hot weather. • If dizzy, lie down on your side. 	<ul style="list-style-type: none"> • Persistent dizziness • Feeling faint • You have diabetes • Shortness of breath/ chest pain • Vaginal bleeding or abdominal pain
Enlarging belly and breasts	Second half of pregnancy	<ul style="list-style-type: none"> • Sleep on your side with a pillow between your legs. • Wear loose, comfortable clothes. • Wear support bra even to bed. • Use maternity support belt. 	
Fatigue or tiredness	Early in pregnancy and again in the last month	<ul style="list-style-type: none"> • Take extra naps during the day if possible. • Avoid fluids before bedtime. • Continue mild exercise but not to the point of exhaustion. • Try to get at least 8 hours sleep at the same time each night. 	
Flatulence (gas)	Anytime, especially after 20 weeks	<ul style="list-style-type: none"> • Eat foods high in fiber daily. • Drink at least 8 glasses of water daily. • Avoid gas-forming foods such as beans, cabbage and sodas. • If approved by your provider, exercise daily. • Walk after meals. 	
Food cravings	First half of pregnancy	<ul style="list-style-type: none"> • OK to indulge if food choice is not harmful. 	<ul style="list-style-type: none"> • Craving excessive ice • Craving non-food items (dirt/paint)

Discomfort	When	What you can do to help	Notify provider if:
Frequent urination	Begins early, gets better mid-pregnancy, and then increases towards the end of pregnancy when baby drops.	<ul style="list-style-type: none"> • Don't cut back on fluids. • Know bathroom locations. • Expect to make many trips to the bathroom, day and night. • Avoid drinking lots of fluids before bedtime. 	<ul style="list-style-type: none"> • Pain or burning with urination • History of urinary tract or kidney infection • Fever/chills/sweats • Pelvic, back, stomach, or side pain
Headaches	First half	<ul style="list-style-type: none"> • Use mild pain relievers such as Tylenol® as directed • Avoid aspirin, ibuprofen and other pain medications, unless you have discussed their use with your health care provider. • Avoid eyestrain. • Rest eyes frequently and take frequent computer breaks. • Get gentle massages and do mild stretching exercises. • Drink plenty of water. 	<ul style="list-style-type: none"> • Persistent headache not relieved by over-the-counter (OTC) medication • Worse headache of your life • Associated with vision changes
Heartburn	Second trimester until delivery	<ul style="list-style-type: none"> • Eat 6 - 8 small meals daily. • Eat slowly, chew food well. • Avoid deep fried, greasy, and spicy foods. • Drink fluids between your meals. • Avoid citrus fruits or juices. • Go for a walk after meals. • Avoid lying down right after eating. • Antacids can help. 	<ul style="list-style-type: none"> • Persistent heartburn not relieved by antacids • Associated with persistent nausea and vomiting
Hemorrhoids	Anytime	<ul style="list-style-type: none"> • Prevent constipation - try not to strain with bowel movement. • Apply hemorrhoid ointment as needed (discuss with provider). • Apply witch hazel pads. • Take sitz baths. • Do your Kegel exercises (see prenatal fitness brochure). 	<ul style="list-style-type: none"> • Bleeding hemorrhoids • Persistent pain from hemorrhoids

Discomfort	When	What you can do to help	Notify provider if:
Increased perspiration	Anytime	<ul style="list-style-type: none"> • Increase fluids intake. • Wear easily washable, comfortable, loose fitting clothing. • Practice good hygiene. 	
Increased saliva	First trimester	<ul style="list-style-type: none"> • Gum and hard candy - watch excess calories. • Use mouthwash. • Avoid starches. 	
Increased vaginal discharge	Entire pregnancy	<ul style="list-style-type: none"> • Wear cotton underwear. • Avoid nylon underwear/panty hose, feminine hygiene soaps or sprays. • Do not douche. 	<ul style="list-style-type: none"> • Yellow or greenish, thick and cheesy, or has a strong fish-like odor • Soreness, itching or burning
Leg cramps	Second half of pregnancy	<ul style="list-style-type: none"> • Extra potassium or calcium may help. Try eating a banana every day or drinking a glass of milk. • Gently stretch by - sitting down, extending legs and flexing toes towards body (grab toes if you can and pull towards yourself). Your partner can help with this. • Mild exercise may help. 	<ul style="list-style-type: none"> • Worsening cramps/pain especially in the back of calves/legs • Redness/swelling in calves
Ligament pain (sharp pulling sensation on either side of the lower abdomen)	Increases with increasing uterine size	<ul style="list-style-type: none"> • Support your weight with your hands when changing positions. • Move slower. • A mild analgesic may help. • Apply ice to affected side. • Use maternity girdle/belt for support. • Lean back in a slant position supporting your back with your knees bent. 	<ul style="list-style-type: none"> • Worsening pain

Discomfort	When	What you can do to help	Notify provider if:
Light headed & dizzy	Begins early and continues	<ul style="list-style-type: none"> • Stop what you are doing and lie on your left side with your legs up for short period of time. • If unable to lie down, sit immediately and tell someone you are dizzy. • If dizziness resolves, get up slowing from lying to sitting, then up to standing position if possible. • Ensure adequate hydration by drinking plenty of water. 	<ul style="list-style-type: none"> • Repeated episodes • Associated with other symptoms such as chest pain/shortness of breath • Loss of consciousness
Low backache	Second half of pregnancy	<ul style="list-style-type: none"> • See page 116. 	<ul style="list-style-type: none"> • See page 116.
Nasal stuffiness & bleeding	First trimester and again at term	<ul style="list-style-type: none"> • Use a saline nasal spray. • Use cool mist humidifier/ vaporizer if air is dry. • Talk with your provider about OTC medications. • Avoid using nasal decongestant sprays. • Blow your nose gently. • Ensure adequate hydration by drinking plenty of fluids. • Stop bleed by squeezing nose between thumb and forefinger for a few minutes. 	<ul style="list-style-type: none"> • If nasal bleeding is frequent
Nausea (Morning Sickness)	Occurs in early pregnancy and usually improves after first trimester.	<ul style="list-style-type: none"> • See page 115. 	<ul style="list-style-type: none"> • See page 115.
Numbness/ tingling fingers/ hands (Carpel Tunnel Syndrome)	Second and third trimester	<ul style="list-style-type: none"> • Elevate hands and wrists as much as possible. • Rest hands with frequent breaks. • Talk with your provider about wrist splints. 	<ul style="list-style-type: none"> • Your hands are weak and not just numb

Discomfort	When	What you can do to help	Notify provider if:
Sleeplessness	Anytime but especially last trimester	<ul style="list-style-type: none"> • Try a warm bath before bedtime. • Avoid stimulating activity before bedtime • Avoid drinks containing caffeine. • Use relaxation techniques. • Get in a comfortable position to sleep; place pillows between legs. • Try a glass of milk before going to bed. 	<ul style="list-style-type: none"> • Talk with your provider If you are feeling very stressed, depressed or nervous about your pregnancy
Varicose veins	Increases as pregnancy progresses	<ul style="list-style-type: none"> • Avoid tight clothing and stockings. • Avoid crossing legs. • Practice good posture. • Put support hose, ace wraps or elastic stockings on in bed before lowering feet - wear all day. 	<ul style="list-style-type: none"> • Painful bulging veins • Redness in area of veins • Leg cramps
Vision changes	Entire pregnancy	<ul style="list-style-type: none"> • Don't buy a new prescription for your glasses as you will probably return to pre-pregnant vision after delivery. • Take frequent eye breaks. • May not be able to wear contact lenses during pregnancy. • Wear glasses as prescribed for reading/distance vision and for driving. 	<ul style="list-style-type: none"> • Blurry (fuzzy) vision • Seeing black spots or shadows • Headache • Loss of vision

Nausea and Vomiting in Pregnancy

(aka “morning sickness”)

Nausea can occur during early pregnancy. It usually gets better after the first trimester.

What can you do?

- Nibble some plain crackers, dry toast, dry cereals before getting out of bed in the morning and when you are feeling queasy.
- Eat six to eight small meals throughout the day instead of big meals.
- Try eating protein snacks.
- Get plenty of rest.
- Avoid odors or foods that set off the nausea.
- You may have to avoid prenatal vitamins during the first trimester if they seem to worsen the nausea.
- Drink liquids between meals not with meals.
 - Avoid dehydration by drinking water and nutritious smoothies and eating ice chips.
 - Sip on ginger ale, water, weak tea, or mild fruit juices.
 - Try diluting a sports drink with half water and sip on this liquid all day.
- Avoid greasy or spicy foods.
- Chew gum or suck on hard candy (mints/ginger) or ice chips.
- Sit and put your head down between your legs.
- Motion/Sea sickness bands may help.
- Acupuncture may be helpful.

Notify your provider if you

- Cannot keep down any liquids or food.
- Have nausea that does not go away.
- Have more than three to five pounds of weight loss since becoming pregnant.
- Have vomiting that is blood tinged.
- Have flu-like symptoms or fever.
- Feel faint.

Low Back Pain

Low back pain in pregnancy is the most common discomfort of pregnancy.

Why does it happen?

- Strain of back muscles.
- Uterus gets bigger and center of gravity changes - thus posture changes.
- Hormones cause ligaments to relax and joints to loosen.

What can you do?

- Use good body mechanics.
- Keep your back straight and your head up.
- Avoid lifting heavy objects by yourself.
- Avoid flat or high heeled shoes (low heel with arch support is best).
- Sleep on a firm mattress (or place a board between mattress and box spring).
- When bending to pick something up, bend from your knees (not waist).
- Gently massage lower back or apply hot/cold compress.
- Take a warm soak in a bathtub. (Make sure to have good grip on hand rail when exiting tub to prevent a fall.)
- Take a warm shower with pulsating/heavy stream aimed at lower back area.
- When sitting, place a small pillow behind your lower back for support.
- Avoid standing for long periods of time.
- If standing for an extended period, prop one foot up on a stepstool or stair, this helps straighten the small of your back.
- Sleep on your side and place a pillow between your legs.
- Stretch and stay active in pregnancy (talk with your provider before starting a new exercise program).
 - Forward bend - Sit in a chair, feet flat on ground bend head/shoulders forward to the knees.
 - Pelvic rock exercises - When on hands and knees, stretch your lower back – arch so back is rounded, then relax it back to original position. Use your stomach muscles to keep your back straight when relaxing.
- Talk with your provider about over the counter pain medication if needed.
- Consider a maternity girdle for support.

Contact provider if any of the following occur

- Severe pain
- Intermittent pain (comes and goes)
- Burning with urination
- Vaginal bleeding
- Pain lasting more than two weeks
- Tingling/numbness in lower legs

Exercise

Exercise is encouraged during pregnancy as it has many benefits including preparing you for labor and childbirth. Exercise should occur at least three or more times per week for a minimum of 20 minutes per session with a goal of 150 minutes of mild to moderate exercise each week. Exercise will help with some of the common discomforts of pregnancy including reducing backaches, constipation, bloating and swelling. It also improves sleep, your mood and posture. Exercise can help prevent or treat gestational diabetes. If you have any medical conditions or complications with the pregnancy, it is important to talk to your health care provider before exercising.

The following activities are safe during pregnancy: walking, swimming, cycling, and aerobics. Running is also safe for women who were runners prior to pregnancy; in fact, it is safe to continue most pre-pregnancy exercise routines throughout pregnancy.

Activities that should be avoided during pregnancy include downhill skiing, contact sports, parachuting, rappelling, and scuba diving. Activities that increase your risk of falling should also be avoided such as gymnastics, water skiing, and horseback riding. You should avoid exercises that involve jumping, jarring motions or quick changes in direction; or sports that risk contact injuries such as soccer or basketball.

You should exercise at mild to moderate intensity and it is important to drink lots of fluids. You should stop exercising if you have any of the following symptoms: vaginal bleeding, dizziness or feeling faint, increased shortness of breath, chest pain, headache, muscle weakness, calf pain or swelling, contractions, decreased fetal movement, or leakage of fluid from the vagina.

Exercise can be resumed postpartum when you feel ready after delivery. If you had a complicated pregnancy or delivery, you need time to recover and should check with your health care provider prior to resuming exercise.

Most women think of physical exertion when they think of exercise. In addition to the exercises mentioned already, women should regularly do pelvic floor exercises, known as Kegels. These should be done during and after your pregnancy. Doing Kegels during pregnancy has been shown to facilitate quicker recovery of postpartum muscle strength. This decreases your risk of urinary and bowel incontinence caused by stretched or injured pelvic floor muscles. Pelvic muscle strength also helps maximize effective pushing during labor. After pregnancy, doing Kegels will help recover strength in the pelvic floor muscles. Strong pelvic floor muscles may also enhance sexual pleasure for you and/or your partner.

Travel During Pregnancy

Questions regarding travel may arise from time to time during your pregnancy. You may ask “Is it safe for me to travel?” Whether or not it is safe to travel depends on how far along you are, whether or not you have complications in your pregnancy, and your overall comfort level. For most women, traveling is safe during most of the pregnancy.

The best time to travel is during the second trimester between weeks 18 and 28. By this time you are usually over morning sickness yet your belly is not so big that you are very uncomfortable. You do not always have to limit yourself to this time period. If you feel up to traveling, discuss your travel plans with your provider. If she or he does not object to your travel plans enjoy your trip! Make sure you keep your Pregnancy Passport with you during the trip.

If you have an option, what mode of travel should you choose? The best mode of travel should be the one that will get you to your destination in the least amount of time. For long distances, such as across the United States, that may be by air. Be sure that during long plane or car rides you get up, stretch, and move about periodically. This will help minimize the amount of swelling that can occur in your legs during such long trips. This also decreases the risk of developing a blood clot. Blood clots are uncommon but happen more often to pregnant women, especially if they are lying or sitting still for a long time. Typically, airlines restrict women beyond 34 weeks from traveling over the ocean and beyond 36 weeks from flying at all. Make sure you contact the airline and notify your provider if you are thinking of traveling late in your pregnancy. You may need to bring a statement from your health care provider approving your travel and stating your due date. If you decide to take a road trip, try to limit your riding or driving to five to six hours a day. During this time, take breaks to stretch your legs as you would with an airplane trip.

Being prepared before you go will ease your mind when you travel and likely make your trip much more enjoyable.

If you are traveling internationally, check the Centers for Disease Control and Prevention (CDC) web site at <http://www.cdc.gov/travel/>. The CDC is a good resource for travel alerts, safety tips, and up-to-date vaccination facts for many countries. The CDC web site has a travel page called “Travelers’ Health” that may be useful to you. The CDC can be reached by phone at 1-800-232-4636.

Another source for help is the US Embassy or Consulate in the country where you are traveling.

Having Twins, Triplets or More!

Having twins or even triplets seems to be on the rise in the United States. This is due in large part to the use of fertility drugs and in vitro fertilization. While having multiples can bring great joy, there are definitely more challenges and often greater risks involved. These risks include preterm delivery and other complications that can affect the mother and the babies.

If you learn you are carrying more than one baby, you and your partner will likely feel both elated and scared. Having one baby brings joy and challenges. Having more than one can add stress. As always, discuss your concerns with your provider. The most important aspect of your care will be for you to understand how to care for yourself while you are pregnant and then how to be prepared for when you and the babies go home from the hospital.

Your prenatal care will likely require more provider visits than a pregnancy with one baby. Your weight gain and uterine growth will be monitored closely. Pregnancy with multiple babies requires greater nutritional intake and often requires you to rest more than you would with one baby. You will be monitored closely for complications such as hypertension, preterm labor, and premature rupture of membranes.

TAKE CARE OF YOURSELF! If you feel tired, rest. Carrying more than one baby can be very taxing on the body. Listen to your body and rest when you need to – both while you are pregnant and after your babies are born.

New parents often benefit from having assistance at home when discharged from the hospital. This is especially helpful with multiple births. Plan for your homecoming and explore arrangements that will allow you to get as much rest as possible in the first few weeks home. While you are pregnant you might also check out community support groups for parents of multiples so that you can be better prepared for the birth of your babies.

Most women who have multiple births are able to successfully breast feed their babies. Sometimes this involves pumping or hand-expressing milk. Since most multiple births are preterm, the babies may have some trouble breastfeeding. However, most benefit from breast milk regardless of how they get it. They can get it in many ways. The nursery staff will help you know how and when to feed your babies. Amazingly, your body will automatically adjust the content of your milk to best support premature or term babies.

Fetal Movement Counting Chart

[illegible]

Counting your baby's movements is an excellent way of knowing that your baby is doing well. It is also a great excuse for you to get off your feet, and get in touch with your baby. You should begin counting your baby's movements when he or she is usually most active and you have time to concentrate. Begin your count around the same time each day and start by lying down on your left side with hands over your uterus. Write the "start time" row. Also write down the date in the top row marked "date" and the number of weeks you are pregnant in the bottom row. Count 10 distinct movements and note how long it took, i.e. 15 minutes, two hours, whatever time it took. Put an "X" in the time box closest to the total time it took for your baby to move 10 times.

If you have not felt 10 movements in two hours you will need to be monitored in Labor & Delivery to make sure your baby is OK. You may want to call Labor & Delivery to tell them you are on your way (but don't let the phone call delay you from going in). In most cases your baby is just fine, but it is always better to be safe than sorry.

Bring this chart with you to your next visit and any time you go to Labor & Delivery.

Fetal Movement Counting Chart											
Date											
Go to Labor and Delivery if less than 10 movements in 2 hours (120 minutes)											
120 min.											
110 min.											
100 min.											
90 min.											
80 min.											
70 min.											
60 min.											
50 min.											
40 min.											
30 min.											
20 min.											
10 min.											
Start time											
Weeks pregnant											

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Weeks pregnant											

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Notes:

[illegible]

Immunizations

Immunizations offer protection against certain diseases and are usually given during our childhood. It is important that all pregnant and breastfeeding women are immunized according to current CDC schedules for vaccination. Some immunizations can be given during pregnancy while others cannot. You will be screened for several of the diseases that you (and your unborn baby) might be at risk for having or getting. This screening is through blood tests (Rubella, Hepatitis B) or through your childhood disease history (measles, mumps, chickenpox) or immunization history (tetanus). It is important to know if you are protected against these diseases, and, if not, what can be done to decrease your risk of getting a disease. If you are at risk for any of the diseases screened for, immunization will be offered during your pregnancy (if safe) or immediately after the baby is born. If you cannot avoid travel to foreign countries during your pregnancy, talk to your health care provider to see what can be done to lessen your risk from other diseases such as yellow fever and malaria.

Vaccine/ Disease	Screening for Immunity	Disease Effect on Pregnancy/Baby	Use in Pregnancy
MMR: Measles, Mumps and Rubella- (<i>German Measles</i>)	Childhood disease history obtained at first visit. Rubella screened through a blood test at initial visit.	Measles: increased risk of miscarriage, birth defects, and low birth weight Mumps: possible increased risk of first trimester miscarriage Rubella: Severe congenital defects especially when disease occurs early in pregnancy	Immunization is not safe during pregnancy. Avoid gatherings of young children and people with disease while pregnant. Receive immunization after delivery and use birth control for three months after delivery.
Influenza: Seasonal Flu & H1N1 Flu	None	Possible increase in miscarriages Increased risk of serious illness and/or death	Single dose injection safe to use in pregnancy. Mist not safe in pregnancy.
Hepatitis B	Screened with a blood test at first visit	Possible increase in miscarriage, pre-term, birth, and neonatal hepatitis	Safe to use in pregnancy for women at high risk of exposure such as laboratory personnel, etc.
Tetanus- diphtheria (Td)	Tetanus shot/booster required every 10 years.	Increased risk of fetal death	Safe in pregnancy. If more than 2 years since last Td, Tdap should be received after delivery, ideally prior to hospital discharge.

Vaccine/ Disease	Screening for Immunity	Disease Effect on Pregnancy/Baby	Use in Pregnancy
<i>Tetanus- Diphtheria- Pertussis (Tdap)</i>	None	Infants in the first several months of life are at the greatest risk of severe illness from pertussis but are too young to be directly immunized, thus vaccination during pregnancy is critical.	Optimal timing for Tdap administration is between 27 and 36 weeks of gestation although Tdap may be given at any time during pregnancy.
Varicella (chicken pox)	Childhood disease history obtained at first visit.	Severe infection in adults Risk for congenital varicella syndrome (limb deformities, skin scarring, eye defects) and death.	For non-immune women it should be given after delivery, prior to discharge with recommendation to use birth control for at least three months. The vaccine is contraindicated during pregnancy.
Smallpox	None	See https://phc.amedd.army.mil/topics/healthyliving/wh/Pages/Women'sHealthPortal-Pregnancy.aspx .	Immunization is not considered safe for pregnant women and pregnancy should be avoided 4 weeks after getting the smallpox vaccine.
Anthrax	None	See https://phc.amedd.army.mil/topics/healthyliving/wh/Pages/Women'sHealthPortal-Pregnancy.aspx .	As a precaution, pregnant women should not be routinely vaccinated with anthrax vaccine.
HPV	None	Low risk for warts in the larynx of the baby.	Not considered safe in pregnancy. Vaccine series can be started immediately postpartum in women up to age 26.

Nutrition in Pregnancy

When you are pregnant, you have special nutritional needs. What you eat affects your baby's development and can affect your baby throughout his or her entire life. Making good food choices during pregnancy will help you and your baby stay healthy.

Nutritional needs

ChooseMyPlate.gov is a good source of nutrition information. There is a special section devoted to pregnancy and breastfeeding. You can get a personalized plan by logging into ChooseMyPlate.gov and looking at the section for Moms/Moms-to-Be. Your nutritional needs will change as the pregnancy progresses.

Weight Gain

The total amount of weight you should gain depends on your body mass index (BMI) when you became pregnant. Your BMI is calculated based on your height and weight. You can calculate your BMI by using the chart on page 136.

Women who were at a healthy weight before becoming pregnant should gain between 25 and 35 pounds while pregnant. The recommended weight gain is different for those who were overweight or underweight before becoming pregnant and for women carrying more than one baby. If you are pregnant with one baby, the table below will help you determine your recommended weight gain based on your BMI.

Calculated BMI	BMI Categories	Weight Gain Guidelines
<18.5	Underweight	Gain 28 - 40 pounds
18.5 - 24.9	Normal weight	Gain 25 - 35 pounds
25 - 29.9	Overweight	Gain 15 - 25 pounds
30 or greater	Obesity	Gain 11 - 20 pounds

At each visit you will be weighed. You can keep track of your weight gain on the table on page 137. If you are gaining weight too fast, you may need to cut back on the calories you are currently eating. If you are not gaining weight, or gaining too slowly, you may need to eat more calories. However, normal women do gain weight in different patterns and don't always follow the average pattern.

If you are not gaining enough weight during your pregnancy, you may need to add calories by eating a little more from each food group. Try adding a healthy snack each day or increasing your portion sizes at each meal. If you keep gaining weight faster than you want to, check with your health care provider. If you aren't gaining as much weight as recommended, check with your health care provider.

If you are gaining too much weight during your pregnancy, consider eating fewer calories from added sugars and saturated fats. Added sugars and saturated fats are found in foods like soft drinks, desserts, fried foods, cheese, whole milk, and fatty meats. Instead, choose foods that are low-fat, fat-free, unsweetened, or contain no added-sugars. According to ChooseMyPlate.gov, if you gain too much weight during pregnancy, it can be hard to lose the weight after your baby is born. Most women who gain the suggested amount of weight lose it with the birth of the baby and in the months that follow. Breastfeeding for more than 3 months can also help you lose weight gained during pregnancy.

Intentional Weight loss

Losing weight intentionally (on purpose) is not recommended during pregnancy. Weight loss can cause low birth weight and other abnormalities. A small amount of weight loss is okay if you began your pregnancy overweight or obese and are now eating a healthy more balanced diet. Some women do lose weight in the beginning of their pregnancies due to nausea and vomiting. Usually this is temporary and not harmful to the woman or her baby. If you are losing weight, please talk with your health care provider.

MyPlate Plan for Moms (from ChooseMyPlate.gov)

When you are pregnant, you have special nutritional needs. Follow the MyPlate Plan for Moms below to help you and your baby stay healthy. The plan shows different amounts of food for different trimesters, to meet your changing nutritional needs.

Food Group	1st Trimester	2nd & 3rd Trimester	What counts as 1 cup or 1 ounce?	Remember to. . .
Below are the daily recommended amounts from each food group *				
Fruits	1 ½ cups	2 cups	1 cup raw, frozen, or cooked/canned fruit; or ½ cup dried fruit; or 1 cup 100% fruit juice	Focus on whole fruits Eat a variety of fruits rather than juice
Vegetables	2 ½ cups	3 cups	1 cup raw or cooked/canned vegetables; or 2 cups leafy salad greens; or 1 cup 100% vegetable juice	Vary your veggies Eat more dark-green and orange vegetables
Grains	6 ounces	7–8 ounces	1 slice bread; or 1 ounce ready-to-eat cereal; or ½ cup cooked rice, pasta, or cereal	Make half your grains whole grains Choose whole instead of refined grains
Protein	5 ounces	6–7 ounces	1-ounce cooked/canned lean meats, poultry or seafood; or 1 egg; or 1 Tbsp peanut butter; or ¼ cup cooked beans or peas; or ½ ounce nuts or seeds	Vary your protein routine Choose low-fat or lean meats and poultry
Dairy	3 cups	3 cups	1 cup milk; or 1 cup yogurt; or 1 cup fortified soy beverage; or 1 ½ ounces natural cheese or 2 ounces processed cheese	Move to low-fat or fat-free milk or yogurt Go low-fat or fat-free when choosing milk, yogurt and cheese

***These amounts are for a pregnant woman of average height, average pre-pregnancy weight, and moderate daily activity level. You may need more or less than the average. Check with your doctor to make sure you are gaining weight as you should.**

Dietary Supplements

When you are pregnant, you have a higher need for some vitamins and minerals. This is especially true for folic acid and iron. In addition to eating a healthy diet, most health care providers recommend that pregnant women take a vitamin and mineral supplement every day. Supplements designed for pregnant women are called “prenatal supplements.”

Folic Acid: Folic acid is a B vitamin that helps prevent serious birth defects of a baby’s brain or spine. These are called neural tube defects. Getting enough folic acid can also help prevent birth defects like cleft lip and congenital heart disease. These birth defects often happen before most women know they are pregnant. Most prenatal supplements contain 600 micrograms of folic acid or more. Pregnant women should take at least 400 micrograms per day and if a multivitamin is not tolerated, this vitamin should be taken separately.

Iron: Pregnant women need extra iron for the increasing amount of blood in their bodies. Iron helps keep your blood healthy and able to carry oxygen to your cells. Plus, your baby needs to store iron in his or her body to last through the first few months of life. Too little iron can cause a condition called anemia. If you have anemia, you might look pale or notice paleness under your nails, and feel very tired. Your health care provider checks for anemia with blood tests during your pregnancy. Most prenatal supplements contain 27 milligrams of iron. This is the amount recommended for pregnant women.

Omega-3 Fatty Acids: For pregnant and nursing women, omega-3 fatty acids, particularly DHA, are important for the health of mom and baby. DHA is the most common omega-3 in the brain and eyes. Getting plenty will help to support a baby’s brain and eye development and function. Women should get at least 200 milligrams of DHA every day.

DHA and other omega-3 fatty acids can be found in fatty fish, algae oil and fish oil. Pregnant moms need to be careful about the kinds of fish they eat (see section on page 133 on eating fish during pregnancy).

Flaxseed is a source of omega-3 fatty acids. Some animal studies have shown that flaxseed can be harmful during pregnancy. Little research has been done in humans. But because we know so little, it’s wise to avoid flaxseed if you are pregnant or breastfeeding.

If you are not getting enough DHA from food, another option is to take a supplement containing at least 200 milligrams of DHA. Several prenatal supplements include DHA, either from fish oil or other sources. As with all supplements, talk to your health care provider beforehand to make sure this choice is right for you.

Take a prenatal vitamin instead of individual vitamins or minerals:

This ensures that you and your baby get balanced amounts of the vitamins and minerals you need. A high dose of some nutrients, in particular vitamin A, can be harmful to your baby. Too much vitamin A can cause birth defects.

Do not take dietary supplements or herbal products on your own:

Scientists have not determined the risks to your baby from taking most herbal or botanical supplements. For this reason, avoid them when you are pregnant or breastfeeding. Not all “natural” products are safe. In fact many poisons are natural. These supplements are not tested or regulated like other drugs and medicines. You should avoid taking these substances without first talking with your health care provider.

Taking too much of a dietary supplement can have harmful effects:

Take supplements or herbal products only if approved by your health care provider. Some dietary supplements can interact with prescribed medications or may not be safe for your baby. To avoid the possibility of harmful effects, discuss any supplement or medication you are taking or considering with your provider.

Food Safety

When you are pregnant, your ability to fight off infections you can get from food is decreased. In addition, your unborn baby’s immune system is not fully developed. This means both you and your baby have a greater chance of getting sick from eating unsafe food. Eating unsafe food can cause foodborne illness.

If you get a foodborne illness, the effects may be worse than if you were not pregnant. Some foodborne illnesses can cause a woman to have a miscarriage or premature delivery, or cause the baby to die. They may also result in serious health problems for the baby after birth.

To protect your health and your baby’s health, you need to be especially careful about food safety while you are pregnant.

Food safety advice for everyone: Keep food safe to eat by following these general guidelines to avoid foodborne illness. Practice the following when preparing food:

- **Clean:** Wash hands and surfaces often.
- **Separate:** Don’t cross-contaminate raw meats with other food that will not be cooked (salads, fruits and vegetables).
- **Cook:** Cook to proper temperature.
- **Chill:** Refrigerate promptly.

Keeping food safe from toxoplasmosis: Toxoplasmosis is an infection caused by a parasite. For most people, the body's immune system usually keeps the parasite from causing illness. However, if you become infected while pregnant, you can pass an infection to your unborn child, even if you are not ill. The best way to protect your unborn child is by protecting yourself against toxoplasmosis.

Follow this advice to prevent toxoplasmosis:

- Wash your hands with soap and water after touching soil, sand, raw meat, or unwashed vegetables.
- Cook your meat completely. The internal temperature of the meat should reach 160°F. Chicken and turkey need to be cooked to a higher temperature (165°F). Do not sample meat until it is cooked.
- Freeze meat for several days before cooking to greatly reduce the chance of infection.
- Wash all cutting boards and knives with hot soapy water after each use.
- Wash and/or peel all fruits and vegetables before eating them.
- Cats can spread this parasite. Have someone else change the litter box if possible. If you must change it, wear disposable gloves and wash your hands thoroughly with soap and water afterward.
- Wear gloves when gardening or handling sandbox material. Cats may use gardens or sandboxes as litter boxes. Wash hands afterward.
- Avoid drinking untreated water, particularly when traveling in less developed countries.

Keeping food safe from listeriosis: Listeriosis is an infection caused by bacteria. In pregnancy, it can cause miscarriage, serious illness, preterm delivery, or serious illness or death of a newborn baby. To decrease your risk of listeriosis, do the following:

- Keep your refrigerator at 40°F or slightly lower. Keep your freezer at 0°F or lower.
- Clean up all spills in your refrigerator right away - especially juices from uncooked meat.
- Wash your hands after handling raw meat or seafood or its juices.
- Do not eat hot dogs, lunch meats, or meats from a deli unless they are reheated to steaming hot.
- Do not eat meat spreads, pâté, or smoked seafood from a store deli or meat counter. Canned foods such as tuna, salmon, or packaged pasteurized deli-type meats are safe to eat. Refrigerate contents after opening.
- Do not drink raw milk or eat foods made of unpasteurized milk.
- Do not eat salads made in a store
- Do not eat soft cheeses such as feta, queso blanco, queso fresco, brie, camembert, blue-veined cheeses, or panela unless it's labeled MADE WITH PASTEURIZED MILK.

Eating Fish While Pregnant or Breastfeeding

Fish provide important nutrients, including omega-3 fatty acids, which are good for your health. Omega-3 fatty acids are critical for the development of the baby. Fish can be part of a healthy diet for pregnant and breastfeeding women. However, some types of fish may contain chemicals that can be health risks.

One of these chemicals is **mercury**. Some types of fish have high levels of mercury. It can harm the developing nervous system in an unborn baby. See information below about which fish are safe versus not safe to eat. Choose fish carefully to prevent any harm to your unborn baby while still enjoying the health benefits of eating seafood. Do not eat shark, swordfish, king mackerel, marlin, orange roughy, or tilefish because they contain high levels of mercury.

The Food and Drug Administration (FDA) suggests you may eat up to 12 ounces a week (two average meals) of a variety of fish and shellfish that are low in mercury. However, many experts strongly believe the FDA limits are too restrictive. The FDA limitations did not take into account all the benefits of fish to pregnant women and their unborn babies. Eat plenty of fish but choose those lowest in mercury. As a rule, the benefits of eating fish outweigh the risks, especially during pregnancy. Eat smaller fish and cook and handle fish carefully.

- Catfish, cod, flounder, pollock, salmon, scallop, shrimp, and canned light tuna, are some commonly eaten fish that are low in mercury. To check on mercury in other types of fish, go to ChooseMyPlate.gov or the EPA web site
- White" tuna (albacore) has more mercury than canned light tuna. When choosing fish and shellfish, include only up to 6 ounces per week of white tuna.

Other chemicals in fish: In addition to mercury, fish may contain other harmful chemicals, especially fish caught in local waters. Check local advisories to learn about the safety of fish caught in your local lakes, rivers, and coastal areas. Advisories may recommend that people limit or avoid eating some types of fish caught in certain places. If no advice is available, you may eat up to six ounces per week of fish from local waters, but don't eat any other fish during that week.

Alcohol

Drinking alcohol while you are pregnant can cause your baby to be born with both physical and mental birth defects. The most serious concern is a condition called fetal alcohol syndrome (FAS). The severity of FAS symptoms varies, with some children experiencing them to a far greater degree than others. Signs and symptoms of FAS may include any mix of physical defects, intellectual or cognitive disabilities, and problems functioning and coping with daily life.

No one knows exactly how much alcohol a woman must drink to cause birth defects in her baby. That level may differ from woman to woman. Experts agree the best thing to do is not to drink alcohol at all while you are pregnant—that includes beer, wine, wine coolers and liquor.

If a woman takes an occasional drink before she knows she is pregnant, it probably won't harm her baby. But she should stop drinking alcohol as soon as she thinks she may be pregnant.

No amount of alcohol is safe when you are pregnant. If you find it hard to say no, avoid parties, bars, and other places where people are drinking alcohol. If you have a problem stopping alcohol use, get help. Start by talking with your provider or someone you trust. There is no more important time to stop than when you are pregnant.

Food Items to Limit

Caffeine: Among experts there is no strong agreement regarding how much caffeine is safe during pregnancy. Most sources recommend that pregnant women limit their caffeine intake to less than 200 milligrams per day. This is the amount of caffeine in one cup of coffee. Of course, the amount of caffeine in a cup of coffee will vary depending on how it was made. Also, pregnant women should be aware that there is some caffeine in tea, chocolate, and soft drinks. Even energy drinks and non-prescription medications may have some caffeine in them.

Compared to drinking beverages high in caffeine, it is better for you and baby if you drink water, milk, and small amounts of fruit juice during pregnancy. You may drink decaffeinated soft drinks, coffee and tea but be aware that these may contain a small amount of caffeine. Caffeine should be limited whether or not you are pregnant.

Juice: Fruit juices are high in calories. Limit juice intake to four to eight ounces per day. A better choice would be to eat the whole, fresh fruit.

Fats: Be mindful about the amount of fat you eat. Fried foods and fast foods are high in fat (and calories). Some forms of fat are worse for your health. "Trans fats" found in many processed foods are particularly harmful. When choosing cooking oils, olive and canola oils are much better for you and your unborn baby than regular vegetable oil (soy), margarine, or shortening. Limit the amount of fast food you consume to no more than one meal per week.

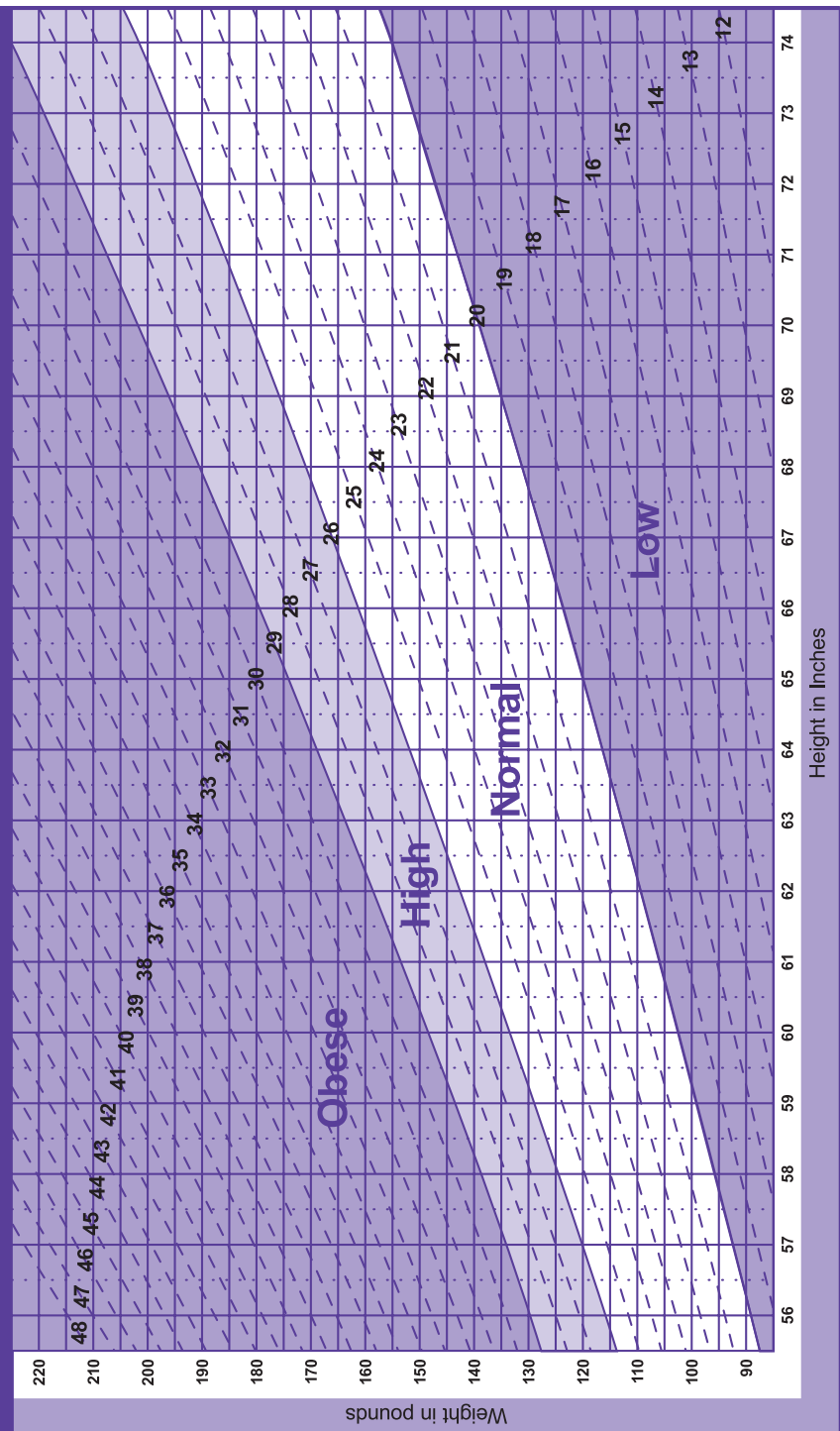
Sugar: Excess sugar is not good for you or your unborn baby. It can lead to problems with your teeth and excessive weight gain. Sugar substitutes may be used in moderation.

Herbs: Overall, scientific evidence is lacking about the safety of various herbs in pregnancy. Some "safe" herbal teas include: blackberry, citrus peel, ginger, lemon balm, and rose hip.

Notes:

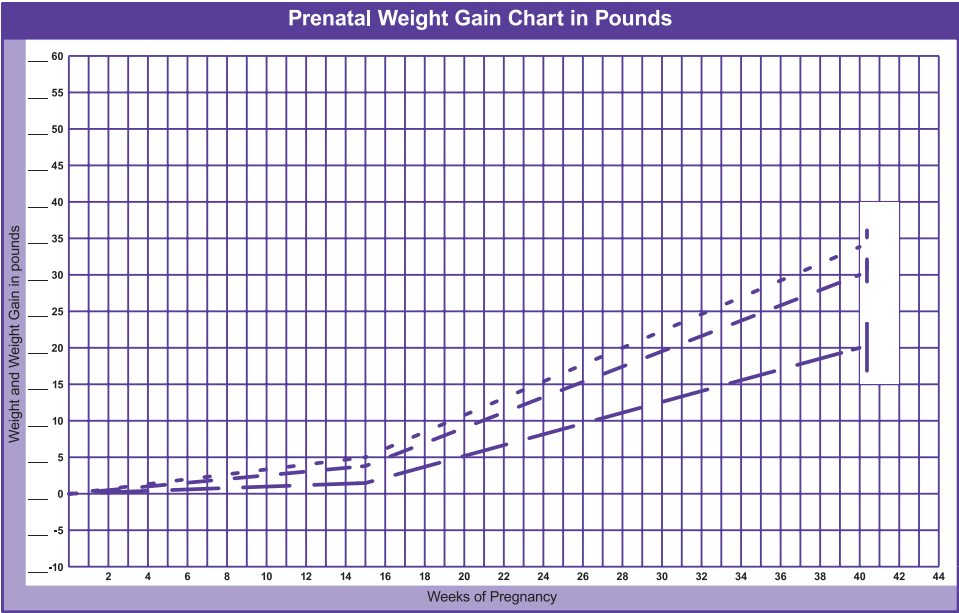
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Chart for Estimating Body Mass Index (BMI) Category and BMI (Pounds and Inches)



Directions:

To find BMI category (e.g., obese), find the point where the woman's height and weight intersect.
To estimate BMI, read the bold number on the dashed line that is closest to this point.



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Weight Record			
Date	Weeks of Gestation	Weight	Notes

Dental Care

Proper care of your teeth and gums is especially important now that you are pregnant. If you have not had a professional dental cleaning within the past six months, we recommend that you do so early in your pregnancy. If you have recently had a dental check-up, we recommend that you continue your preventive visits to the dentist every six months. Dental cleanings and needed dental care are both safe and encouraged before, during and after pregnancy. It is important to floss daily and to brush your teeth in the morning after breakfast and before bed at night. Try to replace juices with water and avoid concentrated sugary foods/drinks. Chewing xylitol-containing gum after meals or sweets may help decrease the likelihood of cavities during your pregnancy.

If your dentist thinks you need dental care beyond cleanings during pregnancy, the following guidance may help you and your dentist make good decisions about your care:

- The x-rays normally taken during routine dental care may be taken during pregnancy. Dental x-rays are considered very safe in pregnancy if you shield your abdomen and pelvis with a lead gown or drape during the x-rays. All dentists who take x-rays have these kinds of gowns as they use them routinely.
- Unless you have an allergy to them, many antibiotics are safe for you and the baby during pregnancy. Common antibiotics that are considered safe include penicillins and cephalosporins. Sulfa antibiotics are safe although when given just before delivery babies have an increased risk of jaundice. Quinolones and tetracycline type antibiotics should be avoided if possible as they can have an impact on the baby's growth and development of bones and teeth.
- If you need pain medication, Tylenol® (acetaminophen) and narcotics are safe as long as they are taken in typical doses. You should avoid Motrin® or Advil® (ibuprofen) and other related medications, such as aspirin, called non-steroidal anti-inflammatory drugs (NSAIDs) unless you specifically talk to your provider. These drugs can affect the baby's kidneys, heart and lungs if they are taken too long or too late in the pregnancy.

Tobacco, Alcohol, and Drug Use in Pregnancy

Most people know that tobacco and alcohol are not good for you. Tobacco causes cancer, heart disease, and other major health problems. Alcohol use has immediate effects that can increase the risk of many harmful health conditions including illness and accidents. E-cigarettes and other products containing nicotine are not safe to use during pregnancy. Nicotine is a health danger for pregnant women and developing babies and can damage a developing baby's brain and lungs. Also, some of the flavorings used in e-cigarettes may be harmful to a developing baby.

Women who smoke during pregnancy put themselves and their unborn babies at risk for other health problems. The dangers of smoking during pregnancy include premature birth, low birth weight, and pregnancy complications. Even being around cigarette smoke puts a woman and her unborn baby at risk for problems.

Pregnant women who smoke expose their unborn babies to all the harmful effects of the cigarette smoked. Nicotine in the cigarette causes blood vessels to constrict, so less oxygen and nutrients reach the baby. Carbon monoxide from the cigarette lowers the amount of oxygen the baby receives. Also, women who smoke during pregnancy are more likely to have certain problems such as tubal pregnancies, vaginal bleeding, problems with the way the placenta attaches to the uterus, low birth weight babies, and even stillbirths. Babies that are smaller than they are meant to be have increased long-term health risks, including diabetes and heart disease as adults.

Breathing in the smoke from the cigarettes of others is also a concern. Pregnant women who are exposed to secondhand smoke have a higher risk of giving birth to a low birth weight baby than women who are not exposed to secondhand smoke during pregnancy. Infants who are exposed to secondhand smoke are more likely to die of Sudden Infant Death Syndrome (SIDS) than infants not exposed. Children who are exposed to secondhand smoke are at increased risk for bronchitis, pneumonia, ear infections, severe asthma, respiratory symptoms, and slowed lung growth. Exposure to secondhand smoke causes premature death and disease in children and adults who do not smoke.

Drinking alcohol during pregnancy can cause a baby to be born with birth defects and have disabilities. These conditions, called fetal alcohol spectrum disorders, are among the top preventable birth defects and developmental disabilities. The effects of the alcohol can cause problems in how a person grows, learns, looks, and acts. Alcohol during pregnancy can also cause birth defects of the heart, brain, and other major organs. These problems last a lifetime.

There is no known amount of alcohol that is safe to drink while pregnant. All drinks with alcohol can hurt an unborn baby. A 12-ounce can of beer has as much alcohol as a five-ounce glass of wine or a one ounce shot of liquor. Also, there is no

safe time to drink during pregnancy. Alcohol can harm a baby at any time during pregnancy. It can cause problems in the early weeks of pregnancy, even before a woman even knows she is pregnant.

If you are pregnant and smoking or drinking, it is very important that you speak openly with your provider at your next visit about how to stop. We are here to work with you to help you cut down and quit. Our goal for you is a healthy pregnancy and a healthy baby.

The less a woman uses tobacco or drinks alcohol the less harm it will do. Cutting down or stopping any time during pregnancy is better than not stopping at all. If you kick the habit while you are pregnant, the chances of you quitting for a lifetime go up dramatically. Let us work with you for a healthier outcome that will last a lifetime for you and baby!

The dangers from the use of illegal drugs or drugs that are not prescribed for you are magnified during pregnancy. Cocaine use increases the chances of damage to the placenta and the developing baby. Some substances can cause brain damage by causing fetal strokes. Use of opioids; such as codeine, methadone or heroin can increase the possible risks to your baby. There may be problems in the development of the brain, spine and/or heart; stillbirth can occur as a complication of both withdrawal or drug use. Your baby may need to stay in the hospital for several days to be monitored and treated for narcotic withdrawal. Sudden withdrawal from narcotics can cause you to have seizures or stillbirth. Furthermore, there is a danger of overdosing which could cause harm or even death for you or your baby. If you have used illegal drugs or are taking medications that are not prescribed for you, please talk to your provider to help you safely discontinue use of illegal drugs or drugs that are not prescribed for you during pregnancy.

Prescription narcotics are generally safe in pregnancy when taken as prescribed. Long-term use of narcotics is addicting to both mother and her unborn baby. If the mother is taking narcotics near delivery, the baby may need to stay in the hospital for several days to be monitored and treated for narcotic withdrawal. Sudden withdrawal from narcotics can cause seizures or other potentially harmful problems. Women who take prescription narcotics need to make sure they are not taking more than prescribed. These medications are often given with Tylenol®. While Tylenol® is safe in normal doses, it is very toxic to the liver if taken in even small amounts over the recommended dose. As with any drug, always discuss what you are taking with your provider. To avoid taking too many narcotics during pregnancy, you should get all your medication from one provider.

Sexually Transmitted and Other Infections in Pregnancy

Sexually transmitted infections (STIs) affect one in four Americans at some time. During your pregnancy you will be tested for several STIs and treated if needed. Many STIs require that you and your partner be treated to avoid reinfection.

STIs can cause serious harm to your baby if not treated. Most STIs can be treated during pregnancy, but treatment does not prevent you from becoming infected again or being infected with a new STI during this pregnancy. Using condoms and avoiding sexual contact with an infected person can help protect you against STIs. If at any time you think you have been exposed to an STI or have any symptoms of an STI (vaginal itching, odor, or abnormal discharge), let your health care provider know. You will be tested and treated if you have an infection.

This list includes some of the more common and more potentially harmful STIs and other common non-sexually transmitted vaginal infections. This does not cover all of them, as there are more than 20 known STIs.

Bacterial Vaginosis (BV): This is the most common type of vaginal infection in women. It happens when the normal bacteria in the vagina get out of balance. It is not considered an STI.

- **Signs and symptoms of infection:** Sometimes causes no symptoms. Some women have an increase in white or grey vaginal discharge, itching in or around the vagina and burning or pain when urinating. The discharge is commonly thin and can have a “fishy” odor especially after having sex.
- **Possible effects on baby:** Does not cause baby direct harm but can cause preterm labor and delivery. Preterm birth can cause the baby serious problems such as blindness, lung problems, mental problems or even death.
- **Testing:** A vaginal secretion sample will be examined under a microscope (wet prep).
- **Treatment:** For you the best treatment is antibiotic pills taken by mouth—usually Flagyl (metronidazole). Eating yogurt containing live “good” bacteria (lactobacilli) can sometimes help prevent this infection.

Chlamydia

- **Signs and symptoms of infection:** More than 50% of all infections are without symptoms. You can experience burning on urination or unusual vaginal discharge.
- **Possible effects on baby:** Baby has a 20-50% chance of becoming infected while passing through the birth canal resulting in pneumonia or an eye infection.
- **Testing:** Cervical culture at the time of your initial pap smear
- **Treatment:** Antibiotic pills for you. Antibiotic ointment to baby’s eyes at birth. In some states, these antibiotics are given to all babies by law.

Gonorrhea (Drip, clap, dose)

- **Signs and symptoms of infection:** Burning on urination, unusual vaginal discharge or no symptoms at all.
- **Possible effects on baby:** Baby can become infected as it passes through the birth canal. This infection can result in conjunctivitis (redness of the eye), blindness and/or a serious generalized infection.
- **Testing:** Cervical culture at the time of your initial pap smear.
- **Treatment:** Antibiotic pills for you and an antibiotic ointment for the baby's eyes at birth. In some states, antibiotic eye medications are given to all babies by law.

Genital warts (caused by Human Papilloma Virus)

- **Signs and symptoms of infection:** Skin tags or warts that can be small or large, soft or hard, raised or flat, single, or in clusters like cauliflower.
- **Possible effects on baby:** Baby can get laryngeal papillomas (benign tumors on the vocal cords) from passing through an infected birth canal.
- **Testing:** Let your health care provider know if you think you have warts.
- **Treatment:** Usually delay treatment until after delivery but may be removed in pregnancy. If large enough to block the birth canal, you may need a cesarean section.

Hepatitis B

- **Signs and symptoms of infection:** You often have no symptoms. You can have yellowing of the skin and eyes, loss of appetite, nausea, vomiting, stomach and joint pain, or feel extremely tired.
- **Possible effects on baby:** Can pass to your baby during the pregnancy resulting in liver damage and risk of death.
- **Testing:** Blood test at initial visit.
- **Treatment:** Vaccine, immune globulin, and a baby bath after delivery can help protect baby from becoming infected.

Herpes Simplex Virus (Herpes)

- **Signs and symptoms of infection:** Fluid-filled sores in the genital area that may itch, burn, tingle or cause pain.
- **Possible effects on baby:** Can be transmitted to baby during delivery if mother has blisters near term. Can cause severe disease and death of newborn but transmission is extremely rare, even with vaginal deliveries.

- **Testing:** Tell your health care provider immediately if you think you have an outbreak. Cultures of the blisters can be done.
- **Treatment:** If active infection occurs at or near your delivery date, you may need cesarean delivery within four to six hours of your bag of water breaking.

HIV (AIDS)

- **Signs and symptoms of infection:** Often there are no symptoms of HIV.
- **Possible effects on baby:** Can pass infection to baby while pregnant, during birth or through breastfeeding. Can cause serious complications and death to baby.
- **Testing:** Blood test at initial visit.
- **Treatment:** Medication called AZT® can decrease transmission to baby.

Syphilis (Syph, pox, bad blood)

- **Signs and symptoms of infection:** Painless sores in genital area.
- **Possible effects on baby:** Miscarriage, stillbirth or damage to baby's bones, teeth and brain.
- **Testing:** Blood test at first visit.
- **Treatment:** Antibiotics for the mother.

Trichomonas (Trich)

- **Signs and symptoms of infection:** Common in pregnancy. You may have an increase in bad smelling, thin or thick, white, yellow-green/gray vaginal discharge with itching.
- **Possible effects on baby:** May increase chance of pre-term labor.
- **Testing:** Tell your health care provider. Your vaginal discharge will be examined under a microscope.
- **Treatment:** Flagyl® pills can be given safely after the first trimester.

Yeast (Candidiasis)

- **Signs and symptoms of infection:** Vaginal itching or burning pain, which increases with urination and sex. Can also occur without sexual transmission. More common in pregnancy.
- **Possible effects on baby:** Baby can get a mouth infection (thrush) while passing through an infected birth canal.
- **Testing:** Let your health care provider know if you are experiencing any symptoms. A vaginal secretion sample will be looked at under the microscope.
- **Treatment:** Vaginal creams or suppositories. Nystatin® for baby.

Listing of medications/drugs does not represent endorsement by VA/DoD

Genetic Screening

As a new mother-to-be you might be wondering, “How do I know my baby is OK?” It seems as soon as a pregnancy is confirmed it is normal to begin to wonder and hope that the baby is developing and growing normally. Many of the routine processes and testing that are done during pregnancy are outlined in the visit sections of this book. Your test results can be recorded in this book as well as in your Pregnancy Passport. While health care providers can detect many problems and help correct them, pregnancy is an amazingly complicated process and development does not always proceed normally. There are some problems that begin at conception that are not correctable. Approximately three to five percent of babies born to women in the United States have birth defects.

Birth defects can be caused by many factors including genetic problems. While most birth defects are minor, with little or no significance, others can cause major short and long-term problems. Most of the tests that we do in pregnancy assist your providers to make decisions so you and your baby have the safest pregnancy and delivery possible. There are other tests that primarily provide information to you. These tests have the potential of giving you helpful information but do not necessarily help providers take better care of you or improve the chances of a good outcome for the baby. Such information could either help give you some peace of mind that things are going well or help you prepare for problems, if any are detected. While we all hope this information would provide peace of mind, this information also has the potential to make you worry, usually unnecessarily. As it turns out, there are several such optional tests that you may or may not find helpful depending upon what you would do with the information from the test results.

The following information will help you understand some of the optional tests and help you make a decision about the tests that may be useful for you.

Background

Genetic information is contained in chromosomes. As human beings, we have 23 pairs of chromosomes. Normally, we get 23 chromosomes from our father and 23 chromosomes from our mother for a total of 46. One pair of the chromosomes (sex chromosomes X and Y) is responsible for our gender (male or female) and the other chromosomes (numbered 1-22) are responsible for a multitude of different structures and functions in our bodies. At the time of the egg and sperm joining, or conception, mistakes can occur that result in too many or too few chromosomes. Having more or less than the normal 46 chromosomes is called aneuploidy. Aneuploidy causes major problems because each chromosome contains thousands of genes. Because so many genes are involved, aneuploidy usually causes a miscarriage. Half of all human pregnancies end in miscarriage because of aneuploidy. Most of these pregnancy losses occur before women even recognize they are pregnant. It is rare for pregnancies with aneuploidy to go on and result in a live born baby. However, when certain chromosomes are involved in aneuploidy, such as number 13, 18 or 21, survival is possible, although the majority of these pregnancies also end in miscarriage.

Having an extra copy of chromosome number 21 is called Trisomy 21, which is also called Down Syndrome. People who have this syndrome share a common group of characteristics. The chance that a baby will be born with any aneuploidy increases as the mother gets older. At the age of 20, the chances of having a baby with Down Syndrome is less than 1 out of 1500 but at the age of 43, it is 1 out of 50. Down Syndrome is usually not related to family history or the age of the father.

When considering all pregnant women together, the overall chances of having a live born baby with Down Syndrome are about 1 out of 800 and the chance for a live born baby with Trisomy 18 are 1 out of 6000. Because pregnancies affected by Trisomy 13, 18, or 21 do not always end in miscarriage, testing has been developed to evaluate the possibility of aneuploidy before the baby is born. This type of testing is usually offered during the first half of the pregnancy and is completely optional. This testing does not change baby's chances for being healthy at birth nor does it improve the chances for good long-term health of the child. The primary benefit of this testing is to give parents information. This information can be reassuring when the results show that your risk is low, or can provide parents an opportunity to emotionally and mentally prepare for the birth of a baby that may have problems from the wrong number of chromosomes. Please read this information carefully and discuss your wishes regarding prenatal diagnosis with your provider early in your pregnancy. If you should decide to terminate (abort) the pregnancy due to this information, the procedure cannot be performed at a DoD or VA facility and is not covered by TRICARE.

There are two main categories of tests for aneuploidy: screening tests and diagnostic tests. Tests that calculate your unborn baby's risk of aneuploidy compared to what the risk is based on your age alone are called screening tests. These include: ultrasound evaluation of the baby, blood tests on the mother, or a combination of age, blood tests and ultrasound findings. Because these tests do not provide definite answers, they can give inaccurate results. These tests do not tell you whether your unborn baby has aneuploidy but rather indicate whether the chance that your baby has aneuploidy is high or low.

There are two types of inaccurate results. They are called false positive and false negative. A false positive test result occurs when the test result suggests an increased or high risk of aneuploidy when in fact the baby has a normal number of chromosomes. False negative tests occur when the test suggest that there is low risk for aneuploidy, when in fact the baby actually has an abnormal number of chromosomes. False negative tests are not common. Most of the time, when the test results say there is a lower risk of a problem, the test is right. One example of a false negative test is when the baby looks normal on ultrasound but actually has Down Syndrome. Babies with Down Syndrome can look normal on ultrasound 20-50% of the time. False positive results are relatively common. For example, 5-15% of babies have minor ultrasound abnormalities that suggest the possibility of aneuploidy. In these cases, when there are no other major findings on the ultrasound, more than 99% of these babies have normal chromosomes.

False positive tests can cause a lot of unnecessary worry and anxiety. Depending on what a mother chooses to do when she has an abnormal test, she can end up worrying the rest of the pregnancy.

Diagnostic tests can give definite answers regarding the baby's health including the baby's chromosome numbers. Diagnostic testing involves some risk to the mother and some risk of causing a pregnancy loss. A normal result on a diagnostic test for chromosomes does not guarantee that other problems do not exist (for example a child may have a normal number of chromosomes but still have a learning disability). In addition, small "mistakes" in the chromosomes cannot be detected this way at all. These small mistakes are referred to as microdeletions or copy number variants and can lead to genetic conditions that may or may not have serious health implications. There are no tests that prove the baby will be completely normal, just as there are no tests that can tell us what kind of personality your baby will have. These tests always involve getting a sample of tissue from the baby. This sample comes from either the amniotic fluid or the placenta. After cells from the baby are obtained, they can be prepared in a special way and a picture is taken of the baby's chromosomes. A picture of chromosomes is called a karyotype.

Possibilities for Testing

Since there are several possibilities of tests and combinations of tests for prenatal diagnosis, you have several options. There is a steady increase in the risk of delivering a child with aneuploidy as women age. This is illustrated in the chart on page 150 labeled Age-Related Risk of Aneuploidy. The age of 35 was previously considered the cut off for being "high risk" of having a baby with aneuploidy. However, only 30% of children with Down Syndrome are born to women over age 35. That means that 70% of babies with Down Syndrome are born to women younger than 35.

In January 2007, the American College of Obstetricians and Gynecologists (ACOG) recommended that all prenatal testing options be available to all pregnant women, regardless of age. As a result of the recommendation, the availability of varied types of testing and reimbursement for these tests for all women is changing and becoming more widespread. At present, there are still limitations on the availability of such testing in both the military and civilian communities, primarily because there are not enough qualified ultrasound technicians and obstetricians to do the testing. Further, many insurance companies (including TRICARE) may not currently pay for these tests.

Specific Options for Prenatal Testing at Your Hospital/Clinic

The VA/DoD guidelines recommend that certain kinds of screening and diagnostic tests be available to you either in your hospital/clinic or by referral elsewhere. In addition, ACOG has encouraged individual practices to come up with screening and diagnostic testing strategies that fit their patient population and available resources. While we are going to review all the options that are theoretically available, not all options are offered in all areas.

Check with your local obstetrical provider to find options are available in your area. Depending upon which lab your facility uses, these tests may have slightly different names.

Strategies/Options for Testing

The following section outlines the types of testing and screening strategies that are available in most VA and DoD facilities. If the specific test is not available in your VA or DoD medical facility, it can usually be obtained by referral. You should understand that you have the option of having blood tests and ultrasound examinations in the first trimester and/or second trimester. In addition, these tests can occur separate from each other (so you get results in the first trimester separate from those you get in the second trimester), or can be done together, giving you one result in the second trimester only. (Again, some of these tests may not be covered by TRICARE. Talk to your provider or healthcare benefits advisor for further information.)

Strategy 1: No optional screening. No ultrasound or blood tests for screening. If during your routine care an abnormality is identified, you would probably be offered an ultrasound and additional testing. For example, if when measuring your abdomen in your clinic visit the baby seemed to not be growing well, an ultrasound would be encouraged. If the baby were too small or the amniotic fluid too low, you would be offered additional testing.

Strategy 2: Start with a second trimester screening ultrasound. This usually takes place at 18-20 weeks. You would be notified if an abnormality were detected and be offered additional counseling and testing.

Strategy 3: Start with a second trimester Quad Screen (15-21 weeks) then have a second trimester screening ultrasound (18-20 weeks). You would be notified if the Quad Screen result is considered high risk and be offered a comprehensive ultrasound, Maternal-Fetal Medicine consultation, and amniocentesis.

If the Quad Screen result were considered low risk, you would be scheduled for a screening ultrasound. You would be notified if a major abnormality was detected by the screening ultrasound and be offered additional counseling and testing.

Strategy 4: Cell-free DNA (cffDNA) testing can be offered after 10 weeks gestation. This test is very good at detecting Down Syndrome. It can also detect other aneuploids, but less well. This test is done by the pregnant woman simply giving a blood sample. This test may not be available at all locations.

Strategy 5: Start with a first trimester screen (11-13 weeks). This test involves drawing your blood. Most first trimester tests also involve ultrasound measurements of certain baby structures such as a space on the back of the baby's neck called the nuchal lucency. If the screening test result is considered high risk, you would be notified and counseled and given options for a Chorionic Villus Sampling (CVS) test (this may need to be done at another hospital or clinic), an amniocentesis after 15 weeks, or a comprehensive ultrasound at 16-18 weeks followed by an amniocentesis if desired.

If the screening test result were considered low risk, you would be scheduled for a screening ultrasound at 18-20 weeks. You would also be notified if a major

abnormality was detected by the ultrasound examination and you would be offered additional counseling and testing.

Strategy 6: Start with an amniocentesis after 15 weeks. If the amniocentesis were abnormal, you would be given further counseling regarding your options. If the amniocentesis were normal, you would be scheduled for a screening ultrasound at 18-20 weeks if the ultrasound were not already completed at the time of the amniocentesis.

You would be notified if a major abnormality were detected by the ultrasound examination and you would be offered additional counseling and testing.

Strategy 7: Start with Chorionic Villus Sampling (CVS). In most cases, this would need to be done at a hospital/clinic that specializes in this procedure. If the CVS were abnormal, you would be given further counseling. If the CVS were normal you would be scheduled for a screening ultrasound at 18-20 weeks. If a major abnormality were detected by the ultrasound, additional counseling and testing would be offered.

Your Specific Risks

You may be interested to know your specific risk of having a baby with aneuploidy. You can use the tables below to estimate your specific risk.

Based on your age of _____ at your due date, your risk for delivering a live-born child with Down Syndrome is _____ and the total risk for delivering a live-born child with any aneuploidy is _____ (see chart on page 150).

If an Abnormality is Found

If the screening or diagnostic testing outlined above finds that the baby has a birth defect or genetic problem, your providers will present you with more specific information about that problem. If necessary, they can refer you to another provider who can better help you understand the significance of the problem and your options. They can help you plan the rest of the pregnancy. Your family, friends, military unit, social worker, chaplain or other spiritual leader may be able to provide you support.

Be careful about the medical advice you might receive from well-meaning individuals who are not your medical care providers. Even individuals who have medical training, but don't take care of pregnant women, can give you bad information. The Internet has a lot of information. Some of that information is good and accurate but there is also a lot of misinformation. The bottom line is that your provider will be able to give you the best information or refer you to another provider who can.

Usually, if there are problems, you will be referred to a Maternal-Fetal Medicine specialist. These doctors have special training to take care of women with complicated pregnancies.

If it is confirmed that your baby does have a serious birth defect and you are early in the pregnancy, the two basic options are to continue the pregnancy for as long as it is safe for you or end the pregnancy early. Government facilities and

funds cannot be used to perform abortions no matter what is wrong with the baby. This is true even if there is such a serious problem that the baby would certainly die before or after birth. The only times that government funds (e.g. TRICARE) or facilities can be used to perform an abortion is when the pregnancy is the result of rape or incest or if continuing a pregnancy were life threatening to the mother. At the VA, abortions are not covered in the medical benefits packet no matter the circumstances. Some Veteran's may qualify for Medicaid which will cover early abortions in the case of the pregnancy resulting from rape, incest or if continuing the pregnancy threatens the mother's life.

As long as you have not passed the gestational age limits, whether you are active duty, retired, or a dependent, you can have an abortion if you choose, for a fetal abnormality or any reason. Each state has laws that limit how far along you can be and still have an abortion. If you choose to end the pregnancy, you will be responsible for finding the physician who would do the procedure. It would be your responsibility to pay for the procedure. Remember to involve people you trust in helping you to make decisions about what to do.

Summary

While most babies are born healthy, three to five percent have birth defects. Most of these birth defects are minor. Some more serious birth defects are caused by chromosome number problems (aneuploidy) while other birth defects happen even when the baby's chromosomes are normal. There are several optional tests that can be performed prior to the birth of the baby that can be used to screen for or diagnose aneuploidy.

Screening tests can be performed by ultrasound and maternal blood measurements. These tests modify (raise or lower) the age related risk of aneuploidy but do not give definite answers. They can have false negative and false positive results. Thus, there are potential benefits and hazards of the screening tests. Through most VA and DoD facilities, a basic screening ultrasound is offered to everyone and a comprehensive ultrasound is offered to women at increased risk based on previous testing.

The Quad Screen is the second trimester screening blood test offered at most facilities in the VA/DoD. There are several new screening tests that are becoming available for first trimester testing. Some VA and DoD facilities offer first trimester screening and it is usually available via referral at other VA and DoD facilities.

Tests, such as cff DNA, the first trimester screen and the Quad Screen, are likely to be most useful to women who would benefit from the reassurance of a normal (low risk) test or who would consider diagnostic testing if the screening test is abnormal (elevated risk). Screening tests may be useful for women who would not consider pregnancy termination as the results help you prepare for problems if any are detected.

In such circumstances, screening tests may be harmful by causing significant anxiety for some women who undergo the testing but would choose not to undergo diagnostic testing even if the result returned abnormal (elevated risk).

Diagnostic (yes or no) tests are invasive and include amniocentesis and chorionic villus sampling (CVS). The CVS can be performed as early as 11 weeks but is not

available at most DoD or VA facilities. It can usually be obtained through referral. Amniocentesis is available through most VA and DoD facilities that provide obstetric services.

Table 1.
Risk of having a live-born child
with Down Syndrome or other
chromosome abnormality.

Maternal Age	Risk of Down Syndrome	Total Risk for All Chromosomal Abnormalities
20	1/1667	1/526
21	1/1667	1/526
22	1/1429	1/500
23	1/1429	1/500
24	1/1250	1/476
25	1/1250	1/476
26	1/1176	1/476
27	1/1111	1/455
28	1/1053	1/435
29	1/1000	1/417
30	1/952	1/385
31	1/909	1/384
32	1/769	1/322
33	1/625	1/317
34	1/500	1/260
35	1/385	1/207
36	1/294	1/164
37	1/227	1/130
38	1/175	1/103
39	1/137	1/82
40	1/106	1/65
41	1/82	1/51
42	1/64	1/40
43	1/50	1/32
44	1/38	1/25
45	1/30	1/20
46	1/23	1/15
47	1/18	1/12
48	1/14	1/10
49	1/11	1/7

References:
JAMA.1983 Apr 15; 249 (15): 2034-8.
Obstet Gynecol. 1981 Sep; 58 (3): 282-5.

Table 2. Down Syndrome Detection Rates

TEST	Detection rate at 5% False Positive
First Trimester Screens	83 - 88%
Quad Screen	81 - 85%
Screening Ultrasound	50 - 70%
Genetic Ultrasound	70 - 90%
cffDNA	99.5%*

*0.05% false positive rate.

Table 3. Diagnostic Testing

TEST	Timing (weeks)	Risk of Loss	Comment
CVS	11 - 14	1/10 to 1/1000	Referral usually required
Amnio	>14	1/1500	Available at some DoD facilities

Specific Genetic Testing

Cystic fibrosis (CF) is a genetic disorder that occurs more often in certain races and ethnic groups. Caucasians, Northern Europeans, and those of Ashkenazi Jewish descent are much more likely than others to be carriers of CF. The risk of being a carrier is also increased in those who have a family history of CF.

All genetic disorders are caused by abnormal genes. Some genetic disorders are passed from parent to child. Some disorders can be caused by the transmission of only one abnormal gene but that is not the case with CF. CF is called a recessive disorder, which means that both parents must carry a copy of the abnormal gene in order to make a child who has the disease of cystic fibrosis. People who carry one copy of abnormal recessive genes generally do not have any type of illness themselves.

Cystic fibrosis is a life-shortening illness that causes problems with breathing and digestion. It does not affect a child's appearance or mental ability. The symptoms of CF vary from very mild to quite severe. Most people with CF produce very thick, sticky mucus that can clog up the lungs and make it hard to breathe. It also increases the chance for lung infections like pneumonia. Many people with CF also have problems with digestive organs which makes it hard to break down and absorb food. Most males with CF are sterile and unable to father children.

New treatments and drugs have significantly improved the outlook of people with CF. Most people born today with CF will likely live to be more than 50 years old. Most children with the disease need to have physical therapy for about 30 minutes per day in order to help clear the thick mucus from their lungs. This physical therapy is easy to do and can be performed by family members.

Carrier testing for CF can be done to find out if a person carries a copy of the CF gene. Although testing is available to all women, it may be less useful to women in the lower risk ethnic groups. If a pregnant woman tests positive for being a CF carrier, the next step is to test the baby's father.

If only the woman is a carrier for CF, the chance is very small that the child will be affected. (There are some rare CF gene defects that our best testing is unable to detect, which would mean you and/or the baby's father would be told your test result was normal but you may still be a carrier. The risk of this occurring is low.) If both the woman and father of the baby test positive for being CF carriers, then every time they make a baby together they have a 25% chance that the child will have CF. There is a 50% chance the child will simply be a carrier, like they are, and will not have the disease, and another 25% chance that the child will not have the disease and will not be a carrier.

If both partners are carriers, there are additional tests that may be performed to see if the baby will have CF. Diagnostic prenatal tests such as chorionic villi sampling and amniocentesis are available that will give results during the pregnancy. Alternately, the cord blood of the baby can be sent for testing at birth. Depending on the state where you live, your baby may be tested for CF after delivery. Ask your health care provider about this testing. Even if it is determined that your baby has the genes that cause cystic fibrosis, we cannot tell you how severe your baby's disease might be.

Notes:

Depression Screen (Complete at 28 Week and Postpartum Visits)

Name: _____

Date: _____

As you will soon have a baby, we would like to know how you are feeling. Please CIRCLE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today. *If you have thoughts about hurting yourself or others seek medical help.*

1. I have been able to laugh and see the funny side of things.
0 As much as I always could 2 Definitely not so much now
1 Not quite so much now 3 Not at all
2. I have looked forward with enjoyment to things.
0 As much as I ever did 2 Definitely less than I used to
1 Rather less than I used to 3 Hardly at all
3. I have blamed myself unnecessarily when things went wrong.
3 Yes, most of the time 1 Not very often
2 Yes, some of the time 0 No, never
4. I have been anxious or worried for no good reason.
0 No, not at all 2 Yes, sometimes
1 Hardly ever 3 Yes, very often
5. I have felt scared or panicky for no very good reason.
3 Yes, quite a lot 1 No, not much
2 Yes, sometimes 0 No, not at all
6. Things have been getting on top of me.
3 Yes, most of the time I haven't been able to cope at all
2 Yes, sometimes I haven't been coping as well as usual
1 No, most of the time I have coped quite well
0 No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping.
3 Yes, most of the time 1 Not very often
2 Yes, sometimes 0 No, not at all
8. I have felt sad or miserable.
3 Yes, most of the time 1 Not very often
2 Yes, quite often 0 No, not at all
9. I have been so unhappy that I have been crying.
3 Yes, most of the time 1 Only occasionally
2 Yes, quite often 0 No, never
10. The thought of harming myself has occurred to me.
3 Yes, quite often 1 Hardly ever
2 Sometimes 0 Never

Adapted from: Cox JL, Holden JM & Sagovsky R (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786.

Testing & Monitoring During Pregnancy

At each of your goal-centered visits, your health care provider will monitor your health and that of your baby's through a variety of techniques. These techniques include blood pressure checks, uterine growth measurements, your weight and detailed questioning of your activities, feelings and eating patterns.

Another means of checking your baby's health is through a variety of fetal tests. One such test is the Fetal Movement Count. Beginning at 28 weeks, your health care provider will instruct you on how to count the baby's activity through fetal movement counts. As long as your baby's activity stays above the minimum ten movements in two hours or doesn't drastically decrease, you can be assured that the baby is doing fine. Other tests such as Non-Stress Testing and measuring the amount of your amniotic fluid (bag of water) by ultrasound are routinely begun at 41 weeks. By 42 weeks, the placenta is starting to age and may not be able to meet all the baby's needs. If more information is needed to evaluate your baby's health, your health care provider may recommend the use of tests such as the Biophysical Profile or the Contraction Stress Test.

Fetal testing includes

- Fetal Ultrasound exams (sonograms)
- Fetal Movement Counts
- Non-Stress Tests (NST)
- Amniotic fluid measurement
- Biophysical Profile
- Contraction Stress Tests

Fetal Ultrasound Exams (Sonograms)

Fetal ultrasounds give a picture of your baby through the use of high-frequency sound waves that bounce off solid structures to create black and white images. Fetal ultrasounds are most commonly used to determine the baby's due date, check for twins, measure amniotic fluid volume, determine the baby's size, check the condition of the placenta, and screen for some major birth defects in the baby. A fetal sonogram is typically performed between 18 to 20 weeks of pregnancy to evaluate your baby's development. If there is any uncertainty regarding your due date, a dating sonogram in the first trimester is the best way to clarify your estimated delivery date (EDD). In the third trimester, if your uterine growth measurement (fundal height) is measured to be too big or too small, or if you have health conditions that can affect your baby's growth, your provider may want to order a sonogram to see how your baby is growing. In the majority of cases, if your pregnancy is moving along normally, and you are in good health, there will be no additional fetal sonogram needed after the 18 to 20 weeks ultrasound exam. Sometimes, when doing an ultrasound exam, the sex of your baby is obvious - but this is not always the case. Don't paint the baby's room blue or pink based on ultrasound results alone. If you don't wish to know your baby's sex, let your ultrasonographer know before the exam starts. Although sonogram is a very good test to look for major birth defect(s) in your baby before birth, do keep in mind that this test is not perfect, and that unexpected birth defect(s) may be found in your baby at birth, during childhood, or in adult life.

Most women have at least one ultrasound exam during pregnancy. Ultrasounds provide more accurate due date information and thus may be able to decrease the incidence of labor inductions and increase the detection of serious fetal problems, multiple gestations, and women at risk for placenta problems. The decision to undergo a fetal sonogram is entirely up to you. Sonograms have been used safely in pregnancy for over three decades but there is always the remote possibility that some risk may be found in the future. If you do decide to have an ultrasound, you may want your partner to join you for your baby's first pictures.

Fetal Movement Counts

Fetal Movement Counts are a quick and easy way for you to know your baby is doing well (see charts on pages 120 - 123). Studies show that by recording baby's movement on a daily basis and reporting decreased movement, fetal death rates can be significantly reduced. Most authorities recommend starting fetal movement counting at 28 weeks of pregnancy. Remember to call your provider or Labor and Delivery if your baby has had less than 10 movements in two consecutive hours or any noticeable decrease. This counting is especially important as your pregnancy progresses.

Non-Stress Test (NST)

Non-Stress Tests look at your baby's heart rate in response to its movement. Just as your heart rate increases with exercise, so should your baby's. An external fetal monitor will be placed across your uterus to measure your baby's heart rate. This is the same type of monitor used in the labor and delivery room. If your baby's heart rate or movement is not adequate, further testing, such as Biophysical Profile or a Contraction Stress Test will be done.

Amniotic Fluid Measurement

Amniotic fluid is measured through use of a limited (focusing in on just one thing) ultrasound. Adequate fluid levels tell us that your placenta is functioning adequately and that the baby is doing fine in your uterus.

Biophysical Profile (BPP)

Biophysical Profiling uses ultrasound to look at your baby's heart rate, breathing, body movements, muscle tone and amount of amniotic fluid. Each aspect of the test is scored and these scores are added together. The total score helps determine if the baby well.

Contraction Stress Test (CST)

The Contraction Stress Test uses the same fetal monitor that a Non-Stress test uses except that now you will be given some contractions and your baby's response to these contractions will be observed. If the baby reacts poorly to these very mild contractions, he or she may not tolerate real labor well. If the baby tolerates these contractions without difficulty, then we are reassured that the baby will tolerate labor. An abnormal CST requires further observation and evaluation in the Labor and Delivery suite. If there is any concern about your baby's health, your provider may recommend delivery by inducing labor or by cesarean delivery.

True vs. False Labor

Listed below are some of the differences between true and false labor. If you are not sure what you are feeling try timing your contractions with walking and with rest. If the contractions increase in intensity with walking and do not go away with rest, you are probably having true labor contractions.

Action	True Labor	False Labor (<i>Braxton-Hicks</i>)
Walking	<ul style="list-style-type: none"> Increases the strength of the contraction Decreases the rest time between contractions 	<ul style="list-style-type: none"> Decreases strength of contraction. Increases rest time between contractions.
Strength	<ul style="list-style-type: none"> Contractions become more painful with time 	<ul style="list-style-type: none"> Contraction pain doesn't increase.
Timing: Frequency & Duration	<ul style="list-style-type: none"> Occur at regular time periods The time from beginning to end of the contraction increases with time. 	<ul style="list-style-type: none"> Contractions occur irregularly and the duration does not increase over time.
Location of pain	<ul style="list-style-type: none"> Begins in lower back and spreads to the lower abdomen and sometimes to the legs 	<ul style="list-style-type: none"> Stays in lower abdomen.
Cervix	<ul style="list-style-type: none"> Dilates (opens) & effaces (thins out, shortens) 	<ul style="list-style-type: none"> The cervix will change positions to be in line with the vagina (from its previous posterior position) and start a small amount of dilatation and effacement to get you ready for the real thing.
Other signs	<ul style="list-style-type: none"> Bloody show or mucous tinged with blood occurs as cervix dilates and effaces. 	<ul style="list-style-type: none"> No bloody show unless vaginal exam was recently performed.
"Bag of water"	<ul style="list-style-type: none"> Rupture (break) or leak occurs in only 15% of labors 	<ul style="list-style-type: none"> Does not break or leak.
Drinking fluids	<ul style="list-style-type: none"> Does not affect the frequency or duration of contractions 	<ul style="list-style-type: none"> Will slow down your contractions.
Rest	<ul style="list-style-type: none"> Contractions continue 	<ul style="list-style-type: none"> Contractions lessen or stop.

Preterm Labor

Preterm labor occurs when contractions cause your cervix to dilate and thin out before 37 weeks of gestation (preterm).

Delivery of a baby prior to full maturity is the most common cause of infant death or illness. Babies who survive being born too early may have problems gaining weight or growing tall. They may have problems with vision, hearing, breathing, and coordination. There may also be behavioral or learning problems in these babies as they get older.

Most of the time, we do not know why preterm labor starts. Your chances of having preterm labor are higher if you smoke, use illegal drugs, don't eat properly, or get certain types of infections. If you have already had a preterm delivery, if you are carrying more than one baby or if you have had early rupture of membranes you are at very high risk for preterm labor and delivery. Things you can do to decrease your chances of a preterm delivery include:

- Get regular prenatal care
- Do not use illegal drugs
- Do not smoke
- Be alert to signs of preterm labor
- Eat healthy foods/do not skip meals
- Always follow your providers advice

The best way to prevent preterm delivery is to detect preterm labor early. If you experience any of the following symptoms, contact your provider or Labor and Delivery immediately:

- Change in vaginal discharge such as change in color of mucus
- Leaking or gushing clear fluid or bright red blood

Below is a list of early signs of preterm labor:

- Persistent low, dull backache or low back or pelvic pressure
- Four or more uterine contractions per hour. Contractions may feel like:
 - Menstrual cramps
 - Sensation of the "baby rolling up in a ball"
 - Increased uterine activity (more that you are used to)
 - Abdominal cramping with or without diarrhea
 - Increased pelvic pressure with or without thigh cramps

If you experience any of these symptoms, lie down on your side, place a hand on your lower abdomen and feel for contractions. If after one hour, these symptoms continue, contact your provider or Labor and Delivery immediately.

All pregnant women are at risk for preterm labor, some are at higher risk than others. There are activities and circumstances that may increase your risk for preterm labor. A few examples include: an increase in prolonged high intensity aerobic exercise, standing for numerous hours without breaks, sexual intercourse when other conditions are present, dehydration, bladder infections, vaginal infections, carrying twins or triplets, bleeding in the second or third trimester that doesn't go away, leaking amniotic fluid, or a placenta previa after 26 weeks of pregnancy. Be sure to ask your health care provider if you think you may be at risk for preterm labor.

Labor and Delivery Procedures

AMNIOINFUSION: A procedure where fluid is inserted into the uterus by using an internal pressure catheter (see below) to replace some of the amniotic fluid lost when your water broke. This is sometimes helpful if the fetal monitoring strip indicates that the baby's umbilical cord is being compressed too much during your contractions due to the lack of fluid.

AMNIOTOMY: A procedure that involves "breaking the bag of water" that surrounds the baby in the uterus. A small plastic rod with a hook at the end is inserted through the cervix and used to place a small hole in the "bag" to allow the baby's head to put more direct pressure on the cervix. This procedure is sometimes used to help labor proceed more quickly than it might otherwise, or when internal monitoring is needed to more accurately evaluate contractions or the baby's heartbeat.

ELECTRONIC FETAL MONITORING (EFM): A method of examining the condition of the baby while still in the womb by noting any unusual changes in the baby's heart rate. EFM is usually performed continuously during labor to ensure that the baby is in good health. EFM can be used externally or internally in the womb. External EFM involves the use of belts that wrap around your abdomen to monitor both your contractions and the baby's heartbeat. The belts are not painful to wear but they do somewhat limit your ability to move around during labor. The external monitors do not measure contraction strength, only frequency. Internal EFM uses a Fetal Scalp Electrode (see below) to monitor the baby's heart rate.

EPIDURAL ANESTHESIA: A procedure performed by anesthesia personnel to provide pain relief to laboring women and people who need certain types of surgical procedures. The goal of epidural anesthesia in laboring women is to provide significant pain relief rather than complete loss of feeling, though some women do experience this as well. The epidural blocks the nerve sensation in the lower spine which then decreases sensation in the lower half of the body. This is done by inserting a small catheter into the space in the lower back that surrounds the spine, and injecting medication into that space through the catheter. The catheter remains taped in place until after the baby is delivered and then it is easily removed. Not all women are candidates for epidural anesthesia. Your provider will discuss with you the safest and most appropriate options for pain relief.

EXTERNAL CEPHALIC VERSION (ECV): A procedure that involves turning the baby from an undesirable position to a position more favorable for a vaginal delivery. Generally, this option is available to women whose babies are not in the head-down position by the 36 week visit. The provider will feel the position of the baby through the abdomen. If it feels like the baby is in the breech position (bottom down) or transverse position (sideways), an ultrasound can be performed to confirm the position of the baby. If the baby is not head-down, you may be offered an ECV to help turn the baby into the proper position. This procedure is only performed in the hospital under close ultrasound surveillance and is rarely associated with serious complications. If the baby cannot be turned, your provider will

continue to monitor the baby's position at each subsequent visit. If the baby does not turn on its own (which sometimes they do), your provider will usually schedule you for a cesarean section in the week before your due date.

FETAL SCALP ELECTRODE: A device used to directly monitor the baby's heart-beat while you are in labor. A small electrode is placed just under the skin of the baby's scalp during a cervical exam. Sometimes it is difficult to accurately monitor the baby's heartbeat with the external monitor. If there is a concern about your baby's well-being, your provider may suggest direct monitoring with the fetal scalp electrode.

FOLEY CATHETER: A procedure that involves placing a soft plastic tube through the urethral opening into the bladder where it drains urine continuously during labor or surgery. It is often used with epidural anesthesia as women frequently are unable to feel the sensation of having to urinate once the epidural is fully functioning. If not already in place, it will be inserted prior a cesarean delivery. Not all women will have a Foley catheter. Some women will have urine drained with a catheter that is not left in place. Some women may not need any type of catheter.

FORCEPS ASSISTED DELIVERY: The use of smooth metal tongs applied gently around both sides of the baby's head to guide the baby out of the birth canal. Forceps have been used to safely deliver babies for a long time. If they are needed, your provider will discuss the potential risks and benefits of a forceps delivery with you.

INTRATHECAL ANALGESIA: Similar to spinal anesthesia. The anesthesia provider places a small needle between the bones of the spine into the spinal fluid. A small amount of numbing or pain medication (usually narcotics) is injected into the fluid. The needle is then taken out and no catheter is left in place. The medicine helps relieve the pain of labor or childbirth. The medicine will usually lose its effect within an hour or two but some types of medicine can last for a whole day. Not all women are candidates for intrathecal analgesia. Your provider will discuss with you the safest and most appropriate options for pain relief.

INTRAUTERINE PRESSURE CATHETER (IUPC): A device used to measure the exact strength of your contractions during labor. This can only be used after your bag of water breaks. A soft plastic tube is inserted through your cervix past your baby's head into the uterus next to the baby. The tip of the tube has a pressure sensing device within it which measures the actual strength of contractions. Information from the IUPC helps your healthcare team evaluate if your contractions are strong enough to dilate your cervix and how the contractions are affecting the baby.

VACUUM ASSISTED DELIVERY: The use of a soft plastic suction cup that is placed on the baby's head to guide the baby out of the birth canal. If a vacuum assisted delivery is needed, your provider will discuss the potential risks and benefits of this type of delivery with you.

Labor & Delivery Basics

What exactly is labor and what does it do?

Labor is the term given to the entire process of bringing your baby into the world. It is certainly well named, for it may be the hardest work you will ever do. By understanding the process, knowing how to respond in a positive manner, and having a good support person, you will be ready to face your labor with confidence and knowledge.

The uterus is a muscular organ marvelously designed to house the growing fetus, and, at the appropriate time, to contract for delivery of your baby. During labor, the uterus works as a muscle by contracting and relaxing. Each uterine contraction first softens and shortens your cervix, which is the lower part of your uterus, and then opens it to allow birth to occur.

The softening and shortening of your cervix, called effacement, usually begins early in labor or even during the latter part of your pregnancy. The opening of your cervix, known as dilatation, commonly starts when the cervix is already soft and partially shortened or thinned out (effaced). This is especially true if this is your first baby. Women who have had prior babies may dilate a bit first, then efface and continue dilatation until delivery.

Contractions are measured from the beginning of one, to the beginning of the next, to determine the frequency and from start to finish of one contraction to measure length (duration). If you have contractions at 12:00, 12:07, 12:15 and 12:21, then your contractions are six to eight minutes apart. If your contraction begins at 12:00 and ends at 12:01 then your contraction is one minute long. They will start out as irregular, short-lasting contractions and progress to regular, intense tightening lasting from 1 to 1½ minutes.

The hardest part of the contraction is at its peak and lasts less than 15 seconds. Remember, no matter how hard or painful they feel, they will end, usually in less than 90 seconds. Remember also, that each contraction you have puts you that much closer to having your baby. There are many ways to cope with the pain of labor contractions and all will be explained in the labor pain section of this book.

Before labor begins

Anytime after your 20th week of pregnancy, you may feel an irregular tightening of your uterus or Braxton-Hicks contractions. As you get closer to actual labor, this “tightening” will become harder, more regular, and last longer. As this happens you may experience several other sensations. These include:

- **Lightening** Your baby has dropped down into your pelvis. First time mothers experience this more. Lightening can occur two to three weeks before actual labor begins. You will notice that breathing is a lot easier but you will need to urinate even more frequently. You also may feel an increase in leg cramps and aching in your thighs, pelvis and lower back.

- **Engagement** Your baby's head has passed through the upper pelvis into the lower true pelvis. This feels similar to lightening and is a sign baby is preparing for delivery. Pressure from the baby's head on the cervix will help prepare it for labor.

Preparing for Labor

Preparation for labor should begin early in pregnancy and needs to include both physical and emotional preparation. Classes, reading, and practice will help greatly when actual labor begins.

Physical preparation includes staying physically fit and continuing to exercise throughout your pregnancy unless told to stop by your health care provider. Pregnancy specific exercises on a daily basis are also beneficial.

Relaxation exercises must be practiced with your labor coach so you both will be ready when your true contractions begin. Your coach calls the commands and checks your muscles for tension or tightness. This exercise is designed to help you remain relaxed in labor when your uterus is hard at work.

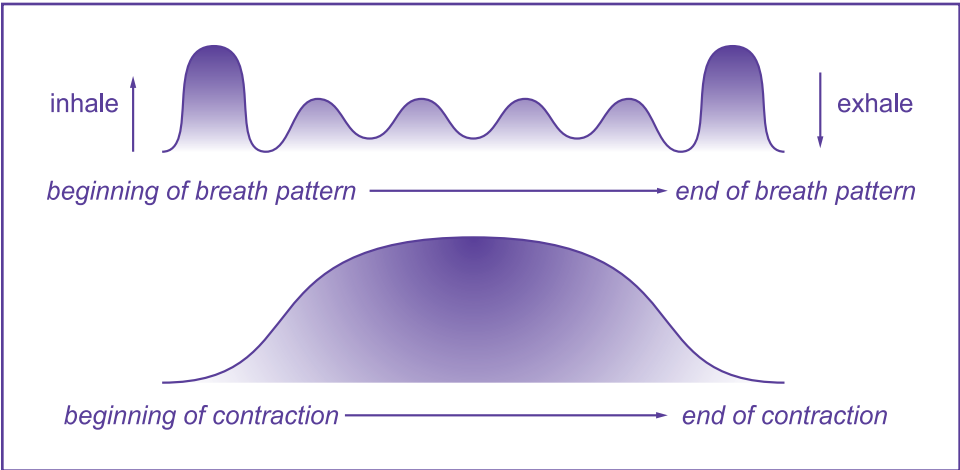
- Begin by lying on a firm surface with one or two pillows under your head and shoulders and one pillow under your knees.
- Raise arms about two feet from the floor or bed, stretch them slightly and hold for a few seconds, then slowly bring them down. When they are about six inches from the floor release your arms and let them fall limply to the floor. Legs should be fully relaxed.
- Repeat with left arm and right leg, keeping the other arm and leg totally relaxed.
- Repeat with right arm and left leg, keeping the other arm and leg totally relaxed.
- Repeat with right arm and leg, keeping the other arm and leg totally relaxed.
- Repeat with left arm and leg keeping the other arm and leg totally relaxed.
- Repeat with three limbs and keep the remaining one fully relaxed.
- Learn to respond on commands such as "tighten" or "relax."
- Coach checks for tightness and relaxation.

Breathing exercises

There is no absolute correct way to breath throughout your labor. Focused breathing is a tool to help you concentrate on your breathing and away from the pain of labor. It helps you stay relaxed and maintain control. There are many different breathing patterns to choose from. The exact breathing pattern that you use is less important than your ability to use it when the time comes. Your ability to use it will depend on how much you practiced! Listed below are some basic focused breathing techniques that you can use to help you through your labor and delivery experience. It is never too early to practice these techniques.

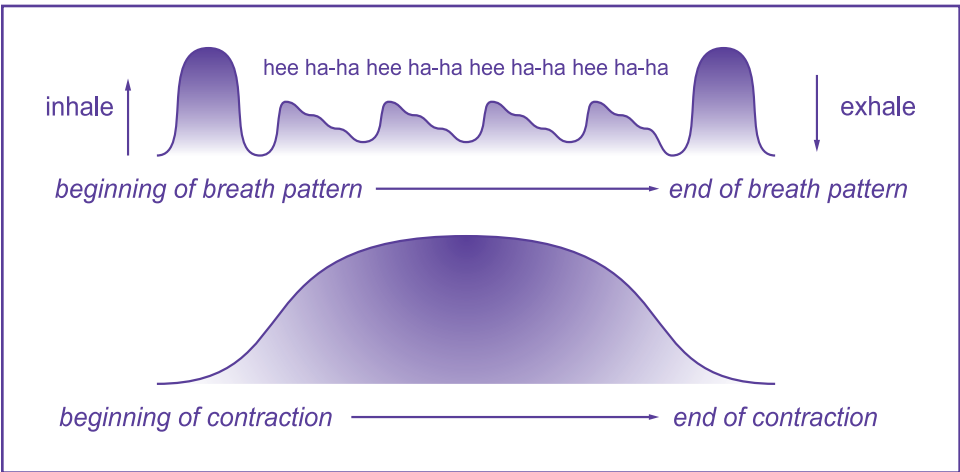
For early labor (First Phase)

Take a deep cleansing breath at the start of the contraction, then breathe slowly in through your nose and out through your mouth. End the contraction with another deep cleansing breath. Continue to breathe in this way until you feel like you need more concentrated breathing. At the point where you feel this early breathing is not helping enough, you should switch to active breathing techniques and be thinking about coming to the hospital.



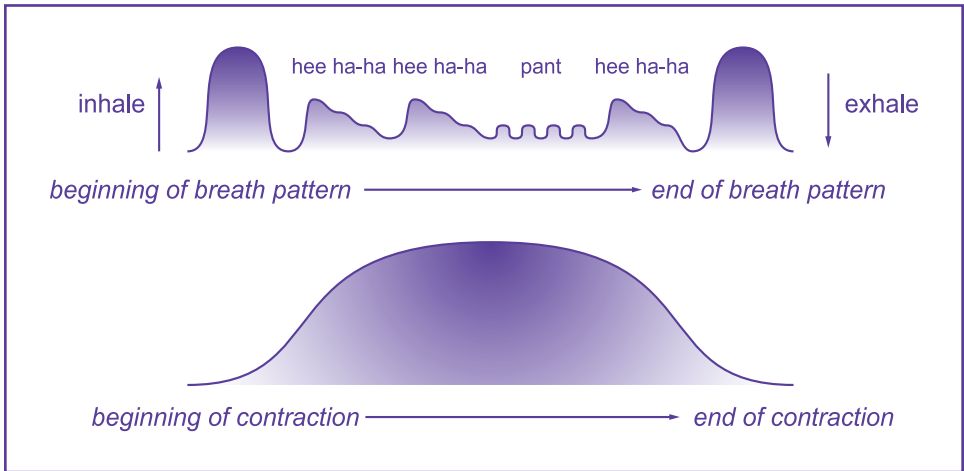
For active labor (Second phase)

Take a deep cleansing breath at the start of the contraction, relax and stare at your focal point. Then breathe in through your mouth. "Hee" is the sound you will make as you breathe in. Follow this breath with two breaths out making the "Ha-Ha" sound. Continue the "Hee Ha-Ha" pattern until the contraction ends. At the end of the contraction take another deep cleansing breath and relax – you finished another one!



Transition breathing

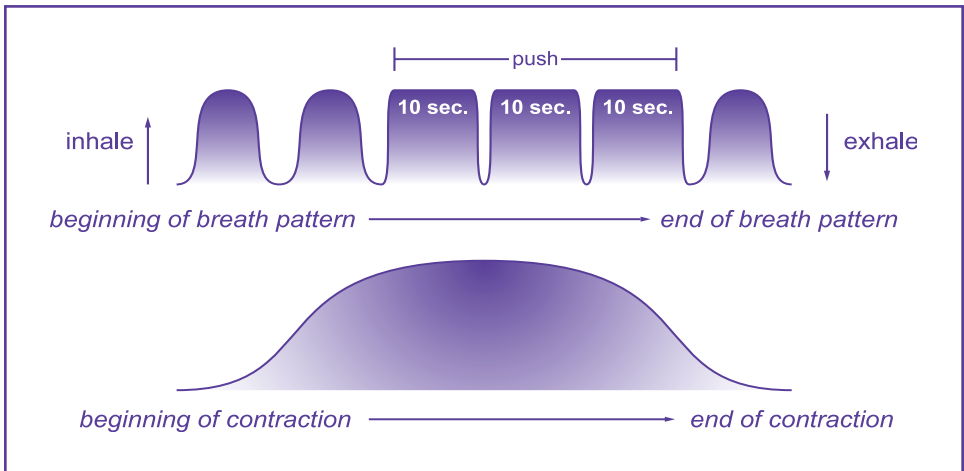
If you feel like you have to push down but are instructed not to do so, you will need to pant like a puppy or breathe quickly in and out through your mouth. This should only be to stop you from pushing (at the peak of your contraction) and for only a short period of time. If you begin to feel dizzy, let your nurse know.



Breathing for coached pushing

Once you are dilated and ready to push, you can either push like a bowel movement as your body tells you to or do coached pushing. The choice is usually up to you.

Coached pushing consists of starting each contraction with two or three deep cleansing breaths and holding the last one in. At the same time of your last breath, put your chin on your chest, grab your knees up and out and begin to push down (just like you are having a bowel movement). You may find it more comfortable to exhale slowly as you are pushing instead of holding your breath. End the contraction with another deep cleansing breath and relax until the next contraction.



Packing for the hospital

Around your 36th week of pregnancy you need to begin getting things packed that you wish to bring to the hospital with you. Your hospital will have gowns, slippers and robes for you to wear but if you would like to have your own make sure to pack them. It's a good idea to pack one bag for you and one for your baby. Baby's bag will not be needed for several hours or maybe not until the day after delivery. Do not bring anything too fancy or valuable.

Mom's bag

	2 or more well fitting bras: Nursing bras may make it easier to breastfeed.
	2-3 pairs of cotton underwear: Bring your oldest pairs, as you will bleed quite a lot and they will probably get stained.
	2 or more comfortable nightgowns: If you plan to breastfeed, it will be easier if your gowns open in the front. Don't bring anything you don't want to get dirty.
	Slippers or slip-on shoes with non-slick soles.
	Personal care items (shampoo, toothpaste, toothbrush, etc.).
	Loose fitting/maternity clothing to wear home: You usually wear your maternity clothes for several days to weeks after delivery.
	Phone and charger, or a camera for pictures.

Baby's bag

	One going-home/picture outfit.
	Car seat.
	Baby bag with diapers, burp cloth, wipes for the trip home.
	Blanket, hat and warm outfit if cold out.

Labor tools

	Lotion or talcum powder - for your coach to give you massages.
	Snack bag: Lollipops, hard candy to suck on in labor, snack foods for coach (since you don't know when the food will be needed), and a treat for both of you after delivery.
	Lip balm or lipstick to prevent dry lips.
	Something for you to concentrate on (focal point) such as a favorite picture, stuffed animal, flower, etc.
	To pass the time: A deck of cards or books for you and coach.
	Favorite pillow(s) with distinctive pillow cases to identify them as yours.
	Music: Bring a device for playing your favorite music.
	Tennis balls in a sock for back rubs.

What to do when you have false or early labor pains

- Keep busy and distract yourself. You can go to a movie, shopping, or find another activity that keeps your mind off these contractions.
- Walking may help you get your labor going but if it does not, do NOT continue to walk until you are exhausted. Save your energy as you will need it soon.
- Rest is important. If you are over-tired, your uterine muscles will be over-tired as well and your contractions will not be as effective as they would be if well rested. You will have the pain, but not the cervical changes.
- Try to relax by:
 - Sipping a cup of warm milk
 - Taking a warm (not hot) tub bath or shower
 - Having your coach give you a back rub or body massage.
 - Listening to some soothing music
- Make sure you continue to drink fluids. If you become dehydrated (low in fluids), your contractions will not be as effective. You will have the pain, but not the cervical changes.
- Don't starve yourself! Eat small amounts of easily digestible foods frequently. You have no way of knowing when your real labor will begin.
- Stay calm. When you tense up, everything you feel will be twice as uncomfortable and labor will not progress as quickly as it should.

When to come to Labor and Delivery

- Rupture of Membranes: Small trickle or big gush. Note color, consistency, and time of membrane rupture. We will want to test the fluid on arrival.
- Bright red vaginal bleeding, more than just a very small amount.
- Losing the mucous plug prior to 36 weeks (see Common Terms in Resource Section).
- Decreased fetal movement: Less than ten movements in two hours after lying down and concentrating on counting.
- Severe headache.
- Difficulty seeing, blurring of vision, sparkles, or flashing lights.
- Severe swelling of your hands and face along with a sudden weight gain.
- Vomiting that continues for 24 hours.

NOTE: Bloody show, losing your mucous plug or spotting, especially if you have had your membranes stripped recently, is normal.

- If you are a first time mom, you will want your contractions to occur every five minutes for at least an hour and get stronger with walking before you go to the hospital. Strong contractions will usually take your breath away and require you to focus on your breathing patterns as described earlier in this section. If you have had prior babies, you should come when your contractions are regular. You may need to come in earlier based on your individual situation which should be discussed with your health care provider.
- If unsure, come in and be checked! It's better to know than exhaust yourself with worry or come in too late.

How to tell if you are in real labor

The first thing to remember is that every woman's labor is different. Sometimes the only way to tell if you are in labor is to go to the hospital for an exam and observation. Never feel embarrassed to call or go into the clinic or to Labor and Delivery. We are here to help you through all aspects of your pregnancy, labor, deliver and postpartum care. Please use our expertise!

What to expect when coming to Labor and Delivery

While each medical treatment facility has a slightly different way of doing things, you can usually expect to:

- Have a vaginal exam (if membranes are intact) to check for dilatation (opening), effacement (thinning), and station (location of baby's head).
- Be examined for questionable rupture of membranes with a sterile speculum to avoid contamination. A small amount of fluid will be collected and put on a microscope slide to determine if it is amniotic fluid (from your bag of water) or normal vaginal secretions. Amniotic fluid will dry on the slide in about five minutes forming a very distinctive fern-like pattern.
- Have your and your baby's heartbeat timed.
- Have your temperature, blood pressure and pulse taken.
- Decide whether you need to be admitted now. You are usually admitted if:
 - Your bag of water is broken or leaking
 - You are four centimeters dilated.
 - Have any potential or current problems that need close observation such as high blood pressure, fever, infection, low or high fetal heart rate, or decreased fetal movements, etc.
- When admitted, your coach may be asked to assist in completing admission paperwork while you are put in a labor room.
- Once in the labor bed you will:
 - Be asked many personal questions.

- Have the external fetal monitor applied to your abdomen to measure baby's heart rate and your contractions.
 - Possibly have an IV or saline lock inserted into a vein in your arm for a fluid access line.
 - Have lab work taken (blood and possibly urine).
 - You may be given a medication, pitocin or oxytocin, to start your labor or to improve the contractions.
- Now you and your coach need to work together to have a safe and meaningful labor and birth experience.

Labor phases and how to cope

To deliver your baby you must pass through several phases of labor. These phases include: pre-Labor (often called false labor), early labor, active labor, and transition. At the end of these phases you will be completely dilated (10 cm) and effaced (100%) and will be ready to push your baby out into the world.

The following is a guide to each of the phases of labor, what you may feel, what you can do to help yourself, what your labor coach can do and some simple breathing techniques to help you cope with the process. The more practice time you devote to preparing yourself, the better off you, your coach and baby will be. You may want to bring your notebook with you to Labor and Delivery as a reference during labor.

Pre-Labor

Characteristics	What You May Feel	Helping Yourself	Coach's Help
Duration: hours to several days; may start and stop; change of activity affects contractions. Not everyone feels this phase.	Abdominal or pelvic pressure, crampiness, low backache.	Relax with contractions.	Be sure to sleep and eat well.
	Burst of energy or its opposite—laziness	Breathe normally or try slow early labor breathing.	Help with meals and chores, last minute preparations for baby.
	Nesting instinct.	Don't overdo. This energy is for labor. Finish packing for hospital.	Stay in close touch. Be available for transportation.
Birthing Progress: Effacement, slight dilatation, cervical positioning.		Eat small amounts of easily digested foods.	Encourage daily practice of breathing and relaxation techniques.
Contractions: Increased Braxton-Hicks, some uncomfortable, may begin a pattern, then fade.		Don't forget to drink fluids.	
		Pelvic rock for backache, side lying position for resting.	Provide: <ul style="list-style-type: none"> – Moral support. – Entertainment. – Back massage. – Loving words.

The real thing may begin with any of the traditional labor signs. It may begin slowly (the onset of labor may not be clear to you) or it may surprise you by beginning with contractions that are strong and as close as those described under active labor in the following pages. With the guidance of your provider, you will decide at some point in early or active labor to make the trip to the hospital.

Once there, progress will be measured by:

Effacement: thinning and softening of the cervix, measured as a percentage.

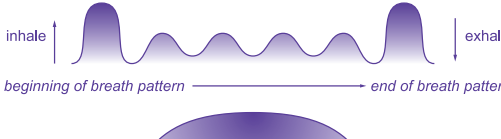
Dilation: opening of the cervix, measured in centimeters (1 to 10).

Station: the dropping down of the baby (-5 to +5 station), in relation to the pelvis.

Also of interest will be what part of the baby is "presenting" (coming first through the birth canal), condition of membranes, your blood pressure, fetal heart tones, pattern of contractions, and how you are feeling.

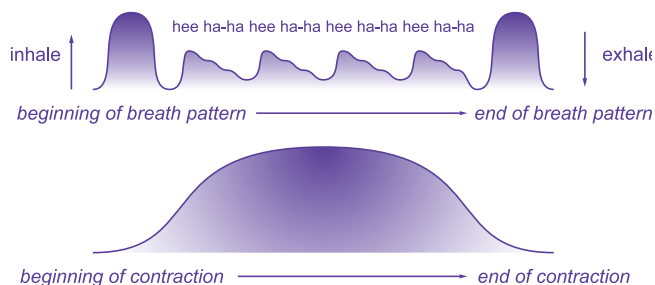
The **First Stage**, the longest part of labor, has three phases which progress from the first "real" labor contraction until the cervix is fully dilated and you start your pushing.

First Stage Labor – Phase 1: Early Labor

Characteristics	What You May Feel	Helping Yourself	Coach's Help
Duration: ranges from 2 hours to days.	Bubbly, excited. A little stage fright.	Enjoy this! You know your cues. Normal, light activity, plenty of rest.	This phase is usually spent at home and you will need to be in close contact in case she needs you.
Birthing Progress: Cervix dilates to 4 cm.	Wish to tell the world.	Relax and breathe thru contraction; use good positioning.	Stay in touch hourly.
Contractions: Last 30-60 seconds; are 5-15 minutes apart, and are mild but definite; progressively longer, stronger, closer together.	Gradually less sociable, more serious, beginning to realize it's work.	Call the L&D unit.	Support, entertainment.
	Wavelike pressure/ crampiness in back or front- all over tummy or very low in the tummy with contractions.	Pelvic rock for backache, slow breathing for each contraction. Warm shower.	Extra rest for you too.
	Hungry, thirsty, "time to get going."	Limit food and drink to clear liquids and hard candy, so that your stomach can be relatively empty. If an emergency delivery is necessary and you have to undergo general anesthesia, it is much safer for you if your stomach is empty.	Call sitter for older children.
			Encourage relaxation.
			Start coaching breathing exercises just for practice.
<p>For early labor (1st Phase Breathing):</p> 			Hand on tummy to get acquainted with contractions.
			Back massage if needed.
			When she needs to concentrate on breathing, begin to time each contraction.
			Watch for change of attitude.
			Offer fluids often.
			Carefully drive to hospital when she is ready.

First Stage Labor – Phase 2: Active Labor

Characteristics	What You May Feel	Helping Yourself	Coach's Help
Duration: 4-8 hours.	Serious, need to concentrate.	Focal point away from traffic pattern in room.	Be prepared with information for admissions if not pre-admitted. Return quickly to labor and delivery.
Birth Progress: Cervix dilates from 4 to 8 cm.	Intense pressure with contractions.	Switch to focused breathing.	
	Vaginal bleeding. Backache may intensify or vanish.	Urinate often.	
Contractions: Last 45 - 75 seconds and are 3-5 minutes apart and are quite strong, peak more quickly.	Trembling legs.	Change position.	Time contractions. Talk her thru them.
	Flushed warm, dry mouth.	May want to suck on lollipop.	Check for relaxation and help get her to relax.
	Nausea.	Tell others of needs!	
	Discouraged if no progress.	Turn on background music.	Anticipate needs for comfort and handle distractions.
	Very self-centered.	Walk or shower if possible.	
		Try squatting or sitting on exercise ball.	Walk with her if able.
			Help her to bathroom often (tell nurses).
			Help her change positions often.
			Tell nurses if she has urge to push.
			Massage.
For active labor (2nd Phase Breathing):			Praise!
			Encourage often!



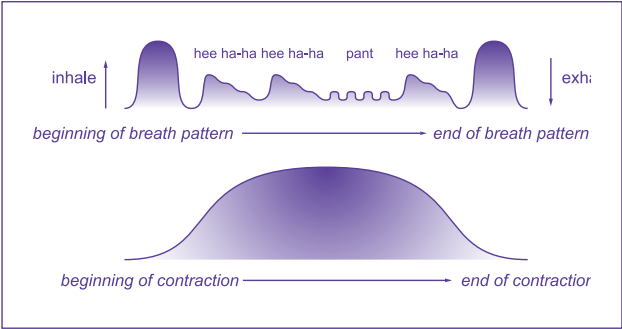
First Stage Labor – Phase 3: Transition

Characteristics	What You May Feel	Helping Yourself	Coach's Help
Duration: 15 minutes to 1½ hours.	Confused, irritable, not wanting to be touched, afraid of losing control.	Switch to transition breathing pattern; take each contraction one at a time.	Be firm in coaching, never mind her mood. She'll thank you later for coaching breathing.
Birthing Progress: Cervix dilates from 7-8 to 10 cm.	Increased rectal pressure.	DON'T push! Pant or blow till urge has passed.	Put your face about 10 inches in front of her face and do the breathing exercise if she is having difficulty in maintaining control and breathing.
Contractions: 60-90 seconds long, 2-3 minutes apart. Very strong, tremendous pressure, may have more than one peak.	Urge to bear down, very tired and sleepy.	Concentrate on relaxing, especially between contractions.	If she doesn't want to be touched, back off—this is only temporary—but keep on coaching her breathing though the contractions.
	Nausea, vomiting, burps, shaky legs, or trembling all over, leg cramps.	Try to keep breathing slow - don't hyperventilate.	
	Hiccups, dizziness, tingling hands and face (hyperventilation).	Ask to change bed pads if needed.	Coach her to pant or blow if she starts to push and call your nurse.
	More vaginal discharge caused by descent of baby.	Change positions often.	
	Hot and perspiring, or cold and shivering.	Urinate often.	Let her sleep between contractions-keep distractions down, dim the lights, lower the sound.
		Stay in bed.	
	Increased backache as baby descends.	Rest between contractions-many women fall asleep between them.	At onset of each contraction coach her to start breathing.
			Have cool cloth ready for face, lips and mouth.

First Stage Labor – Phase 3: Transition (cont.)

Characteristics	What You May Feel	Helping Yourself	Coach's Help
			Stroke legs, back, and shoulders if it helps her relax.
			Straighten limb and flex foot to relieve leg cramps.
			Remind her she is getting closer to holding her baby!
			Help her get into different positions often.
			Make sure she is urinating often.
			Ask staff about getting ready for delivery.
			PRAISE!

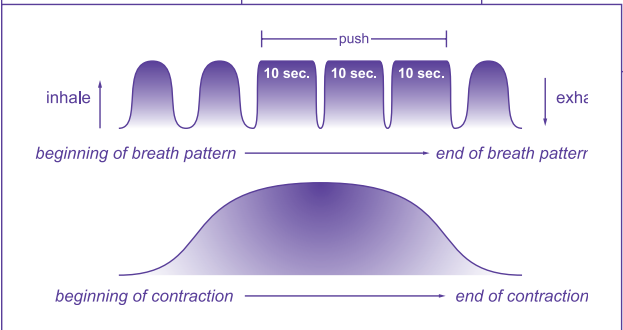
Transition breathing:



The **Second Stage** includes the time from full dilation of the cervix until the baby is born. Setup for delivery will begin now if it is not your first baby.

Second Stage Labor – Pushing

Characteristics	What You May Feel	Helping Yourself	Coach’s Help
Duration: Varies greatly - 2 pushes to 2 hours.	Urge to push varies, usually strong.	Take two cleansing breaths, and rest between contractions.	Check her position and help her to change it frequently.
Birth Progress: Pushing the baby down the birth canal and out into the world.	Great relief to push.	Listen closely to coaching from team.	Remind her of cleansing breaths at beginning and end of each contraction.
	May feel uncertain at first but you will soon get into it.		Encourage long pushes.
			Let her rest/sleep between contractions.
			Keep distractions to a minimum.
			Wet her forehead, lips and mouth with cool wet cloth.
			Give ice chips between pushes.
			Ask for mirror to increase motivation.
			Respect her mood. She may be quiet, bubbly or crabby. Remember she is working really hard.
Coached breathing:			Coach firmly.



Second Stage Labor – Pushing (cont.)

Characteristics	What You May Feel	Helping Yourself	Coach's Help
Contraction: Last 60 - 90 seconds and are 2-5 minutes apart, peak more slowly than transition contractions, and may have more rest breaks between.	Alertness returns, new burst of energy.	Enjoy the excitement.	Support her during pushes.
	Back pain may vanish or return.	Pushing harder may help you to cope with pain.	Limit movement. Stay next to or behind her head now unless told otherwise.
	Great pressure in rectum. Stretching, stinging sensation around vagina as crowning approaches; numb for birth of baby.	Release perineum as completely as you can and think "Open, baby out!"	Remind her to "Relax her bottom."
		Lie back and pant or blow for birth of baby's head.	Support her head and shoulders so she may watch baby emerge.
	Actual feel of baby emerging is warm and pleasant relief!	Push as directed for baby's shoulders.	Look to see WHO'S HERE!
		Get ready to hold your new baby.	If this has been discussed and planned: Get ready to cut cord.
			Get the camera out and ready for first shot of new baby.
			Welcome your baby into the world!

The **Third Stage** includes the time from baby’s birth to expulsion of the afterbirth.

Third Stage Labor

What is Happening	What You May Feel	Helping Yourself	Coach
Duration: up to 30 minutes.	May or may not notice contractions.	Ask to push placenta out yourself.	Reinforce instructions.
Birth Progress: Afterbirth comes out (placenta, membrane, cord).	Chilled, shivery, impatient.	Respond to coaching.	Remind her to relax.
	Overwhelmed and overjoyed!	Nursing baby stimulates your uterus to contract.	Enjoy watching or holding your baby.
Contractions: Few, mild ones.		Concentrate on your baby.	Stay near until she is ready to rest.

Pain management in labor

Each woman will respond differently to her contractions. This response depends on many factors to include:

- Time spent in labor
- Level of pain tolerance
- Quality of coaching
- Emotional and physical state
- Preparation for labor
- Size and position of baby
- Stage of labor

Coping techniques

Since it is impossible to predict how your labor will go and how well you will cope with your labor, it is very important for you to know all your options. If you require medications after trying the various non-medication techniques listed below, your health care provider will determine the safest route, amount, and timing of the medication.

- **Breathing with the contractions:** Various breathing techniques are taught in childbirth preparation classes and it doesn’t matter which one you choose to use. By using these breathing techniques you will be focusing on breathing and not on the pain of your contractions. Simple but effective breathing techniques are outlined in the Phases of Labor section (see charts for each phase of labor).

- **Medications:** Several medications can be given in labor to help you cope with contraction pain. How much, when to give the medication and what to give depends on many factors. Your provider will work with you to minimize the pain as much as is safe for you and your baby. There is no labor medication that is guaranteed to be 100% free of side effects, although with proper monitoring, dosing and timing of medications, side effects can be kept to a minimum.

Narcotics and synthetic narcotics - these can be given through an injection in your muscle or into your IV to dull the pain and help you to relax. IV medications act quickly but don't last as long as an injection into a muscle. We try not to give these medications within an hour of delivery to prevent the baby from being born with effects from the medication. If baby comes quicker than expected then a narcotic blocking medication can be given to your baby to block its effects. Other side effects include slowing of your labor or stopping it if given too soon.

- **Regional Anesthetics:** Epidural and spinal analgesia are popular methods of pain control because they provide excellent pain relief with few side effects to either mom or baby. Both are called regional anesthetics because they provide anesthesia (loss of sensation/pain) to one specific region of the body while leaving you awake and your baby unaffected by the pain control.
 - **Spinal Block:** A spinal anesthetic may be used for create pain control in both labor and delivery. It is most commonly used to provide anesthesia during a cesarean delivery. Common sensations during a spinal anesthetic include the absence of sensation from the toes up to the breast bone.
 - **Epidural:** An epidural anesthetic may be used to create pain control for labor. An epidural may be placed any time during your labor. The decision is based on maternal request and a discussion between your obstetric and anesthesia providers. An epidural is a small catheter that is placed under sterile conditions into the epidural space (a small space located outside of the thick membranes that protect the spinal cord and hold in cerebral spinal fluid). The epidural catheter is placed well below the bottom of your actual spinal cord so that there is minimal risk of injury. Once the epidural catheter is in place, medication is infused through this catheter to provide you pain control during your labor. Usually epidural catheters may be used in the event of an emergency cesarean delivery. In this situation the epidural can provide you and your baby with the necessary medication to enable a quick and safe surgery. The epidural will also permit you to be awake during this surgery so that you will not miss the birth of your child.

There are risks associated with any medical procedure, including spinal and epidural anesthetics. Those risks include but are not limited to bleeding, infection, headache, decreased blood pressure, epidural hematoma, paralysis and total cardiovascular collapse. Fortunately, major complications are extremely rare events.

Cesarean Delivery: Questions & Answers

There are several reasons to perform a cesarean delivery. Often it is a combination of factors that help make the final decision. It is not performed strictly to avoid labor contractions as this is a major surgical procedure. Unless it is an emergency situation in which a delay could harm either you or your baby, the provider performing the surgery will explain to you why a cesarean delivery is needed.

Reasons for cesarean delivery include:

- **Cephalic-pelvic disproportion (CPD):** Baby is too big or your pelvis is too small to allow for your baby to be born through your birth canal.
- **Fetal distress:** Baby's heartbeat is slowing down to a dangerous level and won't come back to normal levels despite usual interventions such as increased fluids, oxygen and position change.
- **Excessive vaginal bleeding**
- **Active Herpes or infections that could affect your baby**
- **Malposition or malpresentation:** Baby is in an unsafe position such as breech, or unsafe presentation such as neck fully extended that will not allow him/ her to be born safely through the birth canal.
- **Failure to progress:** The cervix is not dilating (opening) properly even with adequate period of time with strong contractions.
- **Placenta previa:** Placenta is covering all or part of the cervical opening which could lead to severe vaginal bleeding during labor.
- **Placenta abruption:** Placenta separates from the uterine wall and blocks oxygen exchange to your baby.
- **Previous cesarean section:** Especially if you had a previous classical incision (runs up and down your uterus). Often even if you had a cesarean previously, you can still attempt to deliver vaginally this time.

What usually happens with a Cesarean Delivery?

- You will be counseled as to why a cesarean delivery is needed and you will sign a consent form allowing the cesarean delivery to occur.
- You will have an IV (tube into vein) and Foley catheter (tube in bladder) inserted.
- You will be counseled on what type of anesthetic is best for you and baby:
 - General anesthesia (you go to sleep)
 - Regional anesthesia (you are numb from chest down)
- The operating room can be quite crowded with nurses, doctors and assistants.

Depending on the situation, your partner may be allowed to accompany you. In the operating room, you will be placed on the operating table. Once on the table, your abdomen and pubic area will be washed, shaved and drapes or covers will be placed over your abdomen. The anesthetist will administer anesthesia after taking several blood pressure readings and monitoring your other vital signs (respiration rate, temperature). After the anesthesia begins to work, a cut will be made below your belly button to get the baby out.

You will not be able to see this incision, even if awake, because a drape will be between your head and your abdomen to block your view. After the baby is born, the pediatrician will make sure baby is OK and then let you hold/ see baby depending on your baby's condition. After your abdomen is sutured, you will be taken to a recovery area. You may be very sleepy at this time. When sufficiently recovered you will be taken to the Postpartum area.

After a cesarean delivery can I deliver vaginally?

In many cases you can deliver vaginally after having a cesarean delivery. If you had a prior cesarean delivery with a side-to-side incision in the lower part of your uterus (the non-contracting portion of your womb), you may choose either to attempt to have a vaginal delivery (trial of labor) or have an elective repeat cesarean delivery. The chance of a successful vaginal birth is around 74% (ranged 60 to 80%). Your provider will review with you the conditions of your current pregnancy, as well as the records from your previous cesarean deliveries in order to help you to decide if a trial of labor or an elective repeat cesarean delivery is best for you.

What are the benefits of an elective repeat cesarean delivery?

The benefits of an elective repeat cesarean delivery are:

- The delivery date is scheduled and you and your provider can both plan on the birth of your baby accordingly
- There is a very low risk of uterine rupture (tearing of the uterine scar)

What are the drawbacks of an elective repeat cesarean delivery?

Infants delivered by cesarean delivery may have some problem taking their first breaths, or having to breathe too fast. They can be slow to start breastfeeding, and it may take a little longer time for mother-infant bonding. Possible drawbacks of an elective repeat cesarean delivery are:

- Complications from surgery such as infections, and injuries to the bladder and intestines
- Higher risk of complications with the next pregnancy
- Longer healing time after giving birth

What are the advantages of a successful vaginal delivery after a previous cesarean delivery?

The advantages include the following:

- Less blood loss compared to the average cesarean delivery

- Less risk of blood clots forming in the legs
- A shorter stay in the hospital
- Faster healing after giving birth
- Decreased need for future cesarean deliveries and related complications

What are the risks of trying to have a vaginal delivery after previous cesarean delivery?

Whenever a woman is in labor, emergency complications can occur. These complications can occur not only in women who have had a previous cesarean delivery, but also in vaginal deliveries. The most serious risk of a trial of labor is tearing of the uterine scar during labor (uterine rupture). In general, a trial is quite safe with a very low risk of uterine rupture (less than one percent of the time). Uterine rupture can cause serious injury and harm to you and your baby when it occurs. If uterine rupture is suspected during labor, an emergency cesarean delivery will be performed. Most of the time, there will be no ill effects to you or to your infant from an emergency cesarean delivery. However, from time to time, emergency surgery may have increased blood loss; a need for blood transfusion; and in some situations, there is a need to remove your uterus (hysterectomy) if hemorrhage cannot be controlled by other means.

What factors may increase the risks of uterine rupture?

The risk of uterine rupture is almost three times higher if you have had two or more prior cesarean deliveries. Using medications to start labor can also double the risks of uterine rupture. If your labor is induced, other factors that may increase your risk of uterine rupture are:

- Unfavorable cervix at time of labor induction (cervix not effaced, not dilated, and the baby's head is not down in your pelvis)
- If your BMI is more than 30 (BMI or body mass index is a measure of your weight in relationship to your height)
- Time from your most recent pregnancy was less than 18 months
- Your baby is heavier than 4,000 grams (8 pounds 13 ounces)
- Your prior cesarean delivery uterine incision was closed with only one-layer of stitches

What factors may decrease the risks of uterine rupture?

Having had a prior vaginal birth reduces the chance of uterine rupture during a trial of labor.

Is there a difference in the chance of needing a blood transfusion or hysterectomy between trial of labor and repeat cesarean delivery?

The overall chance of needing blood transfusion or hysterectomy is not different between those women who attempted a vaginal delivery and those women who chose to have a repeat cesarean delivery. Factors that can increase the risk of transfusion and hysterectomy are:

- Induction of labor, especially without prior vaginal delivery
- High-risk pregnancies
- Increased number of prior cesarean deliveries

What factors are related to a successful vaginal delivery after a previous cesarean delivery?

You may have a better chance for a successful vaginal delivery if you have the following condition(s):

- Your prior cesarean delivery was due to your baby's position (i.e., breech - when the baby enters the birth canal with buttocks or feet first)
- Your prior cesarean delivery was due to abnormal fetal heart rate during labor (i.e., heart rate going down)
- You have had at least one vaginal delivery in the past
- Your labor has started on its own
- Your BMI is less than 30
- Your baby's estimated weight is less than 4,000 grams (8 pounds 13 ounces)
- Your cervix is already effaced (thinned out) to at least 75 to 90%
- Your cervix is already dilated
- Your baby's head is already engaged (down into your pelvis)

What factors are related to an unsuccessful or "failed" trial of labor?

Race and ethnicity effect the risk. Hispanic women have a lower rate of successful vaginal delivery after cesarean delivery than non-Hispanic white women. African American women have a lower rate than Caucasian women. You may have a higher chance for a failed attempt at a vaginal delivery if you have the following condition(s):

- Medical problems such as high blood pressure, diabetes, asthma, seizures, renal disease, thyroid disease, or heart disease
- A previous cesarean delivery was due to labor not progressing normally
- The birth weight of your baby from a prior cesarean delivery was more than 4,000 grams (8 pounds 13 ounces)
- You've had two or more cesarean deliveries and never gave birth vaginally
- You are more than 40 weeks pregnant
- Your labor was induced
- Your labor needed to be sped up by medications such as Pitocin

What are the complications of a failed attempt at vaginal delivery?

If you attempt a trial of labor, but a cesarean delivery becomes necessary, you will have a higher chance of complications than if you had a planned elective repeat cesarean delivery. Some of the complications from a failed attempt at vaginal delivery are:

- Injuries to your bladder, ureter, and intestines during the cesarean delivery
- Higher risk of infection of your uterus
- Higher risk of infection of your abdominal incision

What are the risks of multiple cesarean deliveries?

The more cesarean deliveries you have had, the higher the risks to you from pregnancy. The risks of multiple cesarean surgeries are:

- Placenta previa (abnormal placenta position blocking the cervix) causing bleeding during pregnancy or bleeding around the time of birth
- Abnormal placenta growth with placenta growing into your uterus leading to bleeding that can be difficult to control
- Scars that make the repeat cesarean surgery more difficult causing injuries to your intestines, bladder and ureter (the tube connecting your kidney and your bladder)
- Higher chance of an emergent hysterectomy
- Higher risk of infection for you

What medications are safe to use for labor induction or augmentation (speeding up labor progress) for trial of labor?

Medications such as oxytocin (i.e., Pitocin) can be used safely during a trial of labor. Medications such as the prostaglandin type of drugs (i.e. Cytotec) carry high risks for uterine rupture and are not recommended for labor induction in women who desire a trial of labor.

Can I choose to try to deliver vaginally if I want my tubes to be tied (tubal ligation or tubal sterilization procedure) after delivery?

Yes, you can choose to attempt vaginal delivery if you have decided to have your tubes tied after giving birth. Please make sure you inform your provider of your decision for a tubal ligation well in advance of your labor. Prior to deciding to have a tubal ligation, which is a procedure that makes you sterile (prevents pregnancy) you should have discussed all birth control options appropriate for you with your partner and provider.

How can I prepare for an attempt at a vaginal delivery?

The preparation requirements to attempt a vaginal deliver after a cesarean delivery vary from hospital to hospital. Please discuss these requirements with your provider. In general, prepare the way you would for any planned vaginal delivery. See Labor and Delivery Basics in Resource Section.

What happens if I become overdue?

In the event you become overdue, you should be prepared to discuss with your provider, the need to schedule a date for labor induction or a date for a repeat cesarean delivery.

Birth Plan

Many of our patients have specific requests for management during labor and delivery. Our goal for managing your labor and delivery is to help you bring your baby into this world in a safe and friendly environment. We hope this will be a wonderful experience for you.

Most published “birth plans” provide a menu of options with check boxes for things that you want during labor and delivery. These forms suggest that having a baby is like having a meal at a smorgasbord, pick what you want for each course the price is the same. However, when it comes to labor, some of these “menu items” are more expensive (have more risk) than others. Below we provide you some information about our common practices and reasons for them. If you have any special requests or would like to discuss any of these issues further, please make a note of them below and we will discuss them with you.

Environment—If you would like to have the lights down, or bring/play your own music, that is usually acceptable. Let the Labor and Delivery staff know of your wishes. During the actual delivery or after the delivery if stitching is required, some lighting is necessary.

Visitors—Your partner is welcome throughout your labor and delivery unless an emergency cesarean section is necessary and you have to have general anesthesia. In addition, depending upon your wishes, their maturity, the room size and your condition, other family members/friends are usually allowed to attend the birthday party.

Pain management—Except in specific circumstances, we usually leave the type of pain management up to you. Available options include Lamaze-type techniques (no medications), IV narcotics and regional anesthetics (such as an epidural). All options for pain relief have their own risks and benefits. We base the type and timing of pain relief methods on your wishes and individual situation.

IV—We strongly recommend that you have an IV in place during labor. This allows you to be quickly cared for in the event of an emergency. It is common to attach the IV to tubing and give some IV fluids but this can usually be limited if you desire. IV fluids may actually help your body labor more effectively.

Food and drink—We recommend limiting intake to clear liquids and hard candy so that your stomach can be relatively empty. If an emergency delivery is necessary and you have to have general anesthesia, it is much safer for you if your stomach is empty.

Monitors—We usually do continuous fetal monitoring once you are admitted to labor and delivery. If your pregnancy is uncomplicated and the initial fetal monitoring is reassuring and there is adequate nursing staff available, it may be appropriate to go for periods of time without fetal monitors in place. Usually the fetal monitors are placed on your abdomen over your uterus. If additional information is necessary we sometime put monitors directly on the baby or inside your uterus.

Labor positions—As long as we can monitor the baby often enough to be sure that the baby is OK (varies with the situation), you can move around the room if you would like.

Delivery positions—Most women deliver while lying on their back or side and most providers have the most experience delivering babies from this position. If you would like to deliver in an alternative fashion, please let us know.

Episiotomy— (A cut through the vaginal wall above the rectum) We do not routinely cut episiotomies. If they are performed it is usually because we need to get the baby out quickly.

Forceps and vacuums—We do not use forceps or vacuums without a reason. Vacuum or forceps assisted delivery is recommended when your cervix is completely dilated but the baby needs to be delivered more quickly than you are able to push the baby out or because you have been unable to make enough progress on your own. If forceps or vacuum is recommended it is because the provider believes that the potential benefits of the procedure outweigh the risks.

The umbilical cord – If you desire, your partner can cut the cord unless, the baby needs extra help transitioning to life outside of the womb and we have to move quickly.

Bonding—You can let us know at the time if you prefer to have the baby placed on your abdomen right after birth or have the baby cleaned off first and then given to you. Unless there is a medical reason to do otherwise, we keep the mom and baby together after the delivery. Getting you and the baby skin-to-skin right away is usually the plan.

Feeding—Usually the best time to begin breastfeeding is shortly after birth. We support and encourage this practice.

Medications for baby—We typically give the baby a shot of vitamin K in the thigh and put some antibiotic ointment on the eyes within the first half an hour after birth. These medications help the baby’s blood to clot properly and decrease the risk of eye infections that the baby may acquire during the birth.

Please share with us any of your concerns or special requests.

Remember in the event of an emergency regarding your health or the health of your unborn baby, we will do our best to keep you informed but we may need to modify your birth plan.

Baby Supplies for the First Week

The following is a list of baby items that will be very helpful to have prior to bringing baby home. Give the list to friends and family when they ask what you need.

Infant car seat

- You will need a rear facing car seat to bring your baby home from the hospital. Make sure you know how to install it safely into your car's backseat. Your baby will not be discharged without the staff first checking the car seat with your baby in it.

Clothing

- 4-6 shirts, sleepers and gowns. Plan on at least a few change of clothes a day.
- Warm clothes such as hats, blankets, booties, etc. as needed. Dress baby as you would dress yourself, but add one layer.

Bedding

- A crib or bassinet: Make sure the slats are no farther than 2 inches apart.
- 4-5 snug fitting sheets
- 6-8 receiving blankets

Bathing/diaper supplies

- 2-3 towels, 4 wash cloths
- 3-4 dozen diapers (disposable or cloth). Plan on your baby using about a dozen per day
- Baby shampoo and soap
- Saline nose drops
- Baby bathtub or pad for sink to prevent slipping
- Baby fingernail clippers or scissors
- Mild laundry soap
- Soft cloths or disposable wipes for cleaning after diaper change

Baby first aid

- Digital thermometer
- Baby acetaminophen
- Rubbing alcohol if you are told to use it for cord care
- Petroleum jelly or other lubricating jelly

Breastfeeding supplies

- Clean soft cloth or disposable breast pads for leaking breasts
- 2-3 nursing bras
- Nursing tops and nightgowns for added convenience

Bottle-feeding supplies

- 8 (4 ounce) baby bottles, caps and nipples
- Bottle and nipple brush for cleaning
- A one quart measuring cup

Extras you might want

- Diaper bag to carry baby items
- Pacifiers
- Burp cloths
- Unscented alcohol-free wipes to carry in diaper bag
- Changing mat
- Baby hairbrush or comb
- Cotton swabs or cotton balls

Sex after delivery

It is best to avoid sex for at least three to six weeks following the delivery of your baby in order to give yourself time to recover from the changes associated with childbirth. Your stitches (if you had any) should be dissolved and your vaginal discharge greatly reduced by this time showing that you are well on your way to complete recovery. The perineal area (or area between the vagina and the rectum) may be slightly tender suggesting some healing is still taking place. In order to help make your first sexual experience after the delivery an enjoyable one, there are a few helpful hints that we suggest you follow:

- Have your partner or yourself apply gentle pressure at the entrance of your vagina towards your rectum. If this is very painful, it is better to wait until it does not cause discomfort before having sex. Discuss this with your provider.
- Use a lubricant such as K-Y Jelly® around the entrance of your vagina as you may be drier for a period of time following your delivery. This is especially true if you are breastfeeding.
- The side position may be more comfortable if you had a midline episiotomy. This position places less pressure on the suture area.
- Make sure baby is asleep so you will be less likely to be disturbed.
- If you are breastfeeding, you may wish to keep your bra on in order to absorb the milk that can be released during your orgasm.
- Be sure to use some form of birth control. You can become pregnant at any time after delivery. You release the egg two weeks before your period. You usually will not know when your egg is being released.
- Be sure to spend time together as a couple even if you are not quite ready to have intercourse.

Masters and Johnson, experts on sexuality, have found that women in the first two months after delivery were slower to respond to sexual stimulation and responded less strongly. In spite of this, women usually found sex enjoyable. Just remember, you must be ready both physically and mentally before resuming sex. Do not rush it. There are many other ways to express your love.

Birth control methods after delivery

Before resuming sexual intercourse, we recommend waiting until your bleeding has stopped, or at least greatly decreased, your stitches (if you had any) have healed and you are on a reliable form of birth control. Ideally it would be best to wait until your six to eight week postpartum appointment to make sure everything is healing without problems and that your birth control method is adequate. If you feel well enough to enjoy sex prior to that time, there are many birth control options.

If you are not breastfeeding, you can expect to have your first period anywhere from four to six weeks after the delivery. With full breastfeeding (no supplements of any kind) your periods may be delayed up to six months.

You will release an egg (and therefore be fertile) before your first period whenever it occurs. This is why women should consider a reliable type of birth control prior to resuming intercourse, no matter when the intercourse occurs. Luckily, there are several good choices of reliable birth control methods available for both breastfeeding and non-breastfeeding women.

Non-hormonal methods

Condoms and foam are excellent methods for women after delivery. These methods avoid the very small possibility of hormones effecting breastfeeding. The small risk of blood clots right after delivery is avoided. Barrier methods include:

- **Withdrawal** The man pulls his penis out of the vagina before he “comes” to keep the sperm from getting to the egg. This takes great self control, experience and trust. Effectiveness is only around 81% but increases greatly when a condom is used as well.
- **Spermicides (foam, cream, tablets, suppositories and film)** Chemicals that are applied in the vagina less than one hour before sex. Much more effective if used with a barrier method.
- **Male condoms** Offers protection against infection. This is especially important in the post-partum period when your uterine wall is healing. To be effective, your partner needs to use these each and every time.
- **Female condoms** Plastic tube that lines the vagina to prevent sperm from reaching the cervix. This method also protects against Sexually Transmitted Diseases (STIs). These are not intended for use with a male condom. You will need to choose one or the other.
- **Diaphragm and spermicidal jelly or cream** A soft rubber cup that covers the cervix and thereby blocks sperm from entering the uterus. Should be used with a spermicidal jelly or cream. Must be used prior to each and every time you have sex. You must be fitted for this device (even if you have one from before this pregnancy) at your postpartum visit. A diaphragm is left in place no shorter than six hours after sex and no longer than 24 hours. For each additional act of intercourse you must apply new spermicide. Do NOT remove the diaphragm when adding new spermicide.
- **Cervical cap and spermicidal jelly or cream** A soft rubber cup similar to the diaphragm but smaller. Should be used with a spermicidal jelly or cream. Must be used prior to each and every time you have sex. You must be fitted for this device (even if you have an old one) at your postpartum visit. You leave this in place no shorter than six hours after sex and no longer than 48 hours. You can use the cervical cap for up to 48 hours of protection.
- **Intrauterine device (IUD)** Small, flexible plastic frame inserted into the uterus through the vagina. These are effective up to 10 years depending on type. If you would like this method, discuss it with your health care provider prior to your postpartum visit so arrangements can be made for its insertion postpartum.

- **Permanent sterilization** A woman can obtain a tubal ligation or a man can have a vasectomy if absolutely sure future children are not desired. These methods are more than 99% effective. Institutions will vary on requirements (often they will require you to be over the age of 21 and have signed a consent at least 30 days in advance) to have this procedure performed. If this interests you, talk to your health care provider early on in your pregnancy. Tubal ligation can often be done prior to leaving the hospital, if arranged for in advance.

Lactational Amenorrhea Method (LAM) for breastfeeding women

This method provides some protection against pregnancy for up to six months postpartum if: you have not had your first period since delivery; you are solely breastfeeding your baby; your baby is breastfeeding at intervals that do not exceed four hours during the day and six hours at night. The use of a condom with foam and/or withdrawal increases effectiveness.

Options for women who are breastfeeding

It is recommended that breastfeeding women avoid using combined oral contraceptives (those that have both estrogen and progesterone) for the first 30 days after delivery to decrease the risk of a blood clot and potential effect on milk supply. After 30 days, there is no impact on future milk supply and the risk of a blood clot returns back to baseline and combined contraceptive methods are considered safe. Progesterone-only methods include:

- **Progesterone only pills (POPs or minipills)** May be started any time postpartum when breastfeeding. Even immediately postpartum is safe.
- **Progesterone injection** This method is a liquid form of progesterone and is very effective in preventing pregnancy for 12 weeks. Several medical treatment facilities will give this injection prior to discharge from the hospital.
- **Implanon** A single rod implantable device that is placed in your upper arm and is effective three years. The most common side effect is irregular bleeding. This method is greater than 99% effective. If Implanon is offered where you deliver, it is safe to place immediately after delivery, and while breastfeeding.

Options for women who are bottle-feeding Combined oral contraceptives can be started three weeks after delivery for almost all women. Waiting the three weeks allows for the recommended vaginal rest and avoids the period of peak risk for postpartum blood clots.

- **Oral Contraceptive Pills/NuvaRing/Ortho Evra Patch** All of these contain estrogen and progesterone. They are easy to use and effective. Your provider can give you a prescription for these prior to your discharge from the hospital after you deliver. They are safe to use 3 weeks after delivery for most women.
- **Progesterone injection** A progesterone injection given prior to discharge from the hospital is effective immediately and lasts for 12 weeks from date of injection.
- **Progesterone only pills (POPs)** Prescribed for women who wish to avoid the estrogen found in combined oral contraceptives. These may be started immediately after delivery.
- **Implanon** A single rod implantable device that is placed in your upper arm and is effective three years. The most common side effect is irregular bleeding. This method is greater than 99% effective.
- **Combined hormonal injection such as Lunelle®** an injection given every four weeks containing both estrogen and progesterone.

These methods are not effective and should not be used if you do not want to become pregnant, when in doubt, check with your health care provider:

- Breastfeeding: if you miss any feedings, are ill, baby gone etc. you could ovulate and become pregnant.
- Withdrawal of the penis
- Fertility awareness immediately after delivery

The following are not birth control methods and should never be used to prevent pregnancy:

- Feminine hygiene products
- Douching
- Urinating after sex

Effectiveness and Side Effects of Various Birth Control Methods

Method	% Pregnant within First Year	Advantages	Side Effects
No Birth Control Used	85 out of 100		Pregnancy and no protection against STIs.
Pill: (Oral Contraceptive Pill) Progestin only or Estrogen & Progesterone combined pills	9 out of 100 9 out of 100 9 out of 100	Easy to use and very effective. Periods are usually lighter, regular with less pain. Studies have shown women using the Pill have less ovarian and uterine cancer in later life, less acne, less Premenstrual Symptoms, less anemia (iron poor blood).	POPs (mini pills): Irregular bleeding, weight gain, breast tenderness, less protection against ectopic pregnancy. Combined: Dizziness, nausea, changes in menstruation, mood, and weight; rarely, cardiovascular disease, including high blood pressure, blood clots, heart attack, and strokes. Serious side effects very rare. Neither pill protects against STIs.
Vaginal Ring	9 out of 100	Place into vagina for 3 weeks then remove. You don't have to worry about taking pill every day, getting an injection or using something prior to sex each time. Similar to oral contraceptive-combined pill.	Similar to oral contraceptive-combined pill. Male may feel it with sex. Can't store in hot location; it releases hormone. No protection against STIs.

Effectiveness and Side Effects of Various Birth Control Methods

Method	% Pregnant within First Year	Advantages	Side Effects
Contraceptive patch	9 out of 100	Once a week patch. Ability to become pregnant quickly returns when stopped. Advantages similar to the oral contraceptive - combined pill.	Similar to oral contraceptives-combined pill. Less effective for women over 198 pounds. Skin irritation. No protection against STIs.
Intra-Uterine Devices	Less than 1 out of 100	Effective up to 10 years depending on type. Do not have to think about it before sex.	Pain, bleeding, infection. No protection against STIs.
Progesterone Injections	6 out of 100	Usually no periods after a few months. May help breastfeeding women have more milk.	Irregular bleeding, weight gain, breast tenderness, headaches. No protection against STIs.
Implanon	Less than 1 out of 100	Effective up to 3 years. Fertile in about 2-4 months after removal. Do not have to think about it before sex.	Irregular, unpredictable bleeding. Serious side effects very rare. No protection against STIs.
Male condoms	13 out of 100	Protection against most STIs. Can use as soon after delivery as needed. Inexpensive and does not require a prescription.	Irritation and allergic reactions (less likely with polyurethane), must use with each time, can break or fall off. Should use with spermicides.

Effectiveness and Side Effects of Various Birth Control Methods

Method	% Pregnant within the First Year	Advantages	Side Effects
Female condoms	21 out of 100	Protection against most STIs. Can use as soon after delivery as needed. Inexpensive and does not require a prescription.	Irritation and allergic reactions (less likely with polyurethane), must use with each time, can break or fall off. Should use with spermicides.
Diaphragm with spermicide	21 out of 100	No drugs or chemicals are absorbed into the body. Does not affect your period.	Irritation and allergic reactions, urinary tract infection. Risk of Toxic Shock Syndrome, a rare but serious infection, when kept in place longer than recommended. No protection against STIs.
Cervical cap Women with children Women without children	36 out of 100 18 out of 100	No drugs or chemicals are absorbed into the body. Does not affect your period.	Irritation and allergic reactions, abnormal Pap test. Risk of Toxic Shock Syndrome, a rare but serious infection when kept in place longer than recommended. No protection against STIs.
Spermicides	26 out of 100	Inexpensive and do not need a prescription. Much more effective if used with a barrier method (condom, diaphragm, cervical cap).	Irritation and allergic reactions, urinary tract infections. No protection against STIs.

Effectiveness and Side Effects of Various Birth Control Methods

Method	% Pregnant within the First Year	Advantages	Side Effects
Withdrawal	19 out of 100	Nothing to buy, inject or put on.	Takes lot of self-control, presence of sperm in fluid prior to ejaculation. Not effective. No protection against STIs.
Fertility awareness (<i>Natural Family Planning</i>)	23 out of 100	No physical health risks to its use and can also be used to get pregnant. Need to know how to record daily basal body temperature and note cervical mucus.	Difficult to learn this method after delivery because your cycles will not be regular. Involves careful checking and recording of daily body signs. No protection against STIs.
Male sterilization: Vasectomy	0.15 out of 100	Done only once and highly effective.	Pain, bleeding, infection, other minor post surgical complications. No protection against STIs.
Female sterilization: Tubal Ligation	0.5 out of a 100	Done only once and highly effective.	Pain, bleeding, infection, other post-surgical complications. No protection against STIs.
Emergency contraceptives (<i>morning after pills</i>)	Reduces pregnancy from single episode by 80%	Only method that can be used after intercourse to prevent a pregnancy. Effective as a back-up method to other methods.	Nausea, vomiting, abdominal pain, fatigue, headache. No protection against STIs.

Effectiveness and Side Effects of Various Birth Control Methods

Method	% Pregnant within the First Year	Advantages	Side Effects
Lactation Amenorrhea Method (LAM)	2 out of 100	Nothing to take therefore no risks to baby or you.	Only effective if not giving supplements, and feeding every 4 hours in the day and every 6 hours at night. Much more effective if used with condoms, or other barrier methods.

Listing of medications/drugs does not represent endorsement by VA/DoD

Notes:

Breastfeeding

Among the many things you must consider before you deliver is how you will feed your infant(s). More and more mothers are choosing to breastfeed, because it is one of the most important contributors to a baby's health. Additional benefits are that breastfeeding helps you feel and be healthier and saves money. Breastfeeding is recommended for the first two years of a baby's life. Many studies have shown that any amount of breastfeeding is beneficial. It is important to know that there are a number of resources available to help you succeed.

Learning as much as you can about breastfeeding early in your pregnancy is the best preparation. The more comfortable you feel with breastfeeding, the easier it will be for you. There are a number of books, pamphlets, and web based resources you can use. Ask your doctor or the nursing staff in the clinic for information regarding local lactation resources.

Benefits to Mom

- Breastfeeding relaxes you – when you breast feed, hormones are released which calm and relax you.
- Breastfeeding saves money by reducing or eliminating the cost of buying formula.
- Breastfeeding reduces health care costs.
- Breastfeeding is convenient – no mixing or measuring.
- Breastfeeding burns extra calories, so it makes it easier to lose the pounds you gained during your pregnancy.
- Breastfeeding helps the uterus to get back to its original size and lessens any bleeding you may have after giving birth.
- Breastfeeding can help you bond with your baby - physical contact is important to a newborn and can help them feel more secure, warm and comforted.
- Breastfeeding is associated with decreased risk of breast cancer, heart disease, osteoporosis, and depression.

Benefits to Baby

- Breast-fed babies have a healthier start in life, because breast milk contains all the nutrients baby needs, regardless of whether your baby is premature or full term.
- Breast milk has the perfect mix of nutrients for your baby's digestive system.
- Breast milk protects a baby from many illnesses such as diarrhea, ear infections, respiratory tract infections, diabetes, urinary tract infections, and severe bacterial infections.
- Breast milk is always the right temperature for your baby.
- Breast-fed babies are less likely to become overweight.

- Breastfeeding promotes the proper development of jaw and facial structures.
- Breast milk aids in the development of baby's brain and nervous system.
- Breastfeeding is associated with decreased risk of chronic conditions such as obesity and diabetes.
- Some studies even indicate that breast-fed babies have higher IQs than formula fed babies.

Myths and Truths

There are many myths or "old wives tales" and breastfeeding has more than its share of them. Listed on the next page are just a few of the more common myths that you may have heard and the truth behind them.

Breastfeeding Myths and Truths

Myth	Truth
<i>You need large breasts to make enough milk.</i>	Shape and size is due to the layers of muscle and fat. Size has no effect on milk production.
<i>You cannot work and breastfeed.</i>	Breast milk can be expressed and stored for feeding the baby while you are at work.
<i>You cannot smoke and breastfeed.</i>	The American Academy of Pediatrics states that it is better to breastfeed than formula-feed even if you smoke. If you do smoke, try to cut down as much as possible. Do not smoke right before breastfeeding and never smoke in the house or anywhere around the baby. Second-hand smoke increases the incidence of pneumonia, bronchitis and SIDS in your baby.
<i>You cannot use birth control and breastfeed.</i>	All birth control methods are safe and won't negatively effect breastfeeding if started 4 weeks after delivery.
<i>You cannot become pregnant while breastfeeding.</i>	Exclusive breastfeeding (no pacifiers or bottles) can delay ovulation for some women. The Lactational Amenorrhea Method (LAM) is more effective when used with another birth control method such as condom. If you plan to use this method of birth control, talk with your health care provider for details.
<i>You will be tied down.</i>	A breast-fed baby is very portable. You do not have to carry extra gear with you. If you return to work or need to be away from your baby, you can express milk for a baby sitter.
<i>You must drink milk to make milk.</i>	Cow's milk is an inexpensive source of calcium and protein. It is not necessary to drink milk in order to produce breast milk. You can get calcium by eating dairy products, collards, canned salmon, calcium enriched tofu, and juices. Other good protein sources are meats, eggs, peanut butter, soy/tofu, legumes/dried beans and nuts/seeds.
<i>Each member of the family has to feed the baby to bond too.</i>	Bonding can occur in a variety of ways such as: cuddling, playing, holding, talking or reading to and rocking the baby. Holding a baby skin to skin is one of the best ways to bond with baby.
<i>You cannot breastfeed if you have had breast surgery (augmentation or reduction).</i>	Mothers who have had breast surgery can breastfeed their babies. Milk production may be reduced and supplementation with formula may be needed. Contact a lactation consultant to discuss the best way to successfully breastfeed after breast surgery.

Diet

- Eat well to feel well
- Eat at least 1800 calories daily
- You should have 1200mg calcium a day
- You need three or more servings of protein a day. See MyPlate Plan for Moms on page 129 for serving examples.
- Fluid intake:
 - Drink six to eight glasses (eight ounce) of non-caffeinated fluids a day
 - Drink when you are thirsty
 - Drink a glass water each time you nurse your baby
 - You may drink caffeinated drinks in moderation. If your baby has trouble sleeping, you may need to eliminate caffeine from your diet.

You do not have to avoid any particular food, unless you have a family history of allergy (shellfish, citrus, dairy, etc). You may eat anything you are used to eating. If your baby is fussy, it does not mean he is allergic to your milk. Babies can be sensitive to something you have eaten. Do not start eliminating foods from your diet. The most common food sensitivity is an excess intake of cow's milk. You may want to reduce or eliminate milk from your diet and see how baby reacts. Usually baby will improve within one to three days.

Supplies

Nursing bras: These will support your breasts and make breastfeeding a lot more convenient. It is recommended that you buy your nursing bras in the last month or two of your pregnancy when your breasts have already increased in size. Sometimes, breasts do not increase in size until after delivery. You may need to purchase a new bra after your milk has come in and the swelling that accompanies your milk "coming in" has subsided (two to three weeks after delivery). When you buy your bras, make sure they're all-cotton, they fit comfortably around your rib cage when fastened on the loose setting, and there is extra room in the cup. A tight bra is uncomfortable and can cause sore nipples, plugged ducts, and breast infections. When trying on nursing bras, make sure you can open the nursing flap with one hand (so you will not have to put baby down each time you feed). Purchase one or two bras to see if you like them, then buy more as needed. *If you are a Veteran, check with your Maternity Care Coordinator to assist with obtaining up to two nursing bras.*

Nursing shirts: Most maternity stores sell clever nursing shirts. These shirts are great, because they are attractive, most people do not know they are for nursing, and they make it easier to breast feed while you are learning. Some mothers are comfortable wearing large T-shirts. Button front tops and two-piece sets work well once you're comfortable with breastfeeding. Some mothers like nursing cover ups or drapes that cover mom/baby when breastfeeding in public.

Nursing pads: These are placed in your bra to protect your bra and clothes. At the beginning, many mothers experience periodic leaking of their

breast milk. Pads range from disposable to washable cotton to silicone. Change pads frequently, especially in warm weather, to prevent yeast infection/bacteria growth. Nursing pads may only be needed the first few weeks.

Pumps: A pump is useful to have for a few reasons. You may need to be away from your baby for short time periods, so you will need to provide your babysitter with some breast milk to feed your baby(ies). If you plan to return to work, you'll need to pump your breasts to maintain your milk supply. An electric pump can be rented or purchased. This is the most efficient type of pump.

Most electric pumps can pump both breasts at the same time. Manual or mini-electric pumps are less expensive and more portable, but not as efficient. Most manual pumps will pump only one breast at a time. Your health care provider or other breastfeeding expert can help you with questions about getting and using a pump that will meet your needs. If you are a Veteran, talk to your Maternity Care Coordinator about obtaining a pump.

Hand expression (nothing to buy): Hand or manual expression of breast milk is a good skill to learn even if you plan to purchase a pump. It is definitely the most portable of all methods and costs nothing. Some women express as much milk by hand as they can by using a pump. You may find it helpful for someone to demonstrate this technique for you. Ask your health care provider or breastfeeding expert for guidance.

Breastfeeding and working

Working mothers who breastfeed say that breastfeeding is easier for them than using formula because:

- They have babies who are sick less often
- Night feedings are faster
- Giving breast milk to their babies makes them feel close even when they are away at work
- They are able to continue breastfeeding at home

Let your supervisor know that you plan to continue breastfeeding when you return to work, so you can locate a clean, private area where you can pump your milk. You will need to pump on breaks and during lunch, so you will need to talk about some flexibility in your work schedule. Your breaks should not take longer than 15 - 20 minutes if you use a double pump. Milk can be stored in a refrigerator or a cooler with ice packs.

Expressed breast milk (EBM)

Expressed breast milk can be used to feed your infant while you're away. Your health care provider or other breastfeeding expert can help you with questions about expressing breast milk and help you to determine a plan that is best for you. You may begin expressing milk for storage after two to three weeks of nursing. Check with a lactation consultant or lactation center to assess your pumping needs. Hospital grade electric pumps are available for rent. Personal use double electric breast pumps are quite efficient and more cost effective than renting.

You can choose one or more of the following methods for expressing milk:

- Hand expression - This means not using a mechanical pump. Some women express as much milk by hand as they can by using a pump.
- Rent or buy an electric pump - If you are a Veteran, talk to your Maternity Care Coordinator about obtaining a pump. This is the most efficient type of pump. If you get one that pumps both breasts at the same time, expressing takes a total of 10 - 15 minutes.
- Buy a mini-electric, battery operated or manual pump - These are less expensive, but not as efficient as an electric pump. Most will only pump one breast at a time. They are best used for occasional pumping.
- Milk Expression Pointers
 - Always wash your hands before you begin.
 - Empty your breasts on a routine schedule to help maintain your milk supply.
 - It is helpful to express your milk on your baby(ies) nursing schedule.
 - Gently massage your breasts before expressing your breast milk.

Storing expressed breast milk

Since many consider breast milk to be a “living substance”, storage is an important thing to consider. Breast milk actually has anti-bacterial properties that help it stay fresh. There are many resources available to answer any questions you might have. Talk with your health care provider or lactation consultant. Keep the following guidelines in mind when expressing milk.

- All milk should be dated before storing.
- The containers used should be washed in hot, soapy water and rinsed well.
- Milk may be stored in hard-sided plastic or glass containers with well-fitted tops or in freezer milk bags designed for storing human milk.
- Breast milk can be stored:
 - At room temperature for up to six hours (Note: the warmer the room, the less time the milk should be left unrefrigerated)
 - In an ice chest/cooler with frozen gel packs for up to 24 hours
 - In a refrigerator for up to eight days
 - In a freezer compartment inside a refrigerator (variable temp due to door opening frequently) for up to two weeks
 - In a freezer compartment with separate door for up to six months (keep in the back of freezer, not on door)
 - In a separate deep freeze for up to 12 months
- When using frozen milk it should be defrosted in the refrigerator. Thawed milk can be safely kept in the refrigerator but must be used within 24 hours. Freeze breast milk in small quantities to avoid waste.

- Breast milk should not be refrozen
- Breast milk in containers should be swirled, not shaken hard
- Thawing breast milk containers
 - Never use the microwave to thaw breast milk
 - Thawing should take place under warm, running water
 - Frozen milk may be placed in the refrigerator or in a bowl of warm water.

Breastfeeding after Cesarean Delivery

It is very possible to breast feed after a cesarean delivery. Be sure to tell your health care provider if you want to do this, so that he/she can make provisions to help you. You can also write this in your birth plan. Some helpful hints include:

- Nurse as soon as possible after delivery as baby will become sleepy soon after birth. Keep baby skin to skin for the first hour after delivery or until after the first breast feeding. Most procedures and infant measurement/assessment may be delayed until after the first feeding. Many facilities are changing their routines to get your healthy baby(ies) to you within one to two hours after delivery.
- Take pain medications as needed; they will not hurt your baby and you will be more comfortable.
- Get help, especially if baby is not latching on or nursing well.

Breastfeeding Challenges

Sore nipples: Studies have shown that the majority of breastfeeding women experience some nipple soreness. In about a quarter of these moms, the soreness progresses to cracking and extreme nipple pain. The most frequent causes of sore nipples are incorrect positioning and poor infant latch.

The first two to four days after delivery, your nipples may feel tender at the beginning of a feeding as your baby's early sucking stretches your nipple and areolar tissue. If a baby is positioned well at the breast, this temporary tenderness usually diminishes once the milk lets down and then completely disappears within a day or two.

Some common treatments for sore nipples include:

- Massage your breast to encourage breast milk flow and emptying of your breast.
- Short frequent feedings are far more beneficial than long extended periods of feeding and reduces the likelihood of the infant being too vigorous at the breast and too irritable.
- Bathing a crack in the nipple with freshly expressed breast milk. This is both soothing and naturally healing.

- If you desire to use a “nipple cream”, use anhydrous lanolin. This is the only cream/ointment recommended for use on nipples. Apply a thin layer to each nipple after breastfeeding.
- Learn proper positioning of your baby at your breast. One position is for the baby to be positioned nose to nipple, and tummy to tummy with you. The baby’s chin should be just below the nipple, and pressed to the breast. The baby needs to open wide to take in a good mouthful of breast. Never let someone push your baby’s head onto the nipple. Instead, keep the shoulders and neck well supported but the back of the head free. Babies tend to resist pressure on the back of their head.
- Talk to your health care provider, your lactation consultant or your nearest La Leche League if the above remedies don’t help

Avoid:

- Placing wet tea bags on your nipples. Tannic acid in the tea can act as an astringent causing drying and cracking, rather than healing.
- Using a hair dryer or sun lamp to dry the skin.
- Most commercial preparations sold for the treatment of sore nipples. They are not useful and some may even cause harm.
- Toughening nipples prior to breastfeeding. This may cause damage and does not help with breastfeeding.

Tingling sensations: After baby has nursed for a few minutes many (but not all) women feel a tingling sensation followed by a strong surge of milk. This is known as the “let down” response and is natural and expected. This can happen with nursing, with just seeing a baby, hearing a baby cry or even thinking about your baby. Often this let down is accompanied by leakage of milk from both breasts. To stop the milk from leaking, gently press on your nipples with a clean cloth or with your forearm. Some women wear nursing pads (without plastic liners) to help prevent leaking.

Engorgement: You will most likely feel your breast milk come in (usually around two to four days after delivery). This is especially true if it is your first time breastfeeding. For first time moms who breast-feed, within a relatively short time period (sometimes only a few hours) your breasts become swollen, and may become painful and difficult for baby to latch on to. These are signs that your breasts are making the final changes necessary to make milk for your baby. This lasts only a few days at most. It is caused by blood engorgement (swelling) that comes with filling of the breast and usually goes completely away by day ten.

If this is not your first baby, you probably will not experience engorgement, even though you are producing more milk now than you were at this time with your last baby. This is often perceived as decreased milk supply, but is not the case. Usually engorged breasts feel much better within 12 - 24 hours of practicing the following comfort measures:

- Gentle breast massages: stroking the breast from the outer edges to the nipple area, especially when in a warm shower or in dependent position.
- Warm packs followed by expressing some milk before feedings.
- Breast feed baby frequently. As many as 8 - 12 feedings per 24 hours is expected. Your baby may feed every one to three hours.
- Start your feedings on the least sore side.
- You may use over the counter pain relief medications such as Motrin® or Tylenol®, if needed. Consult with your health care provider for the best medication for you.
- After breastfeeding, if you are engorged, you may apply cold compresses to your breasts intermittently (10 minutes on/20 minutes off) to help reduce swelling.

Plugged ducts: Occasionally the ducts that store milk inside your breasts can become blocked and inflamed causing a very tender spot, redness or sore lump in the breast. There are many causes including: improper positioning of the baby at your breast, too long between feedings, supplementary bottles, overuse of pacifiers, dried milk secretions covering one of the nipple openings, or wearing tight nursing bras or other restrictive clothing.

To remedy this:

- Loosen all constrictive clothing, especially your bra. Avoid underwire bras.
- Rest often.
- Massage your breasts to help release milk from ducts prior to putting your infant to breast.
- Apply warm compresses to the affected area and massage any lump(s) to help promote release of the plug.
- Nurse your baby on the affected side frequently.
- Change nursing positions often to put pressure on different ducts.
- Clean nipples to ensure no milk is blocking the ducts.
- Make sure the sore breast gets emptied of milk either by nursing your baby or expressing the milk by hand or pump.
- Soaking the sore breast in a basin of warm water may help.
- **DO NOT STOP OR SLOW DOWN ON FEEDINGS** as this can add to the problem.

Since plugged ducts can lead to infection, it is important to remedy the situation as quickly as possible. If symptoms do not resolve within 24 hours or your pain gets worse, call your health care provider or lactation consultant for assistance.

Breast infections: If you notice the signs of a plugged duct becoming more severe and combined with fever or flu-like symptoms, you could have a breast infection called mastitis. You need to treat a breast infection *immediately*. Continue breastfeeding! Apply heat to the affected area, massage breast and try to get plenty of rest. If these steps don't resolve the symptoms within 24 hours, call your provider without delay. You will most likely be treated with antibiotics and mild pain relievers. While taking the medications you will also need plenty of rest, increased fluid intake, moist heat applications to your breasts and frequent nursing beginning with the infected breast. Let your health care provider or lactation consultant know if you have history of mastitis.

Bottle Feeding

Feeding time is an important time for you and your baby to get to know and love each other. This is true whether you breastfeed or bottle feed. Always use feeding time to share comfort and closeness.

Do not give your baby anything but breast milk or iron fortified formula until instructed by your health care provider. Any commercial infant formula is adequate for normal infant growth. In the first months, the baby will take two to four ounces every two to four hours. Follow the instructions on the can carefully. Some formulas are “ready to feed” and don’t need added water, others are concentrated and have to be diluted. If your baby has problems with the brand of formula you are using, contact your health care provider before switching to another formula.

Always check the expiration date and the lot number on the formula cans. Do not use dented, leaking, or damaged containers of formula, since these could have bacteria in them.

- If you are using tap water to mix the formula, let the water run for several minutes before you add it to the container. You do not have to boil the water. Do not keep uncovered formula cans in the refrigerator.
- Warm the milk by setting the bottle in warm water (never in the microwave).
- Once you have warmed the bottle (or removed it from the refrigerator), it should be given immediately. Hold the baby with his/her head higher than his body and touch the nipple to his lips. Let baby open his/her mouth to take the nipple. Do not force the nipple in.
- Never prop the bottle or put the baby to bed with a bottle. This can lead to choking and it causes tooth decay.
- Let the baby decide when he/she has had enough. If baby refuses the bottle, try burping. If baby still refuses to eat after burping, stop until the next feeding.
- A healthy baby will stop eating when full.
- Throw away the formula or breast milk left in the bottle from that feeding. Rinse the bottle and nipple after use with cold water. It makes clean up easier.
- Bottles and nipples can be washed in the dishwasher or in hot, soapy water.
- Breast milk digests easier than formula. Breast-fed babies (or those taking breast milk from a bottle) may feed more often than formula fed babies.

Bottle feeding supplies

- Baby bottles and caps
- Nipples
- Bottle and nipple brush
- Measuring cups

Notes:

Safety Tips for Baby

• General

- Never shake or toss your baby in the air - it can cause brain damage, blindness or even death.
- Be sure anyone having direct contact with your baby always washes their hands first.
- Have your infant seen by a pediatric provider at 2 weeks, 2 months, 4 months, 6 months, 9 months and 1 year of age.
- Avoid direct sun exposure during the first few months of life.
- Never leave a baby unattended in any water. One inch of water is enough for a baby to drown in.
- Never leave baby alone on any surface above the floor. Don't put your baby in an infant seat on the counter or table.
- Never hang anything on baby's stroller as this can cause it to tip over.

• Sleeping

- Always place baby on his or her **back to sleep**.
- Infants must sleep on a firm surface, such as a safety approved crib mattress covered by a fitted sheet. Never place your infant on pillows, quilts, sheepskins, or other soft surfaces.
- Keep soft objects, toys, and loose bedding out of the infant's sleep area. Never use a pillow in the crib.
- Do not allow smoking around the infant.
- The infant should not sleep in a bed or on a couch/arm chair with adults or other children. The infant may sleep in the same room as you.
- You may offer a clean, dry pacifier when placing the infant down to sleep, but don't force the infant to take it. For the strictly breastfed infant, a pacifier may be introduced when a good breastfeeding pattern has been established.
- Avoid products that claim to reduce the incidents of Sudden Infant Death Syndrome (SIDS) because most have not been tested for effectiveness or safety.
- Crib slats should be no farther apart than 2 inches (6 cm).
- Keep crib away from drapery and blind cords, heaters, wall decorations, and other potential hazards.
- Keep mobiles and other crib toys out of baby's reach.
- Never give a baby a bottle in the bed.

- **Car Seat Safety**

- Infant should be in a properly installed, safety approved car seat when vehicle is moving - never in your arms.
- Never place a rear facing seat in front of a passenger side airbag.
- Infants must ride in the back seat facing the rear for as long as possible until the infant or toddler meets the maximum weight or height allowed for the seat.
- Have a certified passenger safety technician check your car seat installation.

- **Feeding**

- Never prop a bottle or leave baby alone with a bottle.
- Do not microwave baby's bottle.
- Never attach a pacifier around baby's neck.
- Shake or stir all bottles and food before giving to baby.

Analgesia

Medication used to reduce your ability to feel pain.

Anemia

Condition in which your blood has decreased oxygen carrying ability as a result of low number of cells (hematocrit) or a decrease in hemoglobin. Adequate intake of iron in the diet can help prevent iron deficiency anemia.

Anesthesia

Medication that causes a loss of feeling or sensation.

Amniocentesis

With the help of an ultrasound, a needle is inserted through your abdomen into your uterus and a small sample of amniotic fluid from the amniotic sac is taken to test for several genetic problems, as well as, for your baby's lung maturity. This test is usually performed between 16 and 20 weeks on women with risks for genetic problems. May be performed near due date when testing for maturity of baby's lungs.

Amniotic Sac

Fluid filled, thin-walled sac in which the fetus develops that is often called the "bag of waters." This sac protects the baby from injury and regulates its temperature.

Aneuploidy

A chromosomal abnormality where there are either extra or missing chromosome(s). This is a common cause of genetic disorders (birth defects). Occurs very early in pregnancy during cell division if chromosomes do not separate properly. Down Syndrome is a form of aneuploidy.

Antepartum

The period of time from conception to labor.

Antibody

Substance in blood that is produced in response to foreign protein to develop immunity.

Antigen

Substance that can induce an immune response and cause the production of an antibody.

Anus

Opening of the rectum located behind the vagina.

Asymptomatic Bacteriuria (ASB)

Bacteria in urine that does not cause any signs or symptoms of an infection. Occurs in two to seven percent of pregnant women and can lead to complications in pregnancy such as pre-term delivery and low birth weight babies. You are checked for this by a urine test at your first visit.

Bloody Show

Bloody discharge of mucus, which forms in the cervix and is expelled right before or at the beginning of labor.

Braxton-Hicks Contractions (False Labor)

Irregular tightening of the uterus you may feel as your body prepares for delivery; may be felt weeks before labor.

Cervix

The neck or opening of the uterus through which the baby passes during the birth process. The cervix projects into the vagina and is made up of mainly fibrous tissue and muscle. Labor contractions result in effacement (thinning or shortening) and dilatation (opening) of the cervix.

Cesarean Delivery (also referred to as Cesarean Section or Birth)

A surgical procedure where the baby is delivered through an incision in the mother's lower abdomen rather than through the vagina. Cesarean deliveries may be planned, unplanned or emergency. If you have had a prior cesarean delivery, you may be able to deliver future babies vaginally if your provider and hospital offer this service.

Chlamydia

Sexually transmitted infection that can cause pelvic inflammatory disease, infertility, and problems during pregnancy. This is tested for at your 10 - 12 week appointment through a speculum (pelvic) exam and can be treated with antibiotics.

Chorionic Villus Sampling (CVS)

This procedure tests for the same genetic problems as an amniocentesis but it is performed earlier in your pregnancy (usually between your 10th and 14th week). With the help of an ultrasound to see inside your uterus, a needle is inserted through your abdomen and into your uterus to take a small sample of cells from the placenta for testing. The risks involved include a 1/10 to less than 1/1000 risk of miscarriage. There is also a risk of limb defects (especially when done before 10 weeks gestation).

Contraction

The shortening and tightening of the uterus, which results in the dilation (opening) and effacement (thinning or shortening) of the cervix.

Crowning

The bulging out of the perineum as the baby's head or presenting part presses against it at time of delivery.

Cystic Fibrosis

A genetic disease that is inherited from both parents and causes life-long illness affecting breathing and digestion. A blood test can tell if you or the baby's father carries this trait. If both of you carry the Cystic Fibrosis trait, your baby has a 25% chance of acquiring the disease. Usually the woman is tested first; then, if positive, the father of the baby will be tested. You may sign a consent form to have this test performed.

Doppler

Device that allows your baby's heartbeat to be heard through a speaker.

Doula

An assistant who provides various forms of non-medical support to women in child-birth process.

Down Syndrome (Trisomy 21)

Genetic disorder caused by the presence of an extra chromosome and characterized by mental retardation, abnormal features of the face, and medical problems such as heart defects. Chances of your baby carrying this disorder increase with increasing age of the mom. This can be tested for between 15 and 20 weeks of your pregnancy.

Elective Repeat Cesarean Delivery

A planned cesarean delivery in a woman who has had one or more prior cesarean deliveries. The delivery may or may not be scheduled.

Embryo

The developing organism from about two weeks after fertilization to the end of the seventh or eighth week.

Epidural

Type of regional anesthesia in which medication is inserted into the spinal space through a small plastic tube.

Estriol

Hormone made by the placenta and the fetal liver. The estriol level is measured as part of the Maternal Serum Analyte Screen (Triple or Quad Screen).

Fetus

A developing baby in the uterus after the eighth week of gestation until birth.

Forceps

An instrument placed on both sides of the baby's head, while in the birth canal, to gently guide the baby out if needed.

Fundal Height

Measurement from the pubic bone to the top of the uterus (fundus). Routinely used to measure the growth of the baby in the uterus from 20 to 36 weeks gestation.

Gestation

Development of the new baby within the uterus from conception to birth.

Gestational Hypertension

A condition associated with the terms pre-eclampsia or toxemia. This is high blood pressure that develops during pregnancy. High blood pressure during pregnancy may cause many complications for both mother and baby. Some of the biggest concerns include pre-eclampsia, eclampsia and placental abruption (when placenta pulls off uterus prior to birth). You will be monitored for this condition throughout your pregnancy with blood pressure checks at each visit and lab work, if needed.

Gonorrhea (GC, the clap)

Sexually transmitted infection that may lead to pelvic inflammatory disease, infertility, and arthritis. It is tested at your 10 to 12 week visit by taking a sample of your vaginal secretions. It can be treated with antibiotics.

Group B Streptococcus (GBS)

A bacteria commonly found in the vagina and the rectum. GBS grows in the vagina or rectum in about 10 - 40% of women and rarely causes symptoms. In pregnancy, it can increase your chances of infection of your amniotic fluid and serious infection in your baby. A different type of streptococcus bacteria causes the condition known as "strep throat." To find out if you have any GBS, vaginal and rectal secretions are collected between the 35th and 37th week of your pregnancy. If you are found to have GBS, antibiotics during your labor are given to protect your baby from these bacteria.

Hematocrit

Blood test that measures the number of cells in your blood. This test shows whether you are anemic (low in iron).

Hemoglobin

Blood test that measures your oxygen carrying ability of your blood and gives information on whether you are anemic (low in iron).

Hepatitis B Virus

Attacks and damages the liver, causing inflammation, cirrhosis, and chronic hepatitis that can lead to cancer. This is tested for at your first prenatal visit. It can be transmitted to your baby and infect the baby. If you think you have been exposed to this you will be tested, and given a vaccine. If you have the disease, you will receive treatment that greatly reduces your baby's risk of getting the disease.

Human Immunodeficiency Virus (HIV)

Attacks certain cells of the body's immune system and causes Acquired Immuno-Deficiency Syndrome (AIDS). There is a blood test which can be drawn at your first prenatal visit to determine if you have the disease. If you test positive, you can receive treatment that can greatly reduce the baby's risk of getting the infection.

Human Papilloma Virus (HPV)

Sexually transmitted infection characterized by soft wart like growths on the genitalia. Commonly referred to as genital warts. Pregnancy can cause warts to increase in size or appear for the first time. Usually no treatment is needed and they go away on their own after the delivery. If the warts grow very large and obstruct the birth canal, treatment and/or cesarean section may be needed. HPV infection can also be without symptoms and only show up years later as a result of a pap test. Certain strains of HPV have been linked to increased cervical cancer.

Induction of Labor

Artificially cause labor to start by giving medications such as Pitocin or prostaglandin or rupturing the bag of water.

Iso-immunization

Occurs when an Rh (D)-negative mom develops antibodies to her baby's Rh (D) positive blood. RhoGAM injection prevents this from occurring to protect the baby and future pregnancies.

Labor

The series of uterine contractions that dilate (open) and efface (thin out) the cervix for birth.

Libido

Sexual desire.

Maternal Serum Analyte Screen

Group of blood tests, also known as a Quad Screen, that check for substances linked with certain birth defects such as Down Syndrome (Trisomy 21), neural tube defects, Edwards Syndrome (Trisomy 18) and other related birth defects. The test is done during the 15th to 21st week of your pregnancy. If you get an abnormal test result, your pregnancy will be further evaluated. This test has many false positives.

Maturation

Achievement of full development or growth.

Meconium

Baby's first bowel movement, usually passed after birth. When it is passed before birth, it stains the amniotic fluid and may be a sign of fetal stress or fetal maturity. When this occurs, it is referred to as meconium staining.

Mucous Plug

A collection of cervical mucus that seals the opening of the cervix. It keeps bacteria from entering into the cervix, providing a protective barrier for the baby. As the cervix opens, the mucous plug may fall out. It may be noticed as a thick glob of stringy mucus, usually thicker than what is seen with normal vaginal secretions. Some women will lose their mucous plug or part of their mucous plug weeks before they go into labor. Losing the mucous plug does not always mean labor will begin shortly. Women with a history of preterm labor, or who have blood tinged mucus before 36 weeks should call their provider right away. After 36 weeks, loss of the mucous plug is of no concern.

Neonatology

Branch of medicine that specializes in the care of ill or premature newborns.

Neural Tube Defects (NTDs)

Birth defects that result from improper development of the brain, spinal cord, or their coverings. This can be tested for between 15 and 21 weeks in your pregnancy with a Maternal Serum Analyte Screen blood test, and by other methods.

Non-Reassuring Fetal Heart Rate

Fetal heart rate pattern changes that raise concern that baby may not be getting enough oxygen.

Pap Test

Cells are taken from the cervix and vagina by gentle scraping and examined to check for abnormalities that may lead to cervical cancer.

Perinatologist (Maternal Fetal Medicine Specialist)

Obstetrician with specialized training to provide care for women with complicated pregnancies.

Perineum

The surface area between the vagina and anus in females; between the scrotum and anus in males.

Placenta (Afterbirth)

An organ of pregnancy attached to the wall of the uterus where oxygen, nutrients, and waste exchange takes place between the mother and fetus. It usually delivers within 30 minutes of the baby's birth.

Postpartum

The 6-week period following childbirth.

Pre-Eclampsia

A condition in pregnancy when blood pressure rises, and it may be associated with abnormal lab tests as well. This increases the risk of seizure and other complications in the mother.

Quad Screen - see Maternal Serum Analyte Screen

RhoGAM®

A medication given through an injection (shot) at 28 weeks to Rh (D-) negative women to prevent iso-immunization. If baby is Rh (D) positive, the new mother will receive another injection after delivery.

Rubella Test

Blood test taken at your first visit to see if you are protected against Rubella (German measles). If you are not protected against this disease, you are encouraged to avoid anyone who has or may have this disease. You are also encouraged to get immunized against this disease after you deliver.

Sexually Transmitted Infection (STI)

An infection spread by sexual contact: Gonorrhea, Syphilis, Chlamydia, HIV, HPV, Hepatitis B, Trichomonas, and Herpes Simplex Virus (HSV).

Syphilis

Sexually transmitted infection that is caused by an organism called Treponema Palladium; it may cause major health problems or death in its later stages. The blood test is taken at your first prenatal visit.

Trial of Labor (TOL)

A planned attempt to labor in a woman who has had a previous cesarean delivery, also known as trial of labor after cesarean (TOLAC).

Ultrasound

Through the use of sound waves, this technology gives a live black and white picture of your baby. Routinely performed at 18 - 22 weeks gestation to screen for problems and confirm your due date.

Umbilical Cord

A fetal structure that connects the fetus to the placenta; contains two arteries and one vein to provide blood flow between the fetus and placenta.

Unsuccessful Trial of Labor

Delivery by cesarean in a woman who has had a trial of labor - sometimes referred to as a “failed” trial of labor.

Uterus (womb)

The hollow muscular organ in which an unborn baby develops and grows. The muscles of the uterus contract during labor and help push the baby out through the vagina.

Vacuum Extraction

Assist with delivery of baby out of the birth canal with application of a metal or plastic cup to baby’s head with suction from a wall or portable suction machine.

Vagina

Lower part of the birth canal behind the bladder and in front of the rectum.

Vaginal Birth after Cesarean Delivery (VBAC)

Vaginal delivery after a trial of labor by a woman who has had a previous cesarean delivery.

VDRL (Venereal Disease Research Laboratory - also called RPR)

Blood tests taken at your first visit to screen for Syphilis, a sexually transmitted infection. If you test is positive, you will be offered treatment and the risk to your baby will be discussed with you.

Types of Providers

Anesthesiologist

A physician specialized in pain relief.

Certified Nurse Midwife (CNM)

A registered nurse with a Master's degree and certification by the American Midwifery Certification Board. Nurse midwifery practice is the independent management of women's health care that focuses on pregnancy, childbirth, the postpartum period, newborn care, family planning, and the gynecological needs of women with an emphasis on education and health promotion. Services provided by a Certified Nurse Midwife (CNM) are covered. The CNM must be certified by the American Midwifery Certification Board, and state licensed (when required by state). Midwife services by a lay midwife, Certified Professional Midwife (CPM) or Certified Midwife (CM) are not covered.

Family Nurse Practitioner (FNP)

A registered nurse with advanced degrees specializing in the treatment and care for patients of all ages. FNP's can provide prenatal care and coordinate care with a physician for delivery of the baby. FNP's do not deliver babies. It should be noted that the following services are non-approved maternity care: home deliveries; deliveries by direct-entry midwives (also known as lay midwives or Certified Professional Midwives); experimental procedures and medical procedures not consistent with the standard of care.

Family Practice (FP) Physician

A physician specially trained to provide medical care to patients of all ages, diagnose and treat all illnesses. They provide prenatal care and delivery services.

Genetic Counselor

A health professional with specialized education and experience in the areas of medical genetics and counseling. They provide information and support to families who may be at risk for inherited conditions or who have members with birth defects or genetic disorders.

Maternal Fetal Medicine (MFM) Specialist

An obstetrician with advanced education in maternal-fetal medicine. This education provides additional competence in managing various obstetrical, medical, and surgical complications of pregnancy. The relationship and referral patterns between Obstetrician-Gynecologists and MFM specialists will depend on the acuity of the patient's condition and local circumstances.

OB/GYN Physician

A physician specialized in the area of Obstetrics and Gynecology. He or she can provide routine or complicated care and can provide surgical services as needed.

Neonatologist

A pediatrician specialized in the care of newborns.

Nurse Anesthetist

A registered nurse with advanced training and specialization in pain relief.

Pediatrician

A physician specialized in the care of infants and children.

Physician Assistant (PA)

A healthcare professional licensed to practice medicine with supervision of a licensed physician. They perform physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and write prescriptions. They may provide prenatal care but do not deliver babies.

Resident

A physician who has graduated from medical school and is in training at a teaching hospital.

Social Worker

Social workers are educationally prepared to assist families or individuals in coping with and solving problems. This is often done by assisting clients to obtain services or navigate through complex systems. They may also provide counseling and psychotherapy.

Women's Health Nurse Practitioner (WHNP)

A registered nurse with an advanced degree specializing in the care of women throughout their life-span, including prenatal, contraception, and menopause. They can provide routine prenatal care and postpartum care, with an emphasis on education and health promotion. WHNPs do not deliver babies.

In addition to the providers listed above, throughout your prenatal experience you will encounter a variety of staff members working to assist you. They may be registered nurses, including ambulatory, perinatal, and postpartum nurses, licensed vocational nurses, medical assistants, corpsmen, and clerical support staff. They work to assist with your needs as their qualifications allow.

It should be noted that the following services are non-approved maternity care: home deliveries; deliveries by direct-entry midwives (also known as lay midwives or Certified Professional Midwives); experimental procedures and medical procedures not consistent with the standard of care.

Notes:

This image shows a single sheet of white paper with horizontal blue lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

EPDS - Completed throughout pregnancy care

Name: _____

Date: _____

As you will soon have a baby, we would like to know how you are feeling. Please CIRCLE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

1. I have been able to laugh and see the funny side of things.
0 As much as I always could 2 Definitely not so much now
1 Not quite so much now 3 Not at all
2. I have looked forward with enjoyment to things.
0 As much as I ever did 2 Definitely less than I used to
1 Rather less than I used to 3 Hardly at all
3. I have blamed myself unnecessarily when things went wrong.
3 Yes, most of the time 1 Not very often
2 Yes, some of the time 0 No, never
4. I have been anxious or worried for no good reason.
0 No, not at all 2 Yes, sometimes
1 Hardly ever 3 Yes, very often
5. I have felt scared or panicky for no very good reason.
3 Yes, quite a lot 1 No, not much
2 Yes, sometimes 0 No, not at all
6. Things have been getting on top of me.
3 Yes, most of the time I haven't been able to cope at all
2 Yes, sometimes I haven't been coping as well as usual
1 No, most of the time I have coped quite well
0 No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping.
3 Yes, most of the time 1 Not very often
2 Yes, sometimes 0 No, not at all
8. I have felt sad or miserable.
3 Yes, most of the time 1 Not very often
2 Yes, quite often 0 No, not at all
9. I have been so unhappy that I have been crying.
3 Yes, most of the time 1 Only occasionally
2 Yes, quite often 0 No, never
10. The thought of harming myself has occurred to me.
3 Yes, quite often 1 Hardly ever
2 Sometimes 0 Never

Adapted from: Cox JL, Holden JM & Sagovsky R (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786.

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This edition of “Pregnancy and Childbirth” is based on the VA/DoD Management of Pregnancy Clinical Practice Guideline, revised in 2018. Compared to the previous Guideline, the scope of this version of the Guideline has expanded to include evidence based research recommendations for prenatal care for all pregnant women receiving care in the DoD and VA healthcare systems. The Guideline also addresses several minor or common complications of pregnancy. The full text of this Guideline can be found at <https://www.qmo.amedd.army.mil> or <http://www.healthquality.va.gov>.

This book has become known as “The Purple Book” for an obvious reason. It is designed primarily as a resource for pregnant women but is also a useful tool for obstetric care providers. It provides quality information that can serve as a reference, guide, journal, and springboard for further discussion and education. It can be used in either one-on-one traditional or group based prenatal care.

The Pregnancy Guideline itself and the recommendations and information contained in this book serve as a basis for world-class prenatal care. However, the very best recommendations can quickly become outdated as new information becomes available. As individual circumstances are unique, the Guideline and this book are no substitute for the personal care and recommendations given by a qualified obstetric provider. Indeed, the very best prenatal care mandates occasional, well-reasoned deviation from these recommendations.

As a final word, we wish to thank the many individuals who have voluntarily given thousands of hours developing the Guideline and this edition of “The Purple Book”. This work represents the efforts of individuals from the Air Force, Army, Navy, and VA communities. Obstetric and non-obstetric personnel from various healthcare professions contributed. Talented pregnant volunteers read the drafts and provided fantastic editorial support. We all hope this book will be of great use to our Nation’s Heroes and their families as they welcome an infant.

The Editors

