



Your pregnancy and you





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Preparing for your baby's arrival

A healthy pregnancy, a healthy start

Ask any expectant mother what she needs to do before her baby is born, and she'll give you a list a mile long. But whether this is your first or fifth pregnancy, make sure that you put your and your baby's health at the top of your "to do" list.

Remember, you play the most important role in maintaining a healthy pregnancy. And there's a lot you can do to ensure your baby's good health and reduce your risk for complications.

The Baby BluePrints program can help.

Baby BluePrints offers a selection of programs and services, available to you at no cost, to help you through each stage of your pregnancy and the arrival of your baby.

Educational material and support:

- an overview of your baby's development during each trimester;
- information about some of the physiological changes you could experience each trimester;
- risk factor identification and periodic health assessments;
- special support and care management for high-risk pregnancies.

Reimbursements and free offers:

- Mother's Option[®] program: a choice of how long you stay in the hospital after delivery;
- a free telephone-based tobacco cessation program to help you and/or members of your household quit smoking.

The importance of prenatal care

Prenatal care can make a big difference in your and your baby's health. It ensures that both you and your baby have the healthiest pregnancy possible. Your prenatal care will include:

- information and advice about pregnancy, birth, and parenting;
- regular scheduled visits to your doctor or midwife early and throughout your pregnancy;
- continual assessments of your health and well-being;
- screening for up-to-date immunization status;
- screening and treating problems and conditions that might affect your pregnancy;
- tests to detect birth defects and other genetic conditions;
- measurements to track your baby's growth and development.



Questions or concerns?

If you have any questions or you would like to speak with an obstetrical nurse case manager, please call 1-800-598-BABY, Monday through Friday between 8 a.m. and 5 p.m. (A registered nurse is available after hours to return your call.)

What to expect

With a normal pregnancy: You can expect to see your doctor or midwife about 13 times. For the first 28 weeks, schedule an appointment at least once a month. As your pregnancy progresses (28 – 36 weeks), you'll want to see your doctor or midwife every 2 – 3 weeks (twice a month). At 36 weeks, you should be seen at least once a week until your baby is born. Your initial schedule may change based on your health needs. Talk to your doctor or midwife at your first prenatal visit to determine the best schedule for your prenatal appointments.

Between visits, write down your questions, so you can remember to ask them at the next visit.

NO REFERRALS NECESSARY

If you are an HMO plan member, you do not need to get a referral from your primary care physician to see a network OB/GYN or midwife for your prenatal checkups.

With a high-risk pregnancy:

If at any point in your pregnancy your provider determines that you might be at risk for premature delivery or medical complications during your pregnancy, an Independence Blue Cross obstetrical nurse case manager will work with you and your doctor or midwife to help you have the healthiest delivery possible. You can expect individualized education on how to reduce risk factors, additional tests and screenings, as well as coordination of home care services as recommended by your doctor or midwife.

Know when to call your doctor or midwife

You're the best judge of how you feel. If you are worried about your pregnancy, or have questions or concerns, be sure to call your doctor or midwife right away!

Call if you notice any of the following:

- pain or burning during urination;
- excessive vomiting, especially inability to keep down fluids;
- diarrhea or constipation;
- bleeding, spotting, or heavy cramping;
- temperature greater than 100.4 degrees;
- something that just doesn't feel right.

Your 1st trimester weeks 1 – 12

Adjusting to change

In your first trimester, big changes are underway. Your baby is busy settling in and growing from a single cell to a fetus about the size of a strawberry — all the while causing you to feel nauseous, tired, and emotional. These changes occur as your body adjusts to the pregnancy and the flow of hormones that come with it. But take heart! Once you reach the second trimester, most of this will pass. For now, be sure to get plenty of rest and fluids!



You and your baby

Your weight gain: Approximately 2 pounds or 10 percent of your total pregnancy weight gain


Baby's length: 1 – 3 inches

Baby's weight: 5/8 of an ounce

By the time your first trimester is over, your baby has fully formed limbs. The main organs, including the heart, have formed and are beginning to function.

Other developments include the formation of eyelids, fingernails, and earlobes. Muscles are developing quickly, and your baby is able to





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move. Unfortunately, you won't be able to feel your baby kick until sometime during the second trimester, usually between four and five months' gestation. Your baby will also be able to move the muscles around his or her mouth. He or she is now capable of sucking, frowning, and pursing his or her lips.

Prenatal care


Your health care provider will review your medical and family history to identify any possible pregnancy risk factors. You can also expect:

- a physical exam;
- tests to confirm your pregnancy (if necessary);
- if you are at risk, tests to screen for some diseases, including but not limited to anemia, diabetes, German measles (rubella), Rh incompatibility, sickle cell disease, cystic fibrosis, HIV/AIDS, and Down syndrome;
- a pelvic exam;
- a Pap test if you haven't had one recently;
- tests for other sexually transmitted infections;

- a urine test to screen for infections and/or diabetes;
- blood pressure check;
- weight check.

Common concerns

The following topics highlight some common concerns associated with the first trimester of pregnancy. As with any question or concern you might have, always talk to your doctor or midwife. He or she is your best resource for more information.

 **Abstaining from smoking, alcohol, and drug use:** Give your baby the best possible start in life by not smoking or drinking alcohol. Both alcohol and smoking can hurt your baby and increase your chances of complications. There is no known "safe" level of exposure. The sooner you stop the better.

No street drugs are safe for your developing baby; you must stop any such use. Help is available through your mental health carrier. Call Baby BluePrints for assistance in getting the help you need, if necessary.

HIV and syphilis screening: It is recommended that both screenings be included in the routine prenatal screening tests for all women. Without proper treatment, HIV and syphilis can pass from an infected mother to her infant while in the womb, during labor and delivery, or through breastfeeding. By knowing your HIV and syphilis status, you and your doctor can decide on the best treatment for you and your baby and can take steps to prevent mother-to-child transmission.

Medications: Because everything you put in your body has the potential to affect your baby, it is important to pay attention to the medications you take during pregnancy. If you were taking medication before you became pregnant, be sure to tell your doctor or midwife. Do not stop taking any prescription medication without consulting your doctor or midwife first. Some medications, if stopped suddenly, can cause severe reactions.

Morning sickness: While there is no remedy for this natural and common symptom of pregnancy, most women find that it ends sometime between the 12th and 16th week of pregnancy. If you experience excessive vomiting and can't keep your food or fluids down, tell your doctor or midwife.

Vaccinations: Check with your doctor to see that you are up to date on vaccinations, including vaccination for the flu and for Tdap (tetanus, diphtheria, and whooping cough).

Visit your dentist: Have a dental checkup and undergo any work you need. Tooth and gum disease can put your pregnancy at risk. Necessary dental work can be done safely during pregnancy, but you should check with your OB provider for specific guidelines about dental anesthesia and medications during pregnancy.

KICK THE HABIT

Get the help you need to quit smoking. Join Quit&Fit® Tobacco Cessation Program today — it's free! (See page 40.)

FOR MORE INFORMATION

 = Refer to the "Index of common concerns" on page 31 for more information.

Your 1st trimester

Things to do and discuss

- Schedule your next prenatal checkup.
- Know how to reach your doctor or midwife in case of emergency; program their numbers into your cell phone.
- Quit smoking.
- Ask your doctor about the right type and amount of exercise during pregnancy.
- Tell your doctor about any medications you're taking.
- Talk to your doctor about keeping your immunizations and flu shots up to date.
- Make an appointment for a dental checkup.
- Discuss dietary and weight gain recommendations.

Remember to take this list with you to your next checkup.



Your 2nd trimester weeks 13 – 27

Growth and development

During the second trimester of your pregnancy, your baby is growing rapidly. For many women, this is an enjoyable and exciting time. At 20 weeks, you've hit the halfway point of your pregnancy. A strong sense of well-being has most likely replaced morning sickness, and you've probably begun to feel your baby move.



You and your baby

Your weight gain: You may gain approximately 12 pounds, or roughly 3 to 4 pounds per month in this trimester

Baby's length: 14 inches

Baby's weight: 2 pounds

By week 16, your baby has eyebrows, eyelashes, and fine downy hair called *lanugo* all over his or her body. Your baby is growing rapidly at this stage as joints form and bones begin to harden.

During an ultrasound, you may notice that your baby can suck his or her thumb and that the sex organs are mature enough to





be noticed. Your baby's chest will rise and fall in breath-like movement, and your baby's heart is beating rapidly, almost twice as fast as your own.

By week 20, your baby has tooth buds. He or she is very active. You should begin to feel movements as your baby grows to approximately 10 inches and fully formed legs and arms begin to kick and punch. Your baby may also react to sounds, such as your or your partner's voice, music, or sudden noises. Don't worry that the movement isn't constant. Developing babies need sleep, too.

At the end of your second trimester, your baby will most likely weigh just over two pounds and may cough and hiccup.

Prenatal care

Your prenatal care will continue with regular monthly checkups. At these visits, you can expect your doctor or midwife to:

- test your urine for sugar and/or protein;
- check your blood pressure;
- measure your abdomen to track your baby's growth;
- listen to your baby's heartbeat;

- schedule routine lab tests and screenings to check for conditions like iron deficiency, gestational diabetes, and Rh incompatibility.

Common concerns

The following topics highlight several pregnancy-related complications that may arise during your second trimester. However, with proper medical care, they can be treated, managed, or even prevented. Familiarize

EXTRA CARE WHEN YOU NEED IT

If you are diagnosed with any pregnancy-related complications, a Baby BluePrints registered nurse case manager is available to help you and your maternity care provider coordinate the care and support you need during this time in your pregnancy. Have your doctor or midwife call Baby BluePrints at 1-800-598-BABY.



Calling it quits

Quitting smoking now, in the 2nd trimester, can still help stop some of the adverse effects smoking has on your baby. Learn more about the Quit&Fit Tobacco Cessation Program on page 40.




yourself with their signs and symptoms so that, should any of these problems arise, you can seek medical care as soon as possible.

👉 Gestational diabetes: Gestational diabetes is diabetes that happens only during pregnancy and resolves soon after delivery. A screening test done between 24 and 28 weeks of pregnancy (or earlier if you are at high risk for this condition) will help your doctor or midwife determine whether you have gestational diabetes.

If you are diagnosed with gestational diabetes, you will learn to modify your diet and monitor your blood sugar. Most women with gestational diabetes can control their blood sugar with dietary changes, but some may need medications. All women who develop gestational diabetes during pregnancy need to be screened for regular diabetes after delivery.

If you have regular diabetes, you may need more help controlling your blood sugars. Baby BluePrints will help you and your doctor get you set up with the services you need to learn about your diagnosis and how to manage this condition.

👉 Gestational hypertension: Also known as pregnancy-induced hypertension (PIH), gestational hypertension occurs in approximately one out of every 14 pregnant women



who are not otherwise diagnosed with hypertension. It is characterized by high blood pressure and protein in the urine. Refer to the “Index of common concerns” on page 31 for more information.

Signs of PIH:

- a severe headache;
- blurry vision or light or spots in front of your eyes;
- abdominal pain;
- swelling or puffiness in your fingers, feet, face, or eyelids;
- rapid weight gain;
- numbness in your hands and feet.

Call your doctor or midwife immediately if you have any of these signs of PIH or any other symptom that causes concern.

👉 Preterm labor: Preterm labor is defined as regular contractions that begin three or more weeks prior to your due date and that result in cervical dilation.

Signs of preterm labor:

- You have four or more contractions in an hour.
- You have a change in vaginal discharge, are leaking fluid, or are bleeding.
- You experience pain in your lower back — it might come and go or remain constant.
- You experience pelvic pressure or the feeling that the baby is about to fall out.
- You experience menstrual-like cramps or abdominal cramping.

Call your doctor or midwife immediately if you have any of these signs of preterm labor.

FOR MORE INFORMATION

👉 = Refer to the “Index of common concerns” on page 31 for more information.

Your 2nd trimester

Things to do and discuss

- Know the signs of gestational diabetes, gestational hypertension, and preterm labor.
- If you haven't yet, quit smoking and encourage those in your home to do the same. (Page 40)
- Continue healthy eating habits.
- Begin to look for a pediatrician for your baby.
- If you're working, review your maternity leave benefits, and begin your search for a daycare provider.
- Schedule your childbirth classes.
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Remember to take this list with you to your next checkup.



Your 3rd trimester weeks 28 – 40

The final stretch

As you enter the last trimester of pregnancy and your baby grows larger, your body will undergo some of the most dramatic changes yet. These changes may bring a host of new and somewhat uncomfortable side effects including breathlessness, heartburn, trouble sleeping, and the need to urinate frequently. One of the best ways to get through this trimester is to take it easy and get as much rest as possible. If you haven't already, now is also a good time to take a childbirth class.



You and your baby

Your weight gain: You may gain up to 9 pounds, or 30 to 40 percent of your pregnancy weight. Most of this increase is due to the baby's change in weight.

Baby's length: Grows from 14 inches to birth size (approximately 20 inches)

Baby's weight: Increases from 2 pounds to birth weight (approximately 7 pounds)

In these final months, your baby will go through many changes. Weight gain of approximately five to six pounds will change the baby's movements. During the early stages





By week 36, your baby looks much as he or she will at birth. Taste buds and the sense of hearing have developed.

of the third trimester, you may be startled by the outline of a foot against your stomach as your baby shifts position.

However, by the end of these three months, your child will be big enough that the movement will have slowed to more subtle kicks and punches. By week 36, your baby looks much as he or she will at birth. Taste buds and the sense of hearing have developed.

Dramatic brain development has occurred, and he or she can tell the difference between light and dark. Your baby will shift into a head-down position. Soft nails have also grown on the baby's toes and fingers.

By the end of your third trimester, your baby is fully developed.

Prenatal care

Your monthly prenatal checkups will continue. In the last month of pregnancy, you will have a checkup every week. In addition to monitoring your weight, blood pressure, urine, and your

baby's movement your doctor or midwife will also:

- take a cervical culture for group B strep;
- discuss any other tests or screenings you may need;
- ask about the baby's movement patterns;
- review plans for infant feeding;
- review plans for pregnancy spacing after delivery;
- review labor and delivery procedures;
- ask if you've had any contractions.

Your doctor or midwife may also perform a vaginal exam and check for cervical changes.

Common concerns

The following topics highlight some common concerns associated with the third trimester of pregnancy. As with any question or concern you might have, always talk to your doctor or midwife. He or she is your best resource for more information.

Difficulty sleeping: If you're experiencing difficulty sleeping during this trimester, don't worry. Insomnia is normal at this stage. Lying on your left side with a pillow between your

When to pack

In the last month of pregnancy, it's a good idea to make sure you're prepared to head to the hospital. Remember, your delivery date is just an estimation and, in fact, you should consider the entire two weeks before and after your due date as your "delivery month."

knees may be more comfortable for you. You might also want to try sleeping in a recliner.

Back and leg massages, warm baths, warm milk, and chamomile tea may also help. If you still can't fall asleep, don't toss and turn — get up and do something! Practice your relaxation exercises or read a book.

Group B strep: Group B streptococcal (group B strep) is a bacterium that can cause a serious bacterial disease that can be passed from mother to child during delivery. However, transmission can be prevented with antibiotics if the mother tests positive prior to labor. It is recommended that all pregnant women be tested for group B strep between 35 and 37 weeks of pregnancy.

Rh incompatibility: If your blood type is negative (Rh-), you will need a shot of RhoGam® or a similar preparation at about 28 weeks' gestation. This protects you from developing antibodies that might be harmful in future pregnancies. See page 54 in the "Index of common concerns" for more information.

False labor and Braxton Hicks contractions:

Throughout your pregnancy, your womb will contract. These faint contractions, known as Braxton Hicks, are not usually very painful. During the last weeks of pregnancy, contractions may become stronger, and you may think you are in labor. However, if these pains do not dilate your cervix, it is considered false labor. If you are unsure, especially if you are more than three weeks from your due date and have four or more contractions per hour that last more than 30 seconds, call your doctor or midwife.

The signs of labor:

- **Your water breaks.** The bag of fluid that surrounds the baby may break before or at any time during labor. You may notice a trickle of clear, yellow, or green liquid or a large gush of fluid. Make note of the amount and color of the fluid and the time it started leaking, and call your doctor or midwife.
- **Contractions.** You may begin labor by experiencing a dull ache in your back, menstrual-like cramps, a feeling of indigestion, or even shooting pains down your thighs. As labor progresses, these

sensations will get stronger and more regular. If you believe you are in labor, contact your doctor or midwife for further instructions and advice.

- **Bloody show.** This refers to a plug of thick, bloodstained mucus that blocks the neck of the uterus (cervix) during pregnancy. It may pass out of the vagina before or during the early stages of labor. Since this may happen prior to labor, it's best to wait for contractions or for your water to break before you call your doctor or midwife. However, if you have any concerns, don't hesitate to pick up the telephone!
- **Bleeding.** If you experience any bleeding, call your doctor or midwife immediately, and go directly to the hospital.

What to pack: In addition to your insurance card and all of the toiletries that you would usually pack when you travel, you may want to include:

- telephone numbers of your doctor's or midwife's office and of the pediatrician you've chosen for your baby;
- telephone numbers of friends and relatives;
- warm socks (several pairs);
- books or magazines;
- camera/video camera and extra batteries;
- snacks/some pocket money;
- two to three regular bras or nursing bras (if you're choosing to breast-feed);

- nursing pads;
- six pairs of underpants;
- two or three baggy T-shirts or nightgowns;
- a bathrobe;
- a comfortable outfit for the ride home.

👉 And don't forget to pack for your baby. He or she will need:

- a onesie or sleeper suit;
- sweater and hat;
- receiving blanket or a warm blanket if the weather is cold;
- a car seat appropriate for a newborn — refer to the “Index of common concerns” for important tips on car seat purchase and use. Remember, this is your baby's first ride, and you want to make it as safe as possible. Be prepared!

Don't forget to make follow-up appointments for both you and your baby before you leave the hospital or as soon as you get home.

FOR MORE INFORMATION

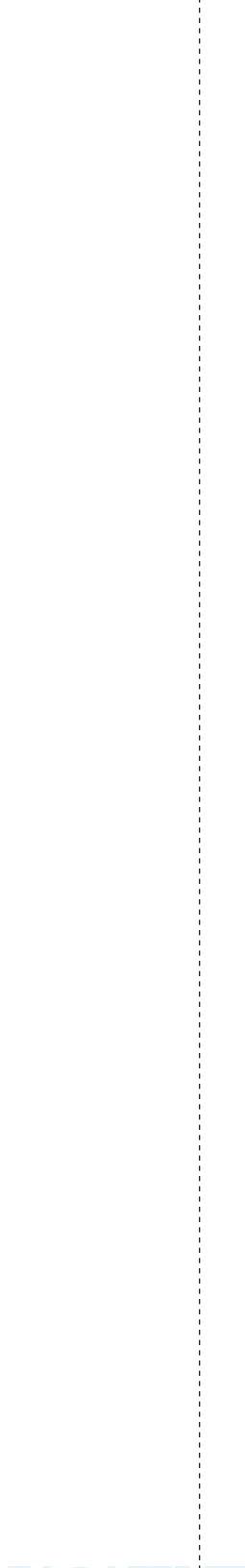
👉 = Refer to the “Index of common concerns” on page 31 for more information.

Your 3rd trimester

Things to do and discuss

- Pack your bag for the hospital.
- Complete and return patient preregistration paperwork to the hospital.
- Know where to park, enter, and check in at the hospital.
- Attend childbirth classes.
- Schedule a tour of the hospital labor and delivery rooms.
- Choose a pediatrician.
- Know the signs of labor and false labor.
- Know how to reach your doctor or midwife in case of emergency or onset of labor.
- Quit smoking and encourage those in your home to do the same. (Page 40)
- Abstain from drinking alcohol. (Page 41)
- Talk to your doctor or midwife about infant feeding plans.
- Discuss birth control for pregnancy spacing with your doctor.
- Prepare and review your employer's disability and/or family leave papers and plans.
- If you are (or may be) expecting a boy, discuss the pros and cons of circumcision with your doctor, midwife, and/or pediatrician.
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Remember to take this list with you to your next checkup.




High-risk pregnancies

While every pregnancy has some risk for complications, some have a higher risk than others. A pregnancy is considered high risk when there is a chance that the mother or baby will develop serious medical problems.

Throughout your pregnancy, your doctor or midwife will be on the lookout for any signs or conditions that indicate you or your baby could be at risk, including:

- young or advanced maternal age;
- excessive or inadequate maternal weight gain;
- problems in previous pregnancies;
- high blood pressure;
- diabetes (preexisting or gestational);
- gestational hypertension;
- placenta previa;
- cervical incompetence;
- intrauterine growth restriction;
- sexually transmitted infections;
- preterm labor;
- multiple (twins or more) pregnancy.

 If you are diagnosed with any of these pregnancy related complications, please have your doctor or midwife contact us at 1-800-598-BABY. Our registered nurse case managers are here to help you and your doctor or midwife coordinate the care and support you need during this time in your pregnancy.

Remember:

If you see a doctor or specialist other than your obstetrician or midwife during pregnancy, be sure to remind him or her that you are pregnant, especially early in pregnancy when your pregnancy may not be apparent.

Prenatal care for high-risk pregnancies

To ensure that you and your baby receive the best care possible, your pregnancy will be monitored closely. Your doctor or midwife may request that you have additional screenings, tests, and checkups and that you take some extra precautions, including:

- fetal kick counts;
- bed rest;
- non-stress tests;
- ultrasounds;
- genetic testing and counseling;
- weekly 17 hydroxyprogesterone caproate injections, if you previously had a preterm delivery between 20 and 37 weeks' gestation.

Common concerns for high-risk pregnancies

The following topics highlight some common concerns associated with a high-risk pregnancy. Always talk to your doctor or midwife. He or she is your best resource for more information.

Bed rest: Some physicians recommend bed rest for certain complications during pregnancy. If this is applicable to you, please discuss with your doctor or midwife the risks and benefits of bed rest.

Medication: Remember to review all medications and supplements you are taking with your doctor or midwife around your 28th week so you can plan any adjustments necessary. Do not stop taking any medication prescribed to you without consulting your doctor or midwife first. Some medications, if stopped suddenly, can cause severe reactions.

FOR MORE INFORMATION

 = Refer to the “Index of common concerns” on page 31 for more information.

High-risk pregnancies

Things to do and discuss

- Know how to reach your doctor or midwife in case of emergency.
- Know the signs of gestational diabetes, gestational hypertension, and preterm labor.
- Quit smoking and encourage those in your home to do the same. (Page 40)
- Abstain from drinking alcohol. (Page 41)
- Tell your doctor about any medications you're taking.

Remember to take this list with you to your next checkup.



In the hospital and at home

The birth of your baby, your first few days together in the hospital, and the start of your new life at home are all memorable events that can be a little overwhelming — even to the most seasoned parent. But if you are well-informed and know what to expect, you can relax and enjoy these milestones.

Common concerns in the hospital

Make the most of your stay in the hospital, and enjoy the opportunity to bond with your newborn. Once you are home, you'll likely have plenty to do. So for the next couple of days, rest and savor this time alone with your baby.

👉 Feeding your baby: The American Academy of Pediatrics “identifies breast-feeding as the ideal method of feeding and nurturing infants.”¹ Hopefully you will choose to breast-feed, as breast-feeding is the best source of milk for your baby. However, whether you choose to bottle- or breast-feed your baby, use your time in the hospital to establish a comfortable routine.

Keep in mind that eating is an entirely new task for your little one and requires a lot of effort and concentration. Talk with your doctor, midwife, nurse, or hospital lactation consultant about any questions you have. If you are having challenges

nursing your baby, request the assistance of a lactation consultant or your nurse.

👉 How long you'll stay in the hospital:

Depending on the type of delivery you have and if there were any complications, you have some choices as to how long you'll stay in the hospital after you deliver. Talk to your doctor or midwife about the option that's right for you. See the enclosed information on Mother's Option for more information.

👉 Common procedures: Your baby will receive some shots and undergo some common procedures including:

- a vitamin K injection;
- antibiotic eye cream;
- the first dose of the hepatitis B vaccine;
- heelstick blood testing for a number of conditions;

¹American Academy of Pediatrics.
Breast-feeding — Expressing Breast Milk;
www.aap.org.



*Don't forget to enroll your baby!
Your latest addition needs to be added to
your health plan as soon as possible. To do
this, talk to your benefits administrator or
call Customer Service at the number on
your member ID card.*

- for boys, circumcision – you should discuss the pros and cons with your OB provider and pediatrician prior to delivery.

You may also receive some shots prior to discharge from the hospital, including:

- a rubella (German measles) vaccination if your prenatal tests showed you were not immune to this disease;
- a Tdap vaccine, which is a booster shot against tetanus, diphtheria, and whooping cough. Any adult who will be directly caring for your baby at home should also receive a Tdap booster shot if he or she has not already been vaccinated.

Rh incompatibility: If your blood type is negative (Rh-), your blood will be tested. As a result, you may be given RhoGam® or a similar antibody after delivery to continue to protect you from developing antibodies to Rh positive cells, which could affect future pregnancies. See page 54 in the “Index of common concerns” for more information.

Refer to the “Index of common concerns” (page 31) for more information about procedures you or your baby may experience while in the hospital.

Common concerns at home

Postpartum doctor/midwife visit:

Even though you are no longer pregnant, it is important that you see your doctor or midwife four to six weeks after delivery. Take this opportunity to discuss any questions, feelings, or concerns you might have.

If you haven't discussed birth control for child spacing, be sure to do it during this visit. You won't know when you ovulate next after a delivery, and you could become pregnant again quickly. This puts both you and your next baby at risk, so do plan to space your pregnancies to give your body time to recover.

Postpartum blues and depression:

While having a baby is often one of the happiest moments in your life, it can also be a time of anxiety and depression. While no one knows the exact causes of postpartum blues and depression, they are very real conditions that affect many women after delivery.

Sudden infant death syndrome (SIDS):

SIDS is the sudden death of a seemingly healthy infant less than one year old. In most cases, SIDS occurs while an infant is sleeping.

You can reduce your baby's risk for SIDS by always putting him or her to sleep on his or her back.

👶 Becoming a parent: Parenthood and family life is not without its challenges. This is a time of adjustment for everyone in your family, but with patience and teamwork, you can enjoy the road ahead.

👶 Weight loss and exercise: At your four- to six-week postpartum visit, your doctor or midwife will let you know if it's safe to start exercising. When you get the green light, don't forget about the Healthy LifestylesSM programs.

After you're discharged from the hospital:

Call your doctor or midwife immediately if you notice any of the following symptoms:

- heavy bleeding — more than a normal period;
- fever — higher than 100.4 degrees;
- lower abdominal pain after the first five days;
- pain in the chest, thigh, or calf, or difficulty breathing;
- pain, redness, swelling, or a hard spot in the breast;
- excessive sadness or difficulty coping with being a new mother;

- thoughts of hurting your baby, yourself, or others;
- incision-site soreness, discharge, or swelling;
- symptoms of a urinary tract infection, such as burning, pain on urination, or increased frequency.

FOR MORE INFORMATION

👶 = Refer to the “Index of common concerns” on page 31 for more information.



In the hospital and at home

Things to do and discuss:

- Schedule your baby's first checkup (typically one week after delivery).
- Schedule your postpartum visit four to six weeks after delivery.
- Know how to reach your doctor/midwife and pediatrician in case of emergency.
- Ask your doctor or midwife when you can start exercising.
- While in the hospital, you can request that your nurse demonstrate how to bathe your baby.
- Talk to your doctor or midwife about birth control for child spacing.
- Arrange for help with household chores and meal preparation for the first few weeks you're home with your baby.



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This section offers information and guidance about some of the more common concerns associated with pregnancy and infant care.

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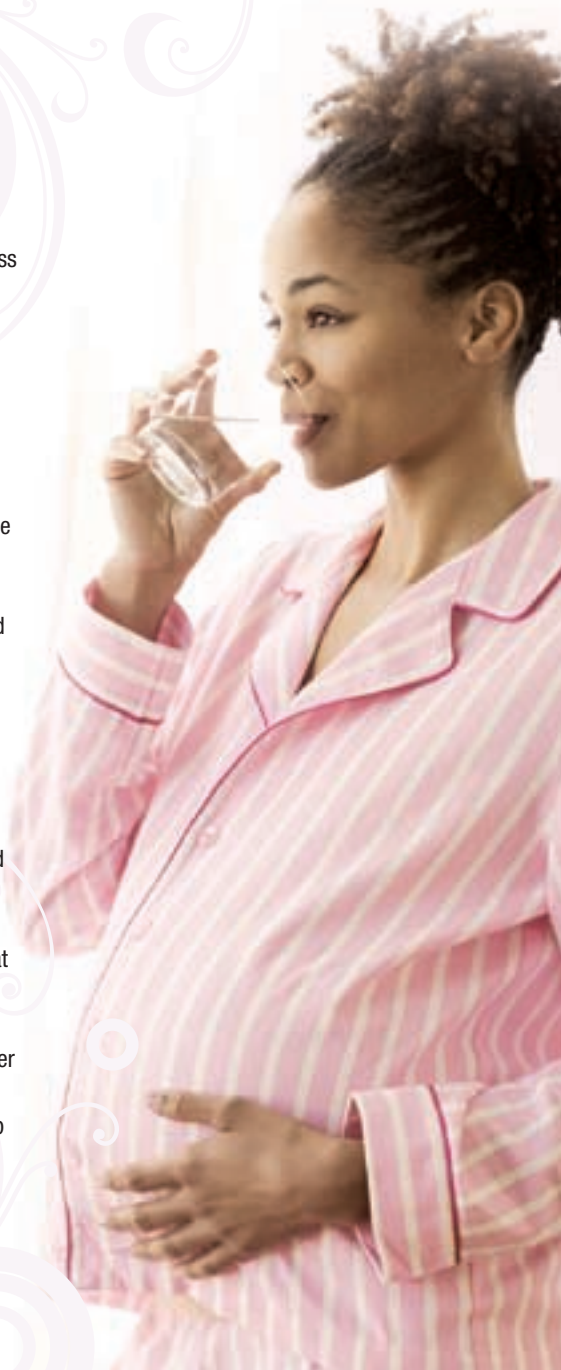
1. Health and well-being

Morning sickness

Let's just start by saying that "morning sickness" is not the right name for this condition. It can strike at any time: morning, noon, or night. Unfortunately, morning sickness has no single cause. Rapidly increasing estrogen levels, an enhanced sense of smell, excess stomach acids, and fatigue all play a role in your current condition.

Here are a few tips to help you through your morning sickness:

- If you feel sick when you wake or during the night, keep a box of crackers next to your bed. Bland foods such as oyster crackers can help to settle your stomach. It is a good idea to carry crackers or pretzels with you when you're out.
- Eat small, frequent meals throughout the day. An empty stomach can make you feel more nauseous. You may also want to try separating foods and fluids.
- Drink plenty of fluids. If you feel dehydrated or you can't keep fluids down, talk to your doctor or midwife immediately!
- Avoid spicy or acidic foods or any foods that have a smell or taste that make you nauseous. Remember, during pregnancy even some of your favorite foods may trigger that queasy feeling, so listen to your body!
- Drink ginger ale or ginger tea — it will help soothe your stomach.



- Some women find the combination of salty and tart flavors to be helpful — potato chips and lemonade, for instance.
- If cooking sights or smells bother you, have someone else assume that job until you are feeling better.

Morning sickness is a natural and common symptom of pregnancy. But what happens if morning sickness begins to interfere with your daily life? If you're experiencing severe and persistent vomiting, talk to your doctor or midwife immediately. You may have a condition known as hyperemesis gravidarum.

Hyperemesis gravidarum

What is hyperemesis gravidarum?

Hyperemesis gravidarum (HG) is a disorder that is characterized by severe and persistent nausea and vomiting causing a weight loss of greater than five percent of your pre-pregnancy body weight. It can also lead to dehydration and vitamin and mineral deficiency.

Who's at risk?

The cause of HG is unknown. However, several factors may contribute to the condition. Multiple gestation (twins or more), hormonal changes, and even emotional changes may play a role. Other risk factors include young maternal age, high body weight, no previous complete pregnancies and/or a first-time pregnancy or a history of HG in previous pregnancies.

What are the signs and symptoms?

Usually occurring before the 20th week of pregnancy, HG has few signs and symptoms that are different from morning sickness, which makes diagnosis difficult. However,

if you're vomiting more than three or four times a day, losing weight, feeling tired and dizzy, unable to keep fluids down, and urinating less than usual, you should call your doctor or midwife.

Will HG affect my child?

Most studies have not demonstrated any difference between infants of women who experience HG during pregnancy and of women who do not. However, some research has found that infants of women who experience HG exhibit a lower birth weight than those of women who did not have the disorder. In addition, research has shown that low birth weight was more common in infants of women who were hospitalized more than once due to HG.¹

I think I'm experiencing HG... what should I do?

Talk to your doctor or midwife immediately. Through a clinical evaluation, your doctor or midwife will determine the best course of action for you.

The Baby BluePrints program is designed to help assess risk factors during pregnancy and to help your doctor or midwife get you the treatment you need. If you are diagnosed with HG, please have your doctor or midwife contact us at 1-800-598-BABY to arrange for a special case management program based on the severity of your condition. Our registered nurse case manager will then work with you, your doctor or midwife, and specialized home health care providers to educate and support you during this difficult part of your pregnancy.

¹"No More Morning Sickness," Miriam Erick, Plum Publisher 1993.

Choosing a physician for your newborn

Your child's physician plays an important role in helping you maintain your child's safety and well-being. More than just someone your child sees when he or she is sick, your child's physician is a specialist in the areas of childhood growth and development, nutrition, immunizations, injuries, and fitness.

Credentials and background

In order to become a pediatrician, a physician must complete a residency for three or more years following medical school. At the end of the residency, the physician must also pass a detailed exam given by the American Board of Pediatrics. You may find that your current family physician is qualified to provide pediatric care. Family physicians who provide pediatric services also must pass board exams that cover pediatric care. Don't be shy about asking any physician about his or her qualifications and the education and training he or she has received.

Finding the right physician

If this is your first pregnancy, you may want to begin by asking your family and friends for recommendations. Your doctor or midwife may also have suggestions. If someone recommends a physician, it's helpful to ask the following questions:

- How do your children relate to their doctor?
- Does the physician talk to your children as well as to you?
- Is the physician knowledgeable about current issues and advances in pediatric medicine?
- Is the office staff patient and helpful?
- Do you feel rushed during your office visits?

- Have you gotten a prompt response when calling for an urgent need after regular office hours?

When deciding on a pediatrician, be sure to check that he or she participates in your health plan's provider network. You can find out by logging on to www.ibxpress.com, clicking *Find a Provider*, and then selecting the *Doctors and Hospitals* link. This online directory is updated weekly and is available 24 hours a day, 7 days a week. You may also call 1-800-ASK-BLUE (1-800-275-2583).


It is also a good idea to set up a face-to-face interview with prospective pediatricians. Some physicians may charge for this interview; however, most doctors will be happy to speak with you for free.

ROUTINE CHECKUPS FOR YOUR BABY

The American Academy of Pediatrics and the American Academy of Family Physicians recommend the following routine visits for your baby:

- During the first year of life, visits should occur at one, two, four, six, nine, and twelve months of age.
- During the second year of life, visits should occur at approximately 15, 18, and 24 months of age.

Talk to your physician about the best schedule for your child.



*Don't forget to enroll your baby!
Your latest addition needs to be added to
your health plan as soon as possible. To do
this, talk to your benefits administrator or
call Customer Service at the number on
your member ID card.*

By interviewing physicians before your child is born, you'll give yourself enough time to know for sure if this is the right one for your child. If possible, both parents should attend a physician interview. Once you arrive, look around the office. Make sure it's clean and comfortable. You might also want to note if the sick children — those with contagious colds or diseases — are kept apart from the well children who are there for a well-child checkup or immunization. Here are a few other questions you may want to ask the physician:

- What are your office hours?
- How does the office handle billing?
- What is your pediatric background?
- How can I reach you after-hours or in the event of an emergency?
- How does your office handle telephone inquiries? Is there a good time to call with general questions?
- Will my child be examined only by you or by other physicians/nurse practitioners in the practice?

You may also want to consider the following when choosing a pediatrician. If you choose a solo practitioner, when he or she is unavailable or away, your child will be seen by the physician who is covering the practice — who may be unknown to both you and your child. If

you chose a multigroup practice, you may deal with a partner whom you have never met but who is part of the same group practice and most likely will have a similar philosophy.

Above all, be sure to ask yourself if you like and trust the physician. If so, he or she may be the physician for your baby.

Recommended health care visits

Your child's health care begins in the hospital. When you check into the hospital for your delivery, the nurse will ask for your baby's physician's name. That physician is notified when your baby is born and will examine your baby before you leave the hospital.

All infants should be examined in the first few days after hospital discharge to assess infant well-being and check for the presence of jaundice (a buildup of bilirubin in the blood).

However, if your baby has had an early discharge, premature birth, jaundice, or breast-feeding problems (alone or in combination), these are important reasons your physician will want to see your baby earlier than the routine 48 to 72 hours after discharge from the hospital.

Your baby's pediatrician will let you know when to schedule your first follow-up appointment when he or she examines your baby in the hospital following delivery. Make an appointment for your baby before you leave the hospital or as soon as you get home. You should also schedule your postpartum checkup for four to six weeks after your delivery.

For the partner of the mom-to-be

Congratulations! You are going to be a parent. You may be experiencing feelings of excitement and confusion. You may wonder if your life will ever be the same again.

You can support your partner in many ways during her pregnancy, including:

- Accompany your partner to her doctor's visits.
- Attend childbirth classes.
- Encourage your partner to stay healthy during pregnancy by eating a healthy diet, exercising if she has no restrictions, and avoiding tobacco, alcohol, and illegal drugs.
- Assist your partner in planning for your baby.

- If you smoke, stop smoking to improve the health of your partner, baby, and family.
- Offer extra help with chores, with the other children, or with pets so your partner can get extra rest, especially in the third trimester.
- Clean the cat's litter box and take care of the gardening (especially the digging in the dirt) to keep your partner away from possible toxoplasmosis infection.

After your baby is born, keep these tips in mind:

- Be involved in your baby's care. Even if your partner is breast-feeding, you can bring her the baby, change diapers, etc.
- Ask your friends and family members for assistance with household chores.
- Be alert to your partner's moods, and call her health care provider if you notice any of the warning signs of depression (see page 43).
- Assist with childcare at night so both of you can get some sleep.
- In the car, remember to buckle everyone up for safety.

Overall, be patient with your partner and yourself. This is an adjustment time for both of you.



Saving your baby's cord blood

Make an investment in your baby's future health

Saving your child's umbilical cord blood stem cells could protect your child or another family member against a long list of life-threatening diseases far into the future.

Why save cord blood?

A newborn baby's umbilical cord blood is an abundant source of life-giving stem cells like those found in bone marrow and can be used to rebuild a person's immune system. Today, cord blood stem cells can be used to treat more than 70 diseases, such as leukemia, non-Hodgkin's lymphoma, and other cancers, anemias, inherited metabolic disorders, and genetic disorders. More than 8,000 transplants using umbilical cord blood stem cells have now been performed worldwide. Medical researchers are currently exploring new uses for cord blood stem cells in treatments for conditions such as heart disease, diabetes, lung disease, liver disease, and other serious ailments.

You can bank your baby's cord blood privately (for use only by your family), or you can donate it to a public cord blood bank, where it may be used by anyone who is a match to it.

Reasons to consider private cord blood banking:

- The stem cells from a baby's umbilical cord blood are a perfect biological match for this same child.
- The cord blood specimen is readily available should that child ever need it for a transplant. There are no rejection

issues, increasing the chances of a successful transplant.

- There is a one-in-four chance the stored cord blood stem cells will match a sibling. Transplant patients recover better from some diseases when they receive stem cells from a related donor instead of an unrelated donor.
- If you already have a child with leukemia or other disease that may be treatable by transplant and you are pregnant, talk with your oncologist or pediatrician about saving your baby's cord blood.
- If there are future regenerative medicine advances and therapies that can repair the body with the patient's stem cells, then families that saved cord blood may have better access to those treatments.

Cord blood donation for public use

You may choose to save your baby's cord blood for your baby's or your family's future use or you may also choose to donate it to a public cord blood bank. If you are interested in banking your baby's cord blood, additional information on private cord blood storage is contained in the brochure in your Baby BluePrints packet.

Donated cord blood is not reserved for your family's private use. If you donate your baby's cord blood to a public cord blood bank, it will be preserved, stored, and potentially listed on the National Marrow Donor Program registry, where it will be reviewed as a potential match for patients in need of stem cell transplants. If it does not meet the criteria for transplant, medical researchers may use it to seek new and more effective medical applications for cord blood stem cells. There is no cost to you

to donate your child's cord blood. Public cord blood banks cover the cost of processing and storage. If you wish to donate your baby's cord blood, ask your physician or hospital if they can arrange for your donation.

A painless, non-invasive, and risk-free procedure

Collecting cord blood is 100 percent painless and safe for mother and baby. Plus, it's free of ethical controversy because life is being preserved and not discarded. Whether the birth is natural or cesarean makes no difference. The entire process is handled by your delivering physician, midwife, or attending nurse within minutes of the birth of your child. And it's important to note that the procedure will not interfere with the birth process or postpartum bonding in any way.

Exercise

We all know exercise is beneficial. It not only makes you feel and look better, but it helps to build strength and endurance as well. What about exercising while you're pregnant?

Especially if you have been exercising regularly before pregnancy, you don't have to limit or stop your program unless your doctor or midwife advises it. Starting a program now is also generally safe.

Exercising while you're pregnant has many benefits, including:

- stress reduction
- lower weight gain
- speedier recovery
- increased energy
- fewer leg cramps and other pregnancy-related pains
- reduced backaches, constipation, bloating, and swelling
- possible prevention or treatment of gestational diabetes
- increased energy
- improved mood
- improved posture
- promotion of improved muscle tone, strength, and endurance
- better sleep

Regular activity also helps keep you fit during pregnancy and may improve your ability to cope with the pain of labor. This will make it easier for you to get back in shape after the baby is born. You should not, however, exercise to lose weight while you are pregnant.

Be sure to talk to your doctor or midwife about your current program or before you begin any exercise program. There are exercise classes specifically for pregnant women; check with your local fitness center.



Weight gain during pregnancy

In 2009 The Institute of Medicine and National Research Council updated the 1990 recommendations for weight gain during pregnancy. The new recommendations are based on body mass index (BMI) — a measure of body fat based on weight and height — and include specific recommendations for obese women. Refer to the chart below for healthy ranges of weight gain. Remember, this chart is only a guide. Be sure to talk to your doctor about how much is right for you.

Dental care

It is important to schedule a dental exam early in your pregnancy and practice good oral hygiene. Pregnant women are at higher risk of tooth decay for several reasons, such as increased acidity in the mouth and sugary dietary cravings. During the dental exam, your dentist will check your gums and the tissues around your gums. If you are diagnosed with

gum disease, early treatment can keep it under control. The following are two common dental problems:

Gingivitis

During pregnancy, your body produces hormones that can affect your gums, making them inflamed and more likely to bleed. Approximately half of all pregnant women experience gingivitis.

Periodontal disease

Periodontal disease is a bacterial infection that affects the gums and bone supporting the teeth. If you are diagnosed with periodontal disease, your dentist may refer you to a periodontist, a specialist who is trained to treat periodontal disease.

New recommendations for total rate of weight gain during pregnancy, by pre-pregnancy BMI ¹

	Pre-pregnancy BMI*	Total weight gain range — single pregnancy	Rates of weight gain during 2nd and 3rd trimester — single pregnancy	Total weight gain range — twins
Underweight	<18.5	28 – 40 lbs.	1 lb. per wk (1 – 1.3 lbs.)	
Normal	18.5 – 24.9	25 – 35 lbs.	1 lb. per wk (0.8 – 1 lbs.)	37 – 54 lbs
Overweight	25 – 29.9	15 – 25 lbs.	0.6 lb. per wk (0.5 – 0.7 lbs.)	31 – 50 lbs.
Obese	≥ 30	11 – 20 lbs.	0.5 lb. per wk (0.4 – 0.6 lbs.)	25 – 42 lbs.

* To calculate your pre-pregnancy BMI, log on to www.ibxpress.com and use the Body Mass Index Calculator.

¹ Weight Gain during Pregnancy: Reexamining the Guidelines, Institute of Medicine, May 2009.

Quitting smoking

Smoking hurts your baby before birth

When you smoke, your baby receives less oxygen and is exposed to carbon monoxide, a poisonous gas. Nicotine (an addictive drug) and many other cancer-causing chemicals are in cigarette smoke and can affect your child's growth, causing your baby to be too small at birth or to be born prematurely.

Smoking during pregnancy can also cause your child to have learning and behavior problems. Worst of all, smoking can sometimes cause complications resulting in miscarriage, stillbirth, and low birth weight.

According to the American College of Obstetricians and Gynecologists, "Health risks associated with smoking during pregnancy include intrauterine growth restriction, placenta previa, and abruptio placentae.

Adverse pregnancy outcomes include premature rupture of membranes, low birth weight, and perinatal mortality. Evidence also suggests that smoking is associated with an increase in ectopic pregnancies."

Smoking hurts you

Smoking causes lung and heart diseases. Smoking can disable or kill you.

Secondhand smoke hurts everyone, including your new baby and other children.

There is no safe amount of secondhand smoke. As an involuntary smoker, you breathe less tobacco smoke than an active smoker, but you're still at risk for health problems.

According to the Surgeon General's report on secondhand smoke, the evidence indicates a

20 to 30 percent increase in the risk of lung cancer from secondhand smoke exposure associated with living with a smoker versus a non-smoker.

Lung cancer is not the only hazard confronting involuntary smokers. Children of smokers have a greater chance of certain illnesses such as:

- colds;
- bronchitis and pneumonia, especially during the first two years of life;
- chronic coughs, especially as children get older;
- ear infections;
- reduced lung function or asthma.

Exposure to secondhand smoke also increases a child's risk of sudden infant death syndrome (SIDS). Please see page 59 for more information on SIDS.

The more smoke a child is exposed to, the more that child's risk for illness is increased. Therefore, if a smoking parent handles most of the childcare, a child's chances of developing the ailments listed above are greater. The risk is highest if both parents smoke.

Help is available

Quitting smoking is hard, but we'll help you find the support you need to kick the habit.

Independence Blue Cross offers you and any other member living in your household a no-cost membership in the Healthyroads Quit&Fit Tobacco Cessation Program. Healthyroads is a leader in the development of telephone-based health improvement programs and provides a variety of tools and resources to help you quit smoking.

Take the road to good health

Independence Blue Cross offers you and any other member living in your household a no-cost membership in the Healthyroads Quit&Fit Tobacco Cessation Program. Healthyroads is a national leader in telephone-based health improvement programs and provides a variety of tools and resources to help you quit smoking.

Even if you're not ready to quit, telephone counseling and support programs are available to help you prepare to quit, cut back, and take control of your smoking habit.

Upon enrollment in Healthyroads, you'll be interviewed via telephone by a professional Healthyroads Coach® who will help you determine the best way to meet your tobacco cessation goals.² For more information on how to enroll in this free program, contact a Baby BluePrints case manager by calling 1-800-598-BABY.

Alcohol and drug cessation

According to the National Council on Alcoholism and Drug Dependence, there's no known safe level of alcohol intake during pregnancy. Therefore, it is recommended that pregnant women avoid all alcohol.

Drinking during pregnancy can cause fetal alcohol syndrome (FAS), which is one of the most common causes of mental retardation and the most preventable. Even moderate drinking can have an effect on your baby. Children diagnosed with a lesser degree of

FAS, called fetal alcohol effects (FAE), may have the following problems:

- low birth weight;
- heart and facial abnormalities;
- problems eating and sleeping;
- poor coordination;
- impaired hearing and vision;
- delays in growth and development;
- trouble following directions or learning;
- short attention span;
- lack of control of their behavior.

Heavy (or binge) drinkers are also more likely to have a miscarriage than non-drinkers. If you had an occasional drink prior to realizing you were pregnant, it's unlikely that it will harm your baby. But if you're still drinking — stop! It's one of the best ways to ensure your baby gets a healthy start. Remember, help is available if you need it.

Do not use street drugs

Using illegal or "street" drugs during pregnancy is risky for both mother and baby. Illegal drug use can cause problems throughout your pregnancy. The early stage of pregnancy is when the main body parts of

²American Specialty Health, Inc. is an independent company that administers its Quit&Fit program for Independence Blue Cross members. Healthyroads Coach and Healthyroads Coaching are trademarks of American Specialty Health, Inc.

your baby are formed. Using drugs during this time can cause birth defects and miscarriage. Illegal drug use during the last 12 weeks of pregnancy can stunt the growth of your baby and even cause preterm delivery and fetal death. If you are using drugs — stop. Help is available if you need it.

Sexually transmitted infections

These are infections that you get through sexual contact. Some infections are transmitted by any kind of sexual activity, not just sexual intercourse. Early detection and treatment can minimize the risks for both you and your developing baby. Please remember that treatment is available for most of these sexually transmitted infections. Be sure you get counseling before and after you have your tests so that you will understand what the results mean and what you and your partner have to do.

Some common sexually transmitted infections:

- chlamydia
- genital herpes
- trichomoniasis
- gonorrhea
- hepatitis B
- hepatitis C
- HIV
- syphilis
- human papillomavirus (HPV)

Who is at risk?

You may be at risk if you have had more than one partner or if your partner has been active with other people. Even with protection, you can become infected. If you have any doubt

about whether you have a sexually transmitted infection, it is always better to be tested.

HIV and syphilis screening should be included in the routine prenatal screening tests for all women. Repeat screening in the third trimester is recommended for those personally at high risk as well as those living in high-risk areas, including parts of Pennsylvania, New Jersey, and Delaware. Discuss this with your health care provider, and explain the reasons you feel you may be at risk. If possible, it is better to be tested and treated prior to becoming pregnant.

What is the treatment?

The treatment differs with each infection. Most sexually transmitted infections can be treated with simple antibiotics. Others require more intensive treatment. In some cases, it is important to have your partner treated so you do not get infected again. The best solution would be to have you both get treated at the same time. If you are not sure your partner needs to be treated, speak to your health care provider. If your partner needs to be treated and chooses not to do so, please refrain from any sexual contact. You are not safe from getting the infection again just because you were treated. Also remember that pregnant women can become infected. Certain treatment may be started even if you are pregnant. If left untreated, the infection can affect not only you but also your unborn child.

What are the symptoms?

Some infections do not have any symptoms; that is why it is important to be tested. If present, symptoms vary with each infection.



Some infections will have a vaginal discharge. Some infections will cause sores. Other symptoms can be burning during urination, itching around the vaginal area, bleeding or pain with intercourse, and pelvic pain. Please consult your health care provider if you have any doubts.

What will happen to my baby?

Sexually transmitted infections can be passed from a pregnant woman to the baby before, during, or after the baby's birth. Some of the harmful effects to babies include low birth weight, conjunctivitis, congenital infection, and pneumonia. Many of these problems can be prevented if the mother receives screening tests and treatment for sexually transmitted infections early in pregnancy and again close to delivery.

For more information about these and other sexually transmitted infections, visit the Centers for Disease Control and prevention at www.cdc.gov/std.

Postpartum blues and depression

More than half of all new mothers get the "baby blues." It usually happens at about the third or fourth day after delivery. You may feel sad, cranky, or worried. You may cry for no reason. The good news is that most women feel better within two weeks of delivery.

Helping yourself through the baby blues

There are things you can do to help yourself feel better. Here are some suggestions:

- Tell your friends and family what is going on. Ask them to be patient and supportive.
- Rest when your baby is sleeping. Let your housework go.
- Eat well and drink fluids. Have healthy snacks available that you do not have to prepare.
- Make some time for yourself. Limit your visitors and screen your telephone calls if necessary.
- When someone asks what he or she can do for you, suggest preparing a meal for you and your family.
- Get out of the house; meet with friends.

Postpartum depression:

When the blues won't go away

Postpartum depression is more serious than the baby blues. It lasts longer and does not go away on its own. It is more likely to get worse if it is not properly treated. Some common symptoms are:

- having no energy and not enjoying things that used to be fun;
- feeling hopeless or sad most of the time;
- sleeping or eating too much or too little;
- feeling tired or having little energy;
- feeling restless or irritable;
- having a hard time focusing or recalling things;
- worrying about the baby's health or your ability to be a good mother;
- thoughts of hurting yourself or your child;
- aches or pains that won't go away but don't seem to have a cause.

Postpartum depression facts

- Postpartum depression is a serious problem. About 10 – 15% of all new mothers have it. It can start even several months after delivery.
- Postpartum depression needs to be treated. It does not go away on its own.
- Many women do not get help for postpartum depression. Those who do often wait three to nine months before asking for help.
- When postpartum depression is not treated, babies may not get the care they need.
- There are safe treatments for postpartum depression that work.

Postpartum depression can affect your baby

Newborns need a lot of attention. Caring for a baby and dealing with postpartum depression

can be hard to handle. If you feel down, get help. When mothers feel better, they give their children the care they need. This helps children's physical and emotional health.

Help is available!

- Share how you are feeling with your health care provider.
- If you feel more comfortable, talk with your family physician, the baby's physician, or a Baby BluePrints nurse case manager.
- You may also call your mental health benefits provider. The phone number is printed on your health plan identification card.

Get immediate help if you:

- are thinking of hurting your baby, yourself, or others;
- are having trouble caring for yourself, your baby, or other children.

Other resources

You can get more information about postpartum depression and local support groups by contacting:

- Postpartum Support International:
www.postpartum.net
- National Women's Health Information Center:
www.womenshealth.gov/faq/depression-pregnancy.cfm
- National Institutes of Mental Health:
www.mededppd.org/mothers/

There is also information about postpartum depression at your local library. Consider reading:

- *Postpartum Survival Guide* by A. Dunnewald & D. G. Sanford.
- *This Isn't What I Expected: Overcoming Postpartum Depression* by Karen R. Kleiman, MSW, and Valerie D. Raskin, MD.

- *Mothering the New Mother* by Sally Placksin.
- *Overcoming Postpartum Depression & Anxiety* by Linda Sebastian.

Being informed will help you understand postpartum depression and how to treat it. You'll also discover that you're not alone.

Get into a “recovery routine”

In addition to seeking medical care for postpartum depression, you should also practice healthy habits. Exercise three times a week. Spend time with friends and family. Give yourself a few minutes of time to yourself every day. Make an effort to recognize what's good in your life, and reward yourself for small accomplishments.

11. Diet and nutrition

Diet and nutrition during pregnancy

Your baby needs good nourishment at regular intervals; your diet during pregnancy greatly affects your baby's health. Be sure to take your prenatal vitamins, select a varied and balanced diet that includes all the essential food groups, and get plenty of dietary calcium, protein, vitamin C, vitamin D, iron, and folic acid.

Calcium

Calcium, found in foods like milk, cheese, cottage cheese, yogurt, and leafy green vegetables, is essential for your baby's developing bones. During pregnancy, women 19 years or older need a minimum of 1,000 milligrams (mg) of calcium per day (equivalent to about four cups of milk or yogurt). If you are lactose-intolerant, talk to your maternity care provider about calcium supplementation and lactase enzyme tablets.

Vitamin D

You also need vitamin D to absorb the calcium properly. Prenatal vitamins, fortified dairy and cereal products, egg yolks, and liver are good sources. Getting outside in the sunlight several times a week helps, too. Do not take more

than 2,000 IU of vitamin D a day without specific physician instruction to do so.

Protein

You will also need to consume a variety of foods rich in protein. Poultry, lean meat, and fish, as well as nuts, seeds, soy products, beans, eggs, and dairy products all supply protein. One meat serving is the amount you can hold in the palm of your hand, similar to the size of a deck of cards. Because of the possibility of mercury contamination of fish, pregnant or nursing women should discuss any questions they may have with their health care provider. In general, large saltwater fish have the highest concentrations of mercury and should be avoided (shark, swordfish, king mackerel, or tilefish contain high levels of



mercury). Visit www.epa.gov/waterscience/fish/advice/ for additional information.

Vitamin C

Fresh fruits and vegetables are the best source of vitamin C. Since the body does not store vitamin C, you need to replenish this vital nutrient every day with foods such as red and green peppers, oranges, grapefruits, and strawberries. Prolonged storage and cooking destroy the vitamin C found in these foods. So remember to keep it fresh!

Iron

During pregnancy, the extra blood your body produces needs iron to carry oxygen. That is why your maternity care provider may prescribe an iron supplement. Iron found in red meat is absorbed into the body. However, if red meat is not included in your diet, beans, dried fruits like apricots and prunes, leafy greens like spinach, and cereals, breads, and pasta fortified with iron can provide you with extra iron. Be sure to combine these sources with vitamin C to aid in absorption.

Folic acid

You need 0.4 – 0.8 mg (400 – 800 micrograms) of folic acid each day for your health and to prevent certain birth defects. The body cannot store this nutrient, so you will need to

For more information on nutrition during pregnancy and breast-feeding visit: www.mypyramid.gov/mypyramidmoms

replenish it daily by consuming fresh dark green vegetables, fruits, nuts, seeds, and/or cereals fortified with folic acid. Whole-grain breads are also a good source of folic acid. Prenatal vitamins contain enough folic acid to protect your baby and you, so be sure to take them daily!

Water

Along with maintaining a healthy diet, you need to drink plenty of fluids. Your body needs about eight 8-ounce glasses of water a day when you're not pregnant. When you are pregnant, your blood volume expands by nearly half, so it's important to keep yourself hydrated. Water, low-fat milk, and 100 percent fruit juice are good sources of fluid. Limit the amount of soda that you drink each day.

Caffeine can have harmful effects on your pregnancy. Minimize your intake, and remember that caffeine is in tea, some sodas, and chocolate as well as coffee.

Visit www.cfsan.fda.gov for information on food safety during pregnancy.

Feeding your baby

When it comes to feeding your baby, there are several options to consider, including:

- breast-feeding;
- bottle (formula) feeding;
- a combination of bottle and breast feeding.

Breast-feeding

Human milk is designed for human babies. It's easier to digest, there's nothing to prepare, and it doesn't cost you anything. Breast-feeding also provides your baby with warmth,

closeness, and contact from the very beginning of life.

When you become pregnant, your body automatically prepares to breast-feed. By the fourth or fifth month of pregnancy, you are capable of producing your first highly fortified milk called colostrum. Colostrum is packed with all the nutrients your newborn needs. It also provides antibodies that may help protect your baby against the following:

- ear infections
- allergies
- vomiting
- diarrhea
- pneumonia, wheezing, and bronchiolitis
- meningitis

After three to five days, your milk will change from colostrum to the thinner white milk your baby will receive for the rest of the time you breast-feed. The American Academy of

Pediatrics (AAP) encourages mothers to breast-feed for at least one year in order to ensure your baby receives the healthiest start.

It is important to check with your pediatrician about any medications you need to take while you are breast-feeding.

All breast-fed babies need vitamin D supplementation — please discuss this with your pediatrician. The FDA's website www.mypyramid.gov/mypyramidmoms is a great resource during pregnancy and breast-feeding.

Women who breast-feed need more fluid and calories than they did before they became pregnant. One suggestion is to drink a glass of water or other beverage every time you breast-feed.

Along with the benefit to your baby, breast-feeding may help you return to your pre-pregnancy weight faster. Breast-feeding also helps the uterus return to pre-pregnancy size more quickly after delivery. Other benefits, according to the American College of Obstetricians and Gynecologists, include a reduced risk of ovarian and premenopausal breast cancer.

For tips to facilitate a good breast-feeding start, visit the AAP website at www.aap.org or www.4woman.gov



If you are experiencing difficulty with breast-feeding or would like more information, call the Baby BluePrints department at 1-800-598-BABY. A registered nurse will assist you by providing valuable community support group information, educational websites, or even information about certified lactation consultants. If those resources don't solve your breast-feeding difficulties, such as latch-on problems, it is important that you seek help from a physician or another professional, such as a lactation consultant.

Breast-fed babies tend to feed more often than bottle-fed babies, usually 8 to 12 times in 24 hours (every two to three hours around the clock). All newborns should be wetting at least six diapers per day and have two to five loose yellow stools per day, depending on their age.

Storing your milk

If you have chosen to breast-feed, you can express your milk and use it in a bottle rather than formula.

Here are a few safe storage tips:

- Always wash your hands before expressing or handling your milk.
- Express milk into a clean container. Try to use screw-cap bottles, hard plastic cups with tight caps, or special heavy nursing bags designed to store breast milk. Do not use ordinary plastic storage bags or formula bottle bags for storing expressed milk.
- Use sealed and chilled milk within 24 hours if possible. Discard all milk that has been refrigerated more than 72 hours.
- Freeze milk if you will not be using it within 24 hours. Frozen milk is good for at least one month (three to six months if kept in a zero-

degree freezer). Store it at the back of the freezer and never in the door section. Make sure to label the milk with the date that you freeze it. Use the oldest milk first.

- Freeze two to four ounces of milk at a time because that is the average amount of a single feeding.
- Do not add fresh milk to already frozen milk in a storage container.
- You may thaw milk in the refrigerator or thaw it more quickly by swirling its container in a bowl of warm water.
- Do not use microwave ovens to heat bottles because they do not heat evenly. Uneven heating can easily scald your baby or damage the milk. Excess heat can destroy important proteins and vitamins in the milk. Bottles can also explode if left in the microwave too long.
- Milk thawed in the refrigerator must be used within 24 hours.
- Do not refreeze your milk.
- Do not save milk from a used bottle for use at another feeding.

Bottle-feeding

There are several reasons you may choose to bottle-feed your baby. Often premature babies have a poor sucking reflex that makes breast-feeding difficult if not impossible for your baby. Other reasons include maternal health conditions that make breast-feeding unsafe for the baby, such as:

- HIV or HTLV-1 positivity;
- cancer chemotherapy;
- abusing drugs or alcohol;
- infectious (contagious) tuberculosis — breast-feeding is safe after the mother has undergone treatment and is no longer contagious;

- hepatitis A — breast-feeding is safe after the mother receives a dose of gamma globulin;
- hepatitis B — breast-feeding is safe after the baby receives a dose of hepatitis B immune globulin (HBIG). The baby should also be started on the first of three doses of hepatitis B vaccine;
- hepatitis C and E — breast-feeding is safe; however, the mother should not nurse if her nipples are cracked or bleeding;
- herpes simplex — breast-feeding is safe if there are no lesions on the breast;
- chicken pox — breast-feeding is safe as soon as the mother is non-infectious, meaning all the spots are crusted over;
- Lyme disease — breast-feeding is safe as soon as the mother initiates treatment.

Remember that it is safe to breast-feed your baby during common infectious illnesses such as colds and flu. Such illnesses are not passed through breast milk. Even mastitis (an infection in the breast) does not pose any risk to your baby.

Some medications are passed through breast milk and some of those are not good for the baby. Please check with your pediatrician or pharmacist about any medication you are prescribed.

If you choose to bottle-feed, only iron-fortified formula is recommended, but check with your child's physician about the type of formula that is best for your baby.

Combination feeding

Sometimes it's just not possible to breast-feed as long as you would like. There might be a need to return to work, or you might want to share the responsibility of feeding with a family member. If you choose to combine breast-feeding and bottle-feeding, try to wait until the baby is at least three to four weeks old. Breast-feeding should be well established by then, but your baby won't be resistant to the new kind of nipple. It's best to have someone other than the mother give the first bottle. Babies recognize smell, and by having a different person give the bottle, your baby will be more likely to accept the milk. This will also help working mothers who choose to use a breast pump after returning to work as bottle-feeding will already be an established part of your baby's routine.

Discuss your feeding options

Before your baby is born, talk to your doctor or midwife about your options for feeding. It's best to begin breast-feeding within the first hour of your baby's life, so if you choose to breast-feed, let your maternity care provider know prior to your delivery. You should also ask for assistance from your doctor, midwife, or nurse if you are having difficulty getting started.



III. Medication and immunizations

Medication during pregnancy and after

It's important to keep your body as healthy as possible during pregnancy. You may have given up alcohol, quit smoking, and cut down on caffeine, but have you thought about the prescription medication, over-the-counter medication, herbal or homeopathic remedies, and/or supplements that you are taking? Be sure to inform your doctor or midwife (and any other doctors or specialists you see) about everything you are taking, and do not start taking anything new without discussing it with your maternity care provider first.

Also, do not stop taking any prescription medication without consulting your doctor or midwife first. Some medications, if stopped suddenly, can cause severe reactions.

For additional information about medication during and after pregnancy, visit:

* The National Library of Medicine:

www.medlineplus.gov

* The Organization of Teratology Information Specialists (OTIS):

www.otispregnancy.org

* The March of Dimes:

www.marchofdimes.com

The following list includes some of the types of medications that may cause a problem for you or your fetus if taken during pregnancy. Not all drugs in each category are equally problematic. Also, this list is not all-inclusive; discuss all your medications with your doctor or midwife. He or she will help you decide what is best for you. You must not use the following medications in pregnancy: DES, thalidomide, oral accutane, or oral blood thinners (anticoagulants).

Discuss these drugs with your doctor as soon as possible:

- ACE inhibitors used for high blood pressure or heart disease;
- any medications used for:
 - seizures or migraine headaches;
 - anxiety or to help you sleep;
 - depression and other psychiatric problems;
 - cancer, psoriasis, rheumatoid arthritis, organ transplant rejection, hepatitis C;
 - ulcers;
 - high cholesterol.
- antibiotics.

Note: If you see a doctor other than your doctor or midwife during pregnancy, be sure to remind him or her that you are pregnant, especially early in pregnancy when your pregnancy may not be apparent.

Immunizations:

Your family's best protection

You can keep your family well-protected by keeping immunizations up-to-date. Use the *Childhood Immunization Schedule* inside the back cover of this book to track your child's immunizations through age six. Also, don't forget to discuss your immunization status with your health care provider.

Recommended immunizations for you and your baby

During pregnancy and after birth, vaccines are some of the best ways to ensure your good health and prevent disease.

The flu

The flu is an acute respiratory infection caused by a variety of influenza viruses. Typical symptoms include fever, cough, sore throat, headache, muscle aches, and extreme fatigue. Epidemics of influenza occur almost every year during the winter months. In general, pregnant women are at higher risk for serious complications, so it is important to try to protect yourself from getting sick and to contact your health care provider if you become ill.

Seasonal flu

The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) recommends all women who will be pregnant at any time during the flu season (between November and March) receive a flu vaccination. The shot contains inactivated virus, so it is safe for you and

your baby. The intranasal vaccine has live virus and is not recommended for pregnant women.

In addition, the following medical conditions could increase your risk of complications from the flu:

- asthma;
- heart disease;
- diabetes;
- kidney disease;
- a bleeding or immune system disorder;
- any condition that can affect respiratory function, including chronic lung disease, spinal cord injury, or seizure disorder.

You should consider a flu vaccine especially if you have any of these conditions.

Be sure to speak to your doctor or midwife if you have any questions or concerns about receiving a flu vaccine.

Pandemic flu

A flu pandemic occurs when a new influenza virus emerges for which there is little or no immunity in the human population. The virus spreads easily from person-to-person

worldwide and may cause serious illness.³ As with the seasonal flu, vaccination is the best protection against a pandemic flu. If you are pregnant during a pandemic flu outbreak, talk to your doctor or midwife about getting vaccinated.

Hepatitis B

In addition to all newborns, pregnant women who have not been immunized should consider vaccination for the hepatitis B virus.

What is hepatitis B?

The hepatitis B is a liver disease caused by the hepatitis B virus (HBV). It ranges in severity from a mild illness, lasting a few weeks (acute), to a serious long-term (chronic) illness that can lead to liver disease or liver cancer.

HBV is spread:

- during birth — from an infected mother to her newborn;
- by sharing needles with a person who has HBV;
- by having sex with a person who has HBV.

What you need to know about HBV immunization during pregnancy:

- If you have not been immunized against HBV, be sure to have a blood test for HBV.
- If you do not show evidence of HBV in your blood, be sure to talk to your doctor or midwife about whether you should be vaccinated and when.
- If you have been immunized, talk to your doctor or midwife about a blood test to determine your current immunity status.

If you tested positive for hepatitis B, then your newborn will be given two shots immediately in the delivery room:⁴

- the first dose of the hepatitis B vaccine;
- one dose of the hepatitis B immune globulin (HBIG).

If you tested negative for hepatitis B, then your newborn will receive the first dose of the hepatitis B vaccine in the hospital.

Whooping cough (pertussis)

All new mothers should receive one dose of Tdap (tetanus, diphtheria, and acellular pertussis) immediately postpartum if they have not already been vaccinated with Tdap. Ideally, the postpartum Tdap should be given before

³ www.pandemicflu.gov/individualfamily/about/index.html

⁴ Hepatitis B Reference Summary. Available from the National Library of Medicine and the National Institutes of Health website, www.nlm.nih.gov/medlineplus/tutorials/hepatitisb/htrm/index.htm.



discharge from the hospital. Tdap is also recommended for those who will be coming into close contact with newborns (less than 12 months old), such as parents, grandparents, childcare providers, and health care professionals (younger than 65). Tdap should be given at least two weeks prior to handling the infant to allow the vaccine to take effect.

What is whooping cough?

Whooping cough (also known as pertussis) is a very contagious disease caused by a type of bacteria called *Bordetella Pertussis*. This is one of the most common vaccine-preventable childhood diseases in the United States and has been responsible for newborn deaths.

Whooping cough is spread by coughing or sneezing while in close contact with others, who then breathe in the pertussis bacteria. Many infants who get pertussis are infected by older siblings or parents who might not even know they have the disease.

Rh factor and Rh incompatibility

The Rh factor is the positive or negative part of your blood type (e.g., your blood type may be O-positive or O-negative, AB-positive or AB-negative, etc.).

If your Rh factor is negative and your partner's blood is Rh-positive, there is a possibility that you and your baby will be Rh incompatible (meaning your baby's blood is Rh-positive, like your partner's, while you are Rh-negative).

If you and your baby are Rh incompatible, your body may make antibodies to fight your baby's blood. This happens when a small amount of the baby's blood mixes with your blood (during

pregnancy or delivery). The antibodies are generally harmless during the first pregnancy. However, if you have another pregnancy with an Rh-positive baby, your antibodies may attack the baby's red blood cells, and the baby may develop a life-threatening condition known as Rh disease.

If you are Rh-negative, your health care provider will likely give you an Rh immune globulin (IG) injection (RhoGam® or similar) at about 28 weeks into your first pregnancy. You'll need another IG injection shortly after delivery if the baby is Rh-positive. Also, you'll likely need an IG injection during any subsequent pregnancies and after the delivery of each Rh-positive baby as well. The IG blocks your body's recognition of Rh positive cells, which prevents any problems with Rh incompatibility.

IV. Safety at home and on the road

Seatbelt use and car safety

Seatbelts, air bags, and car seats are designed to prevent serious injury. Correctly wearing your seat belt during pregnancy and using a car seat from the very first time you take your baby home from the hospital can help ensure both your own and your child's safety.

Seatbelts and pregnancy

During pregnancy, you will need to adjust your seat belt to ensure both your own and your baby's safety. Make sure the lap belt is snug across your pelvis and not across your belly. The shoulder belt should fit snugly between your breasts. During a crash, a sudden jolt may actually cause the placenta to separate from the uterus if your belt is worn incorrectly.

Airbags

Airbags have saved thousands of lives since they were introduced. However, both children and adults face the risk of air bag injury or

death if they are positioned too close to the air bag or are not wearing a seatbelt. Air bags are designed to be used with seat belts, not instead of them. The following safety tips may help prevent injuries from air bags in the event of an accident:

- Always wear your seat belt.
- Move your front seats as far away from the dashboard or steering wheel (and the air bags contained within) as possible while maintaining a safe, comfortable position.
- Never put rear-facing child seats in the front passenger seat (they put your baby's head too close to the air bag).

Car seats

Child car seats are extremely effective when used correctly. But while 96 percent of parents

SAFETY FIRST

If you are in an accident during your pregnancy, be sure to call your doctor or midwife as soon as possible — even if the accident seems minor and you feel fine.



and caregivers believe their child's seat is installed correctly, research shows that seven out of ten children are improperly restrained. Review the following basics of car seat use and help protect your child.

Basic of car seat use:

- You must use a rear-facing infant's seat — starting with your baby's first ride home from the hospital. This type of seat is for infants up to one year old and 20 pounds.
- As your child grows, move to a car seat that is more appropriate for your child's age and weight.
- Read the manufacturer's instructions, and keep them with the car seat.
- Read your vehicle's owner's manual for information regarding seat installation.
- Install your child's car seat in the back seat (in the middle, if possible).
- If your car has it, use the LATCH (Lower Anchors Tethers for Children) system to install your child's car seat. The LATCH system does not require the use of your car's seat belts and offers better head protection for your child.
- Children under 12 should always ride in the back seat and be properly restrained. This not only puts them further away from harm (most car crashes are head-on) but keeps them away from active air bags that may cause injury.

Here are a few things to consider when shopping for a car seat:

- No one seat is the safest or best. The best seat for you is one that fits your child's size and weight and can be installed properly in your car.

- Cost is not an indicator of quality. High prices on car seats may mean added features that may or may not make the seat easier to use or safer.
- When you find a proper seat, test it out before you buy it. Make sure it fits in your car, that you can adjust the harness, and that it buckles correctly.

Babies and kids in back

An airbag can save your life. However, airbags and young children do not mix. Even in a slow-speed crash, the force of a deployed airbag can injure or kill a young child. Riding in the back seat eliminates children's risk of injury from front passenger or side airbags.

Children age 12 and younger should always ride in the middle of the back seat and be properly restrained.

Proper child safety seat use

Most county highway safety departments offer car seat checks to ensure that your seat has been properly installed. To ensure your child is riding correctly on every trip, arrange to have your child safety seat inspected by a certified technician. Once the car seat is in place, be sure to check the following:

- Is your child buckled into the seat correctly?
- Is the car seat buckled or tethered into your vehicle correctly?
- Did you test to see if the seat is snug and secure?

To obtain contact information for a child safety seat inspection location near you, visit www.seatcheck.org or call toll-free 1-866-SEATCHECK.

4 Easy Steps to Protect America's Children



REAR-FACING SEATS in the back seat from birth to at least 1 year old and at least 20 pounds.



FORWARD-FACING TODDLER SEATS in the back seat from age 1 and 20 pounds to about age 4 and 40 pounds.



BOOSTER SEATS in the back seat from about age 4 to at least age 8, unless 4'9" tall.



SAFETY BELTS at age 8 and older or taller than 4'9". All children age 12 and under should ride in the back seat.

Source: National Highway Traffic Safety Administration. Child Passenger Safety. Available from www.nhtsa.gov.



Lead poisoning: protect yourself and your baby

Lead poisoning is a serious health risk to children and pregnant women. By understanding where you or your child may be exposed and taking the steps necessary to prevent exposure, you can create a safer environment.

Know the dangers

From conception through approximately age six, children face the greatest risk of lead poisoning. Even in the smallest doses, lead may affect your baby. Here are some of the most common places where lead is found:

- dust and paint chips from old paint often found on windowsills, doorframes, walls, and porches;
- homes built prior to 1978, particularly those in need of repair or that are deteriorating;
- soil contaminated by lead-based insecticide or chips and dust from exterior paint;
- tap water in homes that have:
 - lead pipes;
 - plumbing fittings made out of brass or bronze;
 - lead solder used to connect plumbing.
- workplace dust brought home on the clothing of people who have jobs that use lead;
- dust from renovations;
- traditional (folk) medicines;
- toys that have been made in other countries and then imported into the United States or antique toys and collectibles passed down through generations.

Lead poisoning is preventable —

Prepare your home

Preparing your home for your baby can help prevent lead poisoning.

Here are a few simple things you can do to make your home safer:

- Watch for chipping and flaking paint, and clean with a wet mop or sponge.
- Use lead-free interior paints on toys, walls, furniture, etc.
- Have your water tested. If you have lead pipes, run the first morning tap water for two minutes before using it for drinking or cooking. Do not use hot tap water for mixing formula, drinking, or cooking.
- Identify and replace lead plumbing materials with lead-free materials.

Signs and symptoms

Unfortunately, there are usually no obvious signs or symptoms associated with lead poisoning. However, they may include:

- stomach aches and cramps
- irritability
- fatigue
- frequent vomiting
- constipation
- headache
- sleep disorders
- poor appetite
- inattention and hyperactivity

These symptoms are often mistaken for other illnesses. If you believe lead poisoning is a possible problem, talk to your baby's physician right away.

For information about lead poisoning

Many state and local health offices offer additional information, support, and resources to parents on how to avoid lead poisoning in their children.

- For residents of Philadelphia, the Lead Safe Babies program also includes an in-home assessment for the presence of lead. For more information, call 215-731-7148.
- New Jersey residents can visit Lead Safe NJ at www.state.nj.us/dca/dcr/leadsafe for more information.
- Delaware residents can learn more at the Office of Lead Poisoning Prevention: www.dhss.delaware.gov/dph/hsp/lead.html

Domestic violence

Domestic violence is a serious problem that affects many women. Pregnant women are particularly vulnerable to abuse and by some estimates suffer partner abuse at a higher rate than women who are not pregnant.

According to the Centers for Disease Control and Prevention (CDC), 1.5 million women in the United States report a rape or physical assault each year. This number includes 324,000 who are pregnant. Unfortunately, domestic violence frequently begins or intensifies during pregnancy. It is one of the most common complications during pregnancy affecting both the mother and unborn child. Even one incident is one too many, although domestic abuse is defined as a pattern of behavior of threatened or actual physical or psychological violence committed by a current or former intimate partner.

Many women do not recognize that they are being abused.

Abuse may take the following forms:

- physical abuse — hitting, slapping, kicking, punching, beating, etc.;
- verbal abuse — criticism, making the victim feel bad, name-calling, yelling;
- sexual violence — rape, forced sexual activities, degrading sexual acts;
- isolation — making it hard to see friends or relatives, reading the victim's mail, monitoring telephone calls, controlling visits;
- unreasonable expectations — making the victim feel guilty for not meeting expectations, sulking, making impossible rules and giving punishments for breaking them;
- economic control — not paying bills, withholding money, not letting the victim work, or taking the victim's earnings;
- threats and intimidation — threats to harm the victim, children, friends, or pets, and shouting, keeping weapons, and threatening to use weapons;
- emotional withholding — not expressing feelings, not giving compliments, ignoring, not taking the victim's concerns seriously, disrespect;
- abusing trust — lying, breaking promises, being unfaithful, overt jealousy, withholding important information;
- harassment — following or stalking, causing embarrassment in public, refusing to leave when asked;
- destruction of property — breaking furniture, punching walls, throwing things, destroying the victim's personal items;
- self-destructive behavior — drug or alcohol abuse, threatening suicide, reckless driving.

What can you do?

Really take a look at your relationship. Is this what you want for yourself or for your

children? Often, abuse during pregnancy will lead to child abuse. The physical and psychological effects from abuse can last a lifetime. If you feel that you are being abused, you do have choices. Help is available!

- Talk with your doctor or midwife. He or she can provide resources to help you.
- Call the toll-free National Domestic Violence Hotline at 1-800-799-SAFE (7233). Trained counselors are able to provide crisis intervention to victims, their families, and their friends.
- To learn more, visit:
 - National Coalition Against Domestic Violence: www.ncadv.org
 - The National Domestic Violence Hotline: www.ndvh.org
- Make a safety plan. This is a plan for when you feel ready to leave your home. Have an escape plan in mind, identifying a person or persons whom you can contact if you need to leave at once. It is good to have collected some things that you will need. It is usually safer to leave them with a neighbor or friend.

SIDS: sudden infant death syndrome

Sudden infant death syndrome (SIDS) is defined as the sudden death of a seemingly healthy infant less than one year of age that remains unexplained after a complete investigation. In most cases, SIDS occurs while an infant is sleeping.

What causes SIDS?

SIDS is the leading cause of death in babies after one month of age. There is no known

cause for SIDS; however, there is evidence that some SIDS babies are born with brain abnormalities that create problems with sleep arousal and an inability to sense a buildup of carbon dioxide in the blood. The peak occurrence for these deaths is between two and four months, and 90 percent of babies who die from SIDS die before six months of age.

In recent years, the number of SIDS deaths has declined dramatically due in part to the National Institute of Child Health and Human Development's campaign to place infants on their backs to sleep. Since the *Back to Sleep* campaign was initiated, SIDS deaths have declined by 40 percent.

Can the risk of SIDS be lowered?

Currently, there is no way to predict if your baby will succumb to SIDS. There are, however, several things you can do while you are pregnant and after your baby is born to reduce his or her risk:

- Be sure to see your doctor or midwife as recommended throughout your pregnancy.
- Eat a well-balanced diet, including at least five servings of fruits and vegetables daily.
- Abstain from smoking, drugs, or alcohol use.
- Take an infant and child CPR/first-aid course.
- Place your baby on his or her back to sleep.
- Make sure your baby sleeps on a firm mattress. Avoid using fluffy blankets, coverings, or pillows and placing stuffed toys in the crib.
- Avoid overheating your baby. Keep the temperature in the baby's room comfortable for an adult, and dress your baby in as little or as much clothing as you would wear, plus one layer.
- Take your child to his or her health care provider for regular checkups and immunizations and to discuss any concerns.



Answers to questions about childhood immunization

1. Haven't many of the diseases the vaccines aim to prevent been eradicated?

Many diseases are controlled as a result of broad-based vaccination programs. However, cases of communicable diseases continue to be a threat, and the Advisory Committee on Immunization Practices recommends vaccination programs as a preventive health measure.

2. What are the possible side effects of these vaccines? You should speak with your health care provider. Some children may develop a fever or a rash in reaction to certain vaccines, but these side effects are short-lived and can be treated with children's medications to minimize discomfort. Serious reactions are highly unusual.

3. Does my child really need this many injections? Yes, say experts. Vaccinations are necessary to protect your child. Your health care provider may be able to give a combined vaccine to reduce the number of times your child must return to the health care provider's office.

4. How critical is the timing of these vaccines? Several authorities indicate that your child should be given the completed primary series of vaccines before age 2 at intervals recommended by your health care provider to give your child the greatest possible benefit.

5. Will there be a cost associated with getting my child vaccinated? You may be responsible for an office visit copayment. Please refer to your benefits description material for complete details of the terms, limitations, and exclusions of your coverage.

6. Do vaccines containing thimerosal cause autism? The medical and scientific communities have carefully and thoroughly reviewed the evidence concerning the vaccine-autism theory and have found no association between vaccines and autism. If parents have questions or concerns about childhood vaccines, they should talk with their child's health care provider. For more information visit:

<http://cdc.gov/features/autismdecision/>

Recommended childhood

Child's name: _____

VACCINE*	Check off <input checked="" type="checkbox"/>
Diphtheria, Tetanus, and Pertussis (DTaP)	<input type="checkbox"/> 1ST dose 2 months Date: _____
Inactivated Poliovirus	<input type="checkbox"/> 1ST dose 2 months Date: _____
Measles, Mumps, and Rubella	<input type="checkbox"/> 1ST dose 12 – 15 months Date: _____
Haemophilus influenzae type b (Hib)	<input type="checkbox"/> 1ST dose 2 months Date: _____
Varicella (chicken pox)	<input type="checkbox"/> 1ST dose 12 – 15 months Date: _____
Hepatitis A	<input type="checkbox"/> 1ST dose 12 – 23 months Date: _____
Hepatitis B	<input type="checkbox"/> 1ST dose Birth Date: _____
Pneumococcal	<input type="checkbox"/> 1ST dose 2 months Date: _____
Influenza	<input type="checkbox"/> 1ST dose Date: _____
Meningococcal	<input type="checkbox"/> Dose Date: _____
Rotavirus	<input type="checkbox"/> 1ST dose 2 months Date: _____
Other	Vaccination Name: _____ Date: _____

* Please check your child's immunization record, provided by your child's health care provider (which lists all vaccinations given and the dates), against this list. If any immunizations are missing, or if you do not have a record, please call your child's health care provider now and schedule a visit.

† There are combination vaccinations, different variations of a similar vaccine, and acceptable variations in vaccination schedules available. Children identified at high risk or with certain chronic illnesses may be vaccinated on a different timetable or need additional vaccines, such as influenza, hepatitis B, pneumococcal, and

immunization health record for children up to age 6

Birth date: _____

vaccinations and record dates received in boxes below.

<input type="checkbox"/> 2ND dose 4 months Date: _____	<input type="checkbox"/> 3RD dose 6 months Date: _____	<input type="checkbox"/> 4TH dose 15 – 18 months Date: _____	<input type="checkbox"/> 5TH dose 4 – 6 years Date: _____
<input type="checkbox"/> 2ND dose 4 months Date: _____	<input type="checkbox"/> 3RD dose 6 – 18 months Date: _____	<input type="checkbox"/> 4TH dose 4 – 6 years Date: _____	
<input type="checkbox"/> 2ND dose 4 – 6 years Date: _____		<input type="checkbox"/> 3RD dose† 6 months Date: _____	
<input type="checkbox"/> 2ND dose 4 months Date: _____	<input type="checkbox"/> 3RD dose† 6 months Date: _____	<input type="checkbox"/> 4TH dose 12 – 15 months Date: _____	
<input type="checkbox"/> 2ND dose 4 – 6 years Date: _____		<input type="checkbox"/> 4TH dose 12 – 15 months Date: _____	
<input type="checkbox"/> 2ND dose To be given 6 months after 1st dose Date: _____		<input type="checkbox"/> 4TH dose 12 – 15 months Date: _____	
<input type="checkbox"/> 2ND dose 1 – 2 months Date: _____	An additional dose is acceptable at 4 months. Discuss with your health care provider.†	<input type="checkbox"/> Final dose 6 – 18 months Date: _____	
<input type="checkbox"/> 2ND dose 4 months Date: _____	<input type="checkbox"/> 3RD dose 6 months Date: _____	<input type="checkbox"/> 4TH dose 12 – 15 months Date: _____	
<input type="checkbox"/> 2ND dose (administered 4 weeks or more from last dose. ‡) Date: _____		<input type="checkbox"/> Annually Date: _____	

Meningococcal conjugate vaccine (MCV) is administered to at-risk children 2 – 10 years of age.†

<input type="checkbox"/> 2ND dose 4 months Date: _____	<input type="checkbox"/> 3RD dose† If RV1 is given at 2 and 4 months, it is not needed at 6 months.
Vaccination Name: _____ Date: _____	Vaccination Name: _____ Date: _____

Haemophilus influenzae vaccines. Please discuss your child's immunization schedule with your child's health care provider. This schedule is adapted from several nationally recognized sources.

‡ Administer two doses (separated by four weeks or longer) to children younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time last season but who received only one dose. Minimum age is 6 months for trivalent inactivated influenza vaccine (TIV).

Temporary shortages of individual vaccines may lead to delay in scheduled immunizations. Be sure to have your child "catch up" on any necessary vaccinations as soon as vaccine is available.

Immunization recommendations are constantly changing. These recommendations were current at the time of publishing. Please refer to your benefits description material for the terms, limitations, and exclusions of your health care coverage.

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