Welcome to motherhood.

Oxford Healthy Mother, Healthy Baby®
A practical guide to caring for yourself and your baby during and after pregnancy.
A new beginning.

Learn about all the big changes coming your way, from when you might want to consider calling the doctor and how to get a good night’s sleep to what physical changes you can expect and how to soothe a crying baby. Consider this a guide to helping you calm your new-parent jitters.

What’s inside:

• Support Services
• Prenatal Care
• Nutrition, Exercise and Sleep
• Preparing for the Big Event
• Newborn Care

This guide is designed provide you with additional tools and resources. It is not intended to replace the advice of a doctor or other health care professional. The health-related information contained in this guide is provided by the parenting experts at KidsHealth®. If you would like more information about pregnancy and your health, log on to your health plan’s member website.
We wish you the best of health during this special time in your life, and we look forward to providing you with access to our network of health care providers.

**Home nurse visits.**
After your baby is born, your coverage provides a minimum of 48 hours of hospital care after a vaginal birth or 96 hours of hospital care after a Caesarean Section (C-Section). For some women, going home sooner may be the right thing to do, so we offer home nurse care to members as an option only if they go home early. A visiting nurse will provide in-home medical care, including a full assessment of your health and that of your baby. Please check your Certificate of Coverage or Summary Plan Description, whichever applies to your plan, for information about your specific benefits.

**Oxford On-Call®**
Whether you’re on vacation or have a question at two in the morning, we understand that you may need immediate health care guidance. In situations like these, you can turn to Oxford On-Call 24 hours a day, seven days a week. When you dial 1-800-201-4911, you’ll get personalized attention from a registered nurse who will follow up with your provider as needed.

**Notification of your baby’s birth.**
Within 48 hours of the birth, it is important to let us know that you have delivered your baby. Call us at the toll-free phone number on your health plan ID card or at 1-800-444-6222. You can also notify us online by visiting the website on the back of your health plan ID card.

Please note that this notification does not automatically enroll your child as a member of an Oxford plan. We’re also available to answer questions about benefits, claims and policies.

**Enrolling your newborn.**
To enroll your baby as a new member under your Oxford plan, you should contact your benefits administrator and complete an Addition/Termination/Change Form. Your benefits administrator must sign the completed form and return it to us within 31 days (61 days for Connecticut plans) of your baby’s birth. Forms that are submitted to us without your benefits administrator’s signature cannot be processed.
A primer to help make your pregnancy go as smoothly as possible.

Choose a health care provider you’re comfortable with.

Choosing a health care provider — whether that provider is an obstetrician/gynecologist, family practitioner or certified nurse-midwife — is one of the most important decisions you’ll make during your pregnancy. Take the time to choose wisely. When interviewing potential providers from the Oxford network, look for someone whose philosophy on childbirth matches your own and whose personality puts you at ease. Here are some points to consider when choosing the provider who will administer your prenatal care:

• Does the provider take time to answer your questions and listen to your concerns, both physical and emotional?
• What hospital is he or she affiliated with and what levels of services are offered there?
• Where does your provider stand on issues like pain management during labor, the birthing environment, C-Sections, spouse participation and inductions?
• Is this a solo or group practice? What are the qualifications of any doctors other than your provider who might care for you during your pregnancy?
• Who should you call in an emergency when your provider is not available?
• What is the office atmosphere like?
• Does the staff seem helpful and responsive?
• Does your provider handle high-risk pregnancies? This is especially important to know if you have a pre-existing health condition or a history of pregnancy complications.

When will I start to show?

When you start showing differs from woman to woman. Everyone's body is different, so don’t be alarmed if you think you are showing too early or too late.
The first visit.

Your first examination should take place during the first six to eight weeks of your pregnancy or when your menstrual period is two to four weeks late. Seeing your health care provider during this time will help him or her determine an expected delivery date (EDD). Your EDD is 40 weeks from the first day of your last menstrual period (LMP). It’s important to remember that your due date is only an estimate — most babies are born between 38 and 42 weeks.

At your first visit, your provider will take a detailed medical history of both parents and perform a full physical examination, which may include a Pap test for cervical cancer. You’ll probably be asked to provide a urine sample and a blood sample, which will be used for a series of tests. An HIV test is also recommended.

Routine visits and diagnostic testing.

If you’re healthy and have no complicating risk factors, you can expect to see your health care provider once a month until the 28th week of pregnancy, then twice a month until the 36th week, and then once a week until delivery.

At each examination, your weight and blood pressure will be recorded, and the size and shape of your uterus will be measured to determine if the fetus is growing and developing well. Then comes the most exciting part — listening to your baby’s heartbeat.

During some visits, your urine will be tested for sugar and protein. Sugar in the urine may indicate gestational diabetes, and protein may indicate preeclampsia (a serious condition characterized by a sudden rise in blood pressure and excessive weight gain). Later in the pregnancy, you may also have a pelvic exam.

As an expectant parent, you may also choose to have one or more of the following diagnostic tests depending on your specific circumstance and doctor’s recommendation.

Ultrasound.

You’ll likely have at least one ultrasound examination to make sure the pregnancy is progressing normally and to verify the expected delivery date. The technician coats your abdomen with a gel and then runs a wand-like instrument over it to produce images of the fetus on a computer screen. Ultrasound scanning is used to determine whether the fetus is growing at a normal rate, to record fetal heartbeat or breathing movements, to see whether you might be carrying more than one fetus, to measure the amount of amniotic fluid, and to identify a variety of abnormalities that might affect the remainder of the pregnancy or delivery. Usually it’s performed at 18 to 20 weeks, but it can also be done sooner or later and sometimes more than once.

HIV test.

It is important for women who are pregnant to have their blood tested for HIV, the virus that causes AIDS. If you test positive for HIV, there is a chance that your baby may have the virus too. Certain medications taken during pregnancy can reduce the chance of the virus being passed on to your baby. Current recommendations are for HIV testing to be offered to all pregnant women.
**Screening for genetic disorders and birth defects.**

Pregnant women are offered many tests that can help determine the risk of the fetus having Down syndrome or certain other chromosomal disorders or birth defects. These tests, done in the first and/or second trimester, include blood tests and sometimes an ultrasound study. If the screening tests indicate a possible problem, additional tests (such as CVS or amniocentesis, described below) may be recommended to specifically determine if there is a problem with the fetus.

<table>
<thead>
<tr>
<th>Test Type</th>
<th>What It Is</th>
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<tbody>
<tr>
<td><strong>Alpha-fetoprotein Test (AFP)</strong></td>
<td>Between 16 and 18 weeks, the level of alpha-fetoprotein, a protein produced by the fetus, can be measured in the mother’s blood. Abnormal levels of any of this substance could indicate a problem with the development of the nervous system of the fetus (such as spina bifida) or other problems that might warrant further testing.</td>
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<tr>
<td><strong>Chorionic Villus Sampling (CVS)</strong></td>
<td>This procedure is used during the first trimester to test for certain developmental or chromosomal abnormalities in the fetus, such as Down syndrome or spina bifida. It involves taking a sample of the tissue that attaches the amniotic sac (the sac around the fetus) to the wall of the uterus. This test is usually performed only if screening tests done earlier in the pregnancy have shown a higher risk for problems in the fetus.</td>
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<tr>
<td><strong>Amniocentesis</strong></td>
<td>In this test, which is generally performed between 16 and 20 weeks, a needle is used to remove a sample of the amniotic fluid in the womb. Testing the fluid can identify certain developmental or chromosomal abnormalities in the fetus, such as Down syndrome or spina bifida. Typically, amniocentesis is recommended only if there is reason to believe that the risk for such conditions is higher than usual, perhaps due to maternal age, abnormal AFP, other abnormal screening test results or family history. The test has a small risk for inducing pre-term labor and miscarriage, but the majority are performed without incident.</td>
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<tr>
<td><strong>Diabetes Screen</strong></td>
<td>This test is usually performed at 24–28 weeks and checks for gestational diabetes, a short-term form of diabetes that develops in some women during pregnancy. After the mother has consumed a sugary drink, blood is drawn, and the glucose level is measured. For some women, such as those who have had gestational diabetes with a previous pregnancy, the test may be done before 24 weeks.</td>
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<tr>
<td><strong>Group B Streptococcus</strong></td>
<td>A bacterium that lives harmlessly in 10 to 35 percent of women, group B streptococcus can infect a newborn during delivery and cause a variety of serious infections. To test for it, at 35 to 37 weeks of pregnancy, samples are taken from the vagina and rectum of the mother and cultured in a lab. Women who test positive will be treated with antibiotics during labor.</td>
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Common health concerns.
Although most women carry their babies to term with no problem, some develop complications that require close monitoring by their doctor. Conditions that can be associated with pregnancy include:

**Gestational diabetes.**
About 2 to 3 percent of women develop this condition during pregnancy. The placenta, which provides the fetus with nutrients and oxygen, also produces hormones that have an insulin blocking effect in the mother. The condition usually develops after the first trimester. Often, gestational diabetes can be controlled with a diet, but sometimes medication is needed.

**Preeclampsia (also called toxemia of pregnancy).**
A potentially serious condition that develops after the sixth month, it causes high blood pressure; sudden, excessive weight gain; swelling of the hands and face; severe headaches and protein in the urine.

**Rh-negative mother/Rh-positive fetus.**
Rh factor is a substance found in the red blood cells of most people. If you don’t have it but your baby does, the incompatibility can cause serious health problems in the baby. Medications given at 28 weeks and just after birth can help prevent these complications. These conditions are serious, but manageable, so it’s important to know about them and discuss them with your health care provider.

When to call the doctor.
It can be hard to know what’s normal and what’s not, especially if this is your first pregnancy. Always err on the side of caution and let your provider know if you have a concern. Here’s a list of symptoms that would warrant a call to the doctor:

- Temperature of 101 degrees Fahrenheit (38.3 degrees Celsius) or higher
- Swelling of the hands, face or feet
- Vaginal bleeding
- Fluid leaking from the vagina
- Decreased fetal movement in the last trimester
- Sharp stomach pains
- Headache that’s unusually severe or associated with visual disturbances
- Urinary discomfort
- Sores or blisters on the genitals
- Any car accident
- Any signs of pre-term labor, including: contractions — more than four in an hour; cramping; abdominal pain; low backache; pelvic pressure that feels like the baby is pushing down; or an increase or change in vaginal discharge (bloody discharge, for example)
Your baby’s growth.

Pregnancy lasts 40 weeks and is divided into trimesters. The first trimester is from conception to the end of week 13, the second trimester is from week 14 to the end of week 26, and the third trimester is from week 27 to the end of the pregnancy.

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<thead>
<tr>
<th>First Trimester</th>
<th>Week 8</th>
<th>Week 12</th>
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<tr>
<td>Marveling over a baby’s tiny fingers and toes is one of the early joys of parenthood. Those fingers and toes are just beginning to form this week, and the arms can even flex at the elbows and wrists. Blood begins to flow through a rudimentary circulatory system.</td>
<td>Your baby’s face has a profile now, complete with a tiny chin and nose. The brain continues to develop, and tiny fingernails and toenails form. Though you haven’t had to change a wet diaper yet, you will soon enough. Your baby’s first urine is made and eliminated into the amniotic sac this week.</td>
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<tr>
<th>Second Trimester</th>
<th>Week 16</th>
<th>Week 20</th>
<th>Week 24</th>
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<td>Your baby now weighs about 2.8 ounces and measures about 4.6 inches in length. This week brings the first voluntary muscle movements. Your baby can hold his or her head erect, and the development of facial muscles allows for a variety of expressions such as squinting and frowning.</td>
<td>You’re halfway there. Now weighing about 9 ounces and measuring 5.5 to 6.3 inches from crown to rump, your baby’s continued growth will put pressure on your lungs, stomach, bladder and kidneys. Under the vernix (a protective, waxy coating), your baby’s skin is thickening and developing layers.</td>
<td>In preparation for the outside world, your baby’s lungs will now begin to produce surfactant, a substance that keeps the air sacs in our lungs from collapsing and sticking together when we exhale. In addition, your baby may be able to tell when he or she is upside down or right side up while floating in the amniotic fluid because the inner ear (which controls balance) is now completely developed.</td>
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<tr>
<th>Third Trimester</th>
<th>Week 28</th>
<th>Week 32</th>
<th>Week 36</th>
<th>Week 40</th>
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<tr>
<td>Your baby now weighs about 2 pounds, 7 ounces and measures about 10 inches. At your next appointment, your health care provider may inform you whether your baby is head first or feet or bottom first (called breech position) in the womb. Babies who are in the breech position may need to be delivered by C-Section. Your baby still has two months to switch, though — and many often do — so don’t worry if your baby is in the breech position right now.</td>
<td>The final touches are being placed on your baby masterpiece. Fingernails and toenails have grown, and eyelashes, eyebrows and the hair on your baby’s head are evident. At about 4 pounds and 11.4 inches from crown to rump, your baby would have a very good chance of survival outside the womb if you delivered now.</td>
<td>The wrinkly, tiny fetus you may have seen on earlier ultrasounds has evolved into an almost plump baby. Fat is deposited on the cheeks this week, and powerful sucking muscles also contribute to your baby’s full face. Your baby now weighs approximately 6 pounds. Maternal calcium intake has helped to create the baby’s firm skull, but it’s still soft enough to squeeze through the birth canal.</td>
<td>After many weeks of anticipation, your baby is here. Or maybe not. Many first-time mothers find themselves waiting up to two weeks after their due date for their baby to arrive. A baby born at 40 weeks weighs, on average, 7 pounds, 8 ounces and measures 19 to 20 inches. Don’t expect your baby to look picture-perfect right off the bat — newborns often have heads temporarily misshapen from passing through the birth canal and may be covered with vernix and blood. Right after birth, someone will suction mucus out of your baby’s mouth and nose, and you’ll hear that long-awaited first cry. Your baby may then be placed on your stomach, and the umbilical cord will be cut.</td>
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Your body is also changing.

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<td>Week 8</td>
<td>Pregnancy symptoms such as a missed period, nausea, extreme fatigue or tight clothes due to the swelling of your uterus have probably prompted you to wonder whether you’re pregnant.</td>
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<tr>
<td>Week 12</td>
<td>Has anyone told you that you have that “pregnant glow”? It’s not just the joy you may feel; there’s also a physiological reason. Your body is bringing more blood to the blood vessels, and the pregnancy hormone HCG is increasing oil gland secretion, resulting in a flushed, plumper, smoother skin appearance. Sometimes, though, the increased oil gland secretion can cause temporary acne.</td>
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<td>Week 16</td>
<td>Congratulations — you’re in the second trimester. Your risk of miscarriage is greatly reduced now, so you can breathe a little easier. You may notice that your breasts have changed considerably since your pregnancy began. More blood is flowing to the breasts, which increases their size (many women increase one to two cup sizes) and this causes veins to become visible.</td>
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<tr>
<td>Week 20</td>
<td>Your constant concern for your baby’s health may give way to reassurance as you feel your baby’s first movements, usually between the 18th and 20th weeks. Known as “quickening,” these first movements may feel like butterflies in your stomach or a growling stomach. Later in your pregnancy, you’ll feel kicks, punches and possibly hiccups.</td>
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<tr>
<td>Week 24</td>
<td>Pregnancy can cause some unpleasant side effects when it comes to digestion. Not only does the hormone progesterone slow the emptying of the stomach to allow for increased absorption of nutrients, but your expanding uterus is putting increased pressure on your intestines. If indigestion and heartburn are making your meals a nightmare, try eating smaller, more frequent meals, and avoiding spicy and fatty foods.</td>
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<tr>
<td>Week 28</td>
<td>Iron is important for making extra red blood cells and providing the baby with adequate iron stores after birth. You should be eating at least 30 milligrams of iron each day during the second and third trimesters. Iron deficiency is common during pregnancy, so your health care provider may prescribe a supplement if your iron levels are found to be low.</td>
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<tr>
<td>Week 32</td>
<td>The milk glands in your breasts may start to make colostrum around this time. Colostrum is the thick, yellowish milk that will provide your baby with calories and nutrients for the first few days before your milk comes in, if you plan to breast-feed. If you notice your breasts leaking colostrum, you can buy disposable or washable breast pads.</td>
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<td>Week 36</td>
<td>Starting this week, you may begin to see your health care provider every week. Your provider may give you an internal exam to determine if cervical effacement (thinning of the cervix) or dilation (opening of the cervix) has begun. You may experience engagement (also known as lightening), which is when the baby drops into the mother’s pelvis in preparation for labor. Your appetite may return because the baby is no longer putting as much pressure on your stomach and intestines.</td>
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<tr>
<td>Week 40</td>
<td>This week you may experience the moment you’ve been anticipating — your introduction to your baby. But first you’ll have to go through labor and delivery.</td>
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There are three stages of labor.

- The first stage of labor works to thin and stretch your cervix by contracting your uterus at regular intervals.
- The second stage of labor is when you push your baby into the vaginal canal and out of your body.
- The third and final stage of labor is when you deliver the placenta.

If you do not go into labor within a week of your due date, your health care provider may recommend you receive a non-stress test, which monitors fetal heart rate and movement to determine if the baby is receiving enough oxygen.

Sometimes Mother Nature may need a little coaxing.

If your labor is not progressing, or if your health or your baby’s health requires it, your health care provider may induce labor by artificially rupturing the membranes or by administering the hormone oxytocin or other medications. If your pregnancy is high risk or if there are any other potential complications, you may require a C-Section delivery.
Weight gain. It happens.

Weight gain is a much-discussed topic among pregnant women. How do you know if you’re gaining the right amount? It’s generally recommended that a woman of average weight gain about 25 to 30 pounds during pregnancy — about two or three pounds each month. Gaining much more than that can put you at higher risk for prolonged labor, which increases the likelihood of fetal distress. Gaining much less can mean your baby’s nutrition is being compromised. Pregnancy is not the time to cut calories or go on a diet.

Of course, patterns of weight gain vary. If you start out heavier, it’s normal to gain less during pregnancy — about 15 to 25 pounds. If you were underweight before becoming pregnant, you might gain more — 28 to 40 pounds. And if you’re carrying twins or triplets, 35 to 45 pounds would be considered typical.

But remember, guidelines on weight are just that — guidelines. More important than how much weight you gain is what makes up those extra pounds, how you’re feeling and how your baby is growing. If you focus more on having a healthy pregnancy than on what the scale says, both you and your baby will benefit.

<table>
<thead>
<tr>
<th>How the pounds add up.</th>
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<tbody>
<tr>
<td>Average baby’s weight</td>
<td>7.5 lbs.</td>
</tr>
<tr>
<td>Breast enlargement</td>
<td>2.0 lbs.</td>
</tr>
<tr>
<td>Your body’s extra stored protein, fat and other nutrients</td>
<td>7.0 lbs.</td>
</tr>
<tr>
<td>The placenta</td>
<td>1.5 lbs.</td>
</tr>
<tr>
<td>Enlargement of your uterus</td>
<td>2.0 lbs.</td>
</tr>
<tr>
<td>Amniotic fluid surrounding your baby</td>
<td>2.0 lbs.</td>
</tr>
<tr>
<td>Your extra blood</td>
<td>4.0 lbs.</td>
</tr>
<tr>
<td>Your other extra body fluid</td>
<td>4.0 lbs.</td>
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Morning sickness.

Nothing can put a damper on the happy haze of early pregnancy quite like morning sickness — nausea and vomiting that, despite its name, can occur at any hour or all day long. If you’re one of the 50 percent of women who experience it, here’s the good news: morning sickness is unlikely to harm the fetus, and it usually goes away by the end of the third month. You can also talk to your doctor about getting medication to help reduce its occurrence.

Morning sickness tips.

- If you are frequently nauseated, eat small amounts of bland foods throughout the day.
- Take your prenatal vitamin before going to bed and after a snack, not on an empty stomach.
- Eat a small snack when you get up to go to the bathroom early in the morning.
- Keep some crackers by your bedside. Avoid rich, spicy or fried foods. Suck on hard candy.
10 things that may surprise you about being pregnant.

1. **The nesting instinct**
   Many pregnant women experience a powerful urge to prepare their homes for their babies by cleaning, decorating, and organizing. Take comfort in knowing you’re not the first mom-to-be who felt compelled to wash the walls or clean out the closets in her ninth month of pregnancy. Just be careful not to overdo it.

2. **Inability to concentrate**
   In the first trimester, fatigue and morning sickness can make you feel mentally fuzzy. But even well-rested pregnant women may experience an inability to concentrate. A preoccupation with the baby is partially the cause, as are hormonal changes. Combat forgetfulness by making lists of important dates and appointments.

3. **Mood swings**
   If you’re happy one minute and crying the next, you have your pregnancy hormones to thank. Mood swings tend to worsen in the first and third trimesters, but if they last longer than two weeks or are accompanied by changes in sleep and eating habits, talk to your doctor. It could be a sign of depression, which affects about 10 percent of pregnant women.

4. **Bra size**
   An increase in breast size is one of the first signs of pregnancy. Breasts usually become swollen and enlarged in the first trimester because of increased levels of the hormones estrogen and progesterone. That growth in the first trimester isn’t necessarily the end, either. Your breasts can continue to grow throughout your pregnancy.

5. **Skin**
   Your “pregnant glow” is a welcome side effect of pregnancy, but some skin changes are less desirable. Acne is common during pregnancy because of increased oil production. Some women develop brownish or yellowish patches called chloasma, or the “mask of pregnancy,” on their faces. And some will notice a dark line on the midline of the lower abdomen, known as the linea nigra, as well as darkening of the skin of the nipples and external genitalia. These are the result of pregnancy hormones, which cause the body to produce more pigment. Skin stretching can make pregnancy an itchy time for a woman, and it can also cause stretch marks. Although stretch marks may lighten after pregnancy, there’s no product that can remove them entirely.

6. **Hair and nails**
   Now that you’re pregnant, you may finally have the thick, luxurious hair you may have always wanted. Hormones cause your hair and your nails to grow faster and become stronger. But don’t get too used to it; these changes are temporary, and most women lose a significant amount of hair in the postpartum period or after they stop breast-feeding.

7. **Shoe size**
   Even though you can’t fit into any of your pre-pregnancy clothes, you still have your shoes, right? Maybe not. Extra fluid can cause swelling in your feet and may cause you to go up one or two shoe sizes, and your feet may remain a size larger after you give birth.

8. **Joint mobility**
   During pregnancy, your body produces a hormone known as relaxin, which is believed to help prepare the pubic area for the birth. The relaxin loosens the ligaments in your body, making you less stable and more prone to injury. When exercising or lifting objects, go slowly and avoid sudden, jerky movements.

9. **Varicose veins**
   Varicose veins occur when blood pools in veins enlarged by pregnancy. Varicose veins often disappear after pregnancy, but you can lessen them by avoiding standing or sitting for long periods of time and elevating your feet when you sit.

10. **Hemorrhoids and constipation**
    Hemorrhoids — varicose veins in the rectum — can be extremely painful, and they may bleed, itch or sting during a bowel movement. Coupled with constipation, another common pregnancy woe, hemorrhoids can make going to the bathroom unpleasant. The best way to combat constipation and hemorrhoids is to prevent them. Eating a fiber-rich diet, drinking plenty of fluids and getting regular exercise can help you stay more regular.
Nutrition, Exercise and Sleep
It all starts by eating smart.

Eating for two doesn’t mean doubling what you eat.
To eat well during pregnancy, you must do more than simply increase how much you eat. You must also consider what you eat. Although you need about 300 extra calories a day (the equivalent of one apple, one banana and one cup of low-fat milk), those calories should come from nutritious foods so they can contribute to your baby’s growth and development. Your goal should be a well-balanced diet that includes plenty of fruits, vegetables and whole-grain breads.

Your growing baby’s calcium demands are high.
To prevent a loss of calcium from your own bones, you’ll have to significantly increase your calcium intake. Good sources of calcium include milk, cheese, yogurt and spinach. Other important nutrients are proteins (lean meat, fish, poultry, egg whites, beans, peanut butter and tofu), iron (lean red meats, spinach and iron-fortified cereals) and folic acid (green leafy vegetables, beans, peas and fortified cereals). Use MyPlate, formerly the Food Guide Pyramid (kidshealth.org/en/kids/pyramid.html), to determine how many servings of each kind of food to eat every day.

Drinking plenty of water is another must.
A woman’s blood volume increases dramatically during pregnancy, and drinking enough water each day can help prevent common problems such as constipation. Monitoring your urine color is a good way to tell if you’re getting enough. If your urine is dark colored and foul-smelling, it’s time to drink up. If your urine is pale yellow and odorless, you’re probably well hydrated.

Have you had any cravings yet?
Researchers have tried to determine whether a hunger for a particular type of food indicates that a woman’s body lacks the nutrients that food contains. Although this probably isn’t the case, it’s still unclear why women get urges for everything from peanut butter to spicy salsa. As long as the food you crave contributes to (or at least doesn’t interfere with) a healthy diet, following your cravings is fine.

Do I need more calcium?
• To prevent a loss of calcium from your bones, you’ll have to significantly increase your calcium intake.
• Good sources of calcium include: milk, cheese, yogurt and spinach.

The importance of folic acid.
• Folic acid is found mostly in leafy green vegetables like kale and spinach, orange juice and enriched grains, but most women get it from prenatal vitamins.
• Women who get 0.4 to 0.8 milligrams daily before and during early pregnancy reduce the risk that their babies will be born with a serious neural tube defect (incomplete development of the brain and spinal cord) by up to 70 percent.
It’s not always easy to eat right.
Your health care provider will likely prescribe a prenatal vitamin as added assurance that you and your baby are getting certain nutrients you both need. Because the iron in prenatal vitamins and other factors may cause constipation, it’s a good idea to increase your fiber intake. Try to eat about 20 to 30 grams of fiber a day.

Foods to avoid during pregnancy.
Foodborne illnesses, such as listeriosis and toxoplasmosis, can be life-threatening to a fetus. Avoid the following foods, which may carry dangerous bacteria:

- Soft cheeses such as feta, goat, Brie, Camembert and blue cheese
- Unpasteurized milk and juices
- Raw or undercooked meats, including hot dogs and deli meats
- Raw eggs or foods containing raw eggs, including mousse, tiramisu and cookie dough
- Raw shellfish
- Pâté
- Shark, swordfish, king mackerel or tilefish because they can contain high levels of mercury. Instead, you can eat up to 12 ounces per week of fish and shellfish that are lower in mercury, such as shrimp, canned light (not white) tuna, salmon, pollock and catfish.

Drinks to avoid during pregnancy.
As for alcohol, no amount is considered safe during pregnancy. And although many doctors feel that one or two 6- to 8-ounce cups per day of coffee, tea or soda with caffeine won’t harm your baby, it’s probably wise to avoid that, too, if you can. High caffeine consumption may be linked to an increased risk of miscarriage.

How much should I eat?
The average woman needs about 300 extra calories a day, which is the equivalent of one apple, one banana and one cup of low-fat milk.
Remember, you’re exercising for two.
Although you may not feel like running a marathon — especially in the first three months of pregnancy — most women benefit greatly from exercising throughout their pregnancies. Strong muscles and a fit heart can greatly ease labor and delivery — not to mention help you regain your pre-pregnancy shape after birth. Exercise can also increase your sense of being in control and boost your energy level at a time when you wonder whether this strange body can possibly be yours.

What’s considered safe?
It depends on when you start and whether your pregnancy is complicated. If you exercised regularly before becoming pregnant, most doctors say you can continue your program with modifications as needed. If you weren’t fit before you became pregnant, don’t give up. Begin slowly, gradually increasing your activity. Whatever your fitness level, talk to your doctor before exercising during pregnancy.

The type of exercise you do should be guided by what you like. Many women enjoy walking, swimming, water aerobics, yoga, biking or dancing. Try for a combination of cardiovascular (aerobic), strength and flexibility exercises.

Be aware that your growing belly is changing your center of gravity, making you more prone to falls. Also, pregnancy hormones are making your ligaments more lax, increasing your risk of joint injuries. Avoid activities that include bouncing, leaping or sudden changes of direction or that put you at risk for abdominal injury. Your doctor may also recommend that you avoid weight training and exercises done on your back after the first trimester because they reduce blood flow to the fetus.

Kegel exercises.
Kegel exercises help strengthen the pelvic floor muscles for delivery and reduce incontinence (leakage of urine) caused by the weight of the baby on your bladder. Kegels are easy, and you can do them any time you have a few seconds. To find the correct muscles, pretend you’re trying to stop urinating. Squeeze those muscles for a few seconds, and then relax. You’re using the correct muscles if you feel a pull.

Once you’re ready to get going:
• Double-check with your doctor before you do anything.
• Start slowly, building up to 30 minutes of activity at a time.
• Whether you’re a pro or a novice, go slowly for the first five minutes to warm up and use the last five minutes to cool down.
• Take frequent breaks and don’t overdo it. If you can’t talk while exercising, you’re pushing yourself too hard. Keep your heart rate below 160 beats per minute.
• Drink plenty of water to avoid dehydration.
• Opt for a walk in an air-conditioned mall on hot, humid days to avoid overheating.
• Skip your exercises if you’re ill.
• Above all, use common sense. If you get short of breath or feel uncomfortable, slow down or stop.
Try and catch more Zs.

You know you’re in for sleepless nights after the baby is born, but who would have guessed that catching some Zs during pregnancy would be so difficult? Actually, you may sleep more than usual during the first trimester of your pregnancy. It’s normal to feel tired as your body works to protect and nurture the developing baby. It’s usually later in pregnancy that most women have trouble getting enough deep, uninterrupted sleep.

The first and most pressing reason is the increasing size of the fetus, which can make it hard to find a comfortable sleeping position. Other issues can include constant trips to the bathroom, leg cramps, heartburn and anxiety over the baby’s health or becoming a parent. Some pregnant women are even kept up by vivid dreams and nightmares.

Experiment with pillows to discover a comfortable sleeping position and try the following tips.

• Cut caffeinated drinks like soda, coffee and tea from your diet.
• Avoid eating a full meal within a few hours of bedtime. Try eating more at breakfast and lunch, and then having a smaller dinner.
• Get into a routine of going to bed and waking up at the same time each day.
• Avoid rigorous exercise right before you go to bed. Instead, do something relaxing, like soak in a warm bath for 15 minutes. (You should not take hot baths or use a sauna.)
• If a leg cramp awakens you, it may help to press your feet hard against the wall or to stand on the leg. Also, make sure you’re getting enough calcium because this mineral can help reduce leg cramps.
• If fear and anxiety are keeping you awake, consider enrolling in a childbirth or parenting class. The more you know, the less you’ll have to fear.

Finally, if possible, take short naps during the day to make up for lost sleep. It won’t be long before your baby will be setting the sleep rules in your house, so you may as well get used to sleeping in spurts. Remember that over-the-counter sleep aids, including herbal remedies, are not recommended for pregnant women.

Lie on your left side.

Some doctors specifically recommend that pregnant women sleep on the left side. Because your liver is on the right side of your abdomen, lying on your left side helps keep the uterus off that large organ. Ask what your doctor recommends. In most cases, lying on either side should help take some pressure off your back.
Preparing for the Big Event

Should I be nervous or excited? Yes.

Childbirth classes.
The more information and support you have throughout your pregnancy, the healthier you’re likely to be — and the same goes for your baby. Facts and support can come from a variety of places, and a birthing class is one of them. Birthing classes address all kinds of birth experiences, from vaginal to C-Section, from labor with pain medication to without. They can help prepare you for many aspects of childbirth — for the changes that pregnancy brings, for labor and delivery, and for parenting once your baby is born — in an atmosphere of support with other expectant couples.

The two most common childbirth methods are the Lamaze technique and the Bradley method.

Lamaze focuses on relaxation techniques, controlled breathing patterns and the support of a coach to help manage the pain of labor. Lamaze courses don’t advocate for or against the use of drugs and routine medical interventions during labor and delivery, but rather educate mothers about their options.

The Bradley method places an emphasis on a natural approach to birth and on the active participation of the birth coach. A major goal of this method is good prenatal nutrition and the avoidance of medications unless absolutely necessary.

Courses that may interest you.
Like you, your family will also benefit from knowing what to expect when you go into labor. Some classes have one session just for fathers, or one for soon-to-be big brothers and sisters. Some even offer a special session for new grandparents, which is a great way to get them involved and to make sure they’re up on the latest in baby care techniques and safety. Many classes also address what to expect after the baby is born, including breast-feeding, baby care and dealing with the emotional changes of new parenthood.
Choosing a doctor for your child.

When it comes to medical care for your child, there are three types of qualified providers: pediatricians (doctors who specialize in health care for children from birth through adolescence), family physicians (doctors qualified to care for patients of all ages) and pediatric nurse practitioners (nurses with advanced training in medical care for children).

Considering that this doctor will be the first to treat your baby, you’ll want to be sure that you feel comfortable with the doctor’s personality, office staff, location and environment. A prenatal appointment is an excellent opportunity for parents to ask questions and meet the office staff.

The interview is also a great time to observe office procedures. Scrutinize the reception area. How many children are waiting? Is there a place where sick children can be separated from those in for a well visit? Is the staff polite and considerate?

Next, get a feel for the doctor’s personality. Is he or she patient and willing to explain things carefully? Do you get the impression that he or she would be supportive if you requested a second opinion? Is the doctor a good listener who seems responsive to your concerns? Are you comfortable asking questions, or do you feel intimidated?

You should also be sure that your parenting style matches your doctor’s on important issues. How does the doctor feel about circumcision? Breast-feeding? Alternative or integrative medicines or techniques? Immunizations? Philosophical issues may not seem important before you give birth, but if you consider that this doctor may see your child for years to come, agreement on larger issues becomes more significant.

Learn how the practice works by asking:

- **What are the office hours?** Flexibility of the doctor’s schedule may be a concern, especially if you work outside the home; you may prefer a doctor who offers weekend and evening hours.
- **Is this a solo or group practice?** If it’s a solo practice and your doctor is not available on weekends or evenings, what are his or her coverage arrangements? If it’s a group practice, what are the qualifications of the other doctors in the office?
- **Does a pediatric nurse practitioner (PNP) work in the office?** How does he or she fit into the practice arrangement?
- **Which hospital is your doctor affiliated with?** Will your doctor come to the hospital to examine the baby once he or she is born? Who will care for your baby if he or she needs to be hospitalized?
- **How does the office handle phone inquiries during and after hours?** Are special times set aside for parents to call in with questions or is there an open advice line (usually staffed by a “phone nurse”) during working hours? How are after-hours calls handled? Is email communication with the office an option?
- **Will your child’s doctor handle emergencies, or will your child be referred to an emergency room or urgent care center?** Are these facilities equipped to handle pediatric emergencies?
- **What are the doctor’s practices regarding referrals to specialists?**
- **Are lab tests done in the office?** Most offices can perform basic tests, such as complete blood counts, urine testing and rapid strep tests, rather than send samples out to a laboratory.

Easy-to-use search tool.

You can use our online search tool at the website on the back of your health plan ID card to find information on network doctors, specialists, hospitals, facilities and more. You can also order a roster of participating physicians and providers online, or through our automated phone system, at 1-800-666-1353.
Making home sweet home, home safe home.

From the moment of birth, you’ll be overwhelmed with a desire to protect your baby. Keep these helpful hints in mind in preparing for your newborn to come home:

The nursery.

Your baby will spend a lot of time in a crib. Make sure it’s up to today’s safety standards, with no protruding screws and with sides that latch securely. The mattress should be firm and fit snugly against the sides. Soft toys and pillows should be kept out of the crib because these items can suffocate a baby. Keep the cords of drapes and window shades well away from little hands. Before your child can stand, move the crib to its lowest position.

If there’s one rule about babies, it’s to expect the unexpected. Babies reach, grasp, roll and eventually crawl. It’s incredibly easy for them to fall off changing tables, sofas and beds. Keep your baby safe by never leaving him or her alone on a high surface, even for a second.

The car.

Using a child safety seat (car seat) is the best protection you can give your child when traveling by car, and all 50 states require one for bringing your baby home from the hospital. Child safety seats can reduce the risk of a potentially fatal injury by 69 percent for babies younger than one year old. Yet as much as 80 percent of all safety seats are used incorrectly.

Visitors.

It’s a good idea to limit your newborn’s guest list early on. Babies can become overstimulated and cranky if there are too many people around, plus their immature immune systems make them more susceptible to illness. Ask anyone who’s sick to wait until they’re feeling well and are no longer contagious before they visit. You should also ask visitors to wash their hands before holding your baby.

Pets.

Bring home a blanket with your baby’s scent on it — even before leaving the hospital. This will help to familiarize your pet with the new baby. But remember, even if your pet seems fine around your baby, the two should never be left alone together.

Using your safety seat correctly.

The National Highway Traffic Safety Administration (NHTSA) has set up child seat inspection stations across the country. If you need help installing your safety seat or would like to check whether you’ve installed your seat properly, visit nhtsa.gov.
It’s go time.

No two labors are alike, but here are some general signs that could indicate your baby’s on the way:

• Contractions that are growing more intense, becoming more regular, lasting longer or getting closer together. Be sure to time them from the start of one to the start of the next.

• Your water breaks. Whether you experience a gush or a trickle, note the color, odor and amount of the fluid, and the time it occurred, and then call your health care provider.

• Lower back pain that feels like premenstrual cramping.

• The appearance of bloody show (a brownish or blood-tinged mucous discharge) or the hardened mucous plug (the plug that seals the cervix and protects the fetus from infection).

Unsure about when to go to the hospital? Call your doctor to see what he or she recommends.

A well-stocked labor bag:

• Photo or object to use as a focal point.
• Books, music and cards.
• Pillows, stopwatch and a camera.
• Food for your support person, or change for vending machines.
• Lip balm and toiletries.
• Robe, nightgown, slippers and socks.
• Nursing bra, breast pads and sanitary napkins.
• A phone to spread the news.
• Going-home clothes for mom and baby.

Welcome to the world, baby.

Bluish, waterlogged and covered with a white, cheesy coating… isn’t your baby adorable? No doubt you’ll think your baby is beautiful the first moment you lay eyes on him or her. But the truth is, it’s a rough trip. Newborns are tiny, wet creatures when they first emerge. Their heads are pointy, their faces puffy and their eyes are often swollen shut.

They also may look scrunched up because the cramped quarters of the womb kept their arms and legs bent at the elbows and knees. Hands and feet may be bluish, and nails appear paper thin and very long. Skin may be wrinkled, mottled and covered with a white, cheesy coating called vernix, which protected the skin from constant exposure to amniotic fluid. Some babies actually look furry because of lanugo, a fine hair that develops all over the body in the womb.

Not to worry. Within a few days, the head will take on a rounded appearance. Facial swelling will go down. The limbs will straighten out, and that folded ear, flattened nose or crooked jaw caused by passage through the birth canal will move back into place. Vernix will be washed off during the first bath, and lanugo will disappear after a week or two. And your baby will still be the most beautiful thing you’ve ever seen.
Breast-feeding.

Breast milk is the best food for babies. It’s nutritionally perfect, plus it contains antibodies that help protect a baby from illness. Its composition even changes over time to meet your baby’s nutritional needs as he or she grows. All that, and it doesn’t cost a cent.

It’s generally recommended that you nurse your baby whenever he or she seems hungry (demand feeding) rather than on a set schedule. Your baby may cue you to his or her hunger by crying, putting fingers in the mouth or making sucking noises.

A newborn baby may need to be fed as often as every two hours or perhaps more frequently for a while. Give your baby the chance to nurse about 10 to 15 minutes at each breast. Watch for signs that your baby is full (such as slow sucking or turning away), and stop the feeding session once these signs appear.

If you’re breast-feeding, you may wonder how you’ll know if your baby is eating enough. If he or she seems satisfied, produces about six wet diapers and several mustard-yellowish stools a day, sleeps well and is gaining weight regularly, he or she is probably fine. Your breasts should also feel soft after nursing.

Some signs your baby is not getting enough and could be becoming dehydrated include too few wet diapers, a sunken soft spot on the head and a dry mouth. By two to three months of age, breast-fed babies will probably want to nurse six to eight times a day, sometimes more if they’re going through a growth spurt. Nursing mothers need not worry; breast-feeding stimulates milk production, and your supply of breast milk will automatically adjust to your baby’s demand for it. Just remember to stay well nourished yourself. Nursing moms require about 500 extra calories a day, plus extra calcium and lots of water.

Bottle-feeding.

Sometimes, breast-feeding doesn’t work out or you (or your baby) may just opt for the bottle instead. As with breast-feeding, let your baby set the pace for how often he or she wants to eat. In the beginning, most bottle-fed infants take about two to three ounces of infant formula every two or three hours. At two months, they require about four to five ounces of formula at each feeding. By three months, they’ll probably take another one or two ounces per feeding. At four months, about 30 ounces of formula takes care of a baby’s nutritional requirements for the day. Be sure to always follow the instructions on the label when preparing your baby’s formula.
Feeding your baby, whether by breast or bottle, provides a great opportunity for snuggling and bonding. Always hold your baby during feeding times; don’t leave him or her unattended to drink from a propped bottle. This can lead to choking, and the formula that remains in your baby’s mouth can lead to tooth decay later on.

As your baby gains weight, he or she should begin to eat more at each feeding and go longer between feedings. Still, there may be times when your baby seems hungrier than usual. Continue to nurse or feed on demand during this time. Even after your baby starts on some solid foods by about four to six months, formula or breast milk will remain the majority of your baby’s diet through the first year of life.

Talk to your child’s doctor if you have concerns about your child’s growth or if you need to awaken your newborn frequently to eat or continually urge your baby to drink from the bottle or breast.

**Burping.**

Babies tend to swallow air during feeding and can become fussy or spit up if they are not burped frequently. Try burping your baby every two to three ounces if you bottle-feed, and each time you switch breasts if you breast-feed. Gently pat your baby’s back as you hold him or her against your chest or as he or she sits up or lies face down on your lap (remember to support the head). Burp again when feeding time is over. You might want to place a cloth under your baby’s chin or on your shoulder to make cleanup easy if he or she spits up.

**Bathing.**

Give your baby a sponge bath (don’t submerge the baby in water) until the umbilical cord falls off and, if you have a boy who’s been circumcised, the penis is completely healed. Make sure you have everything you need before you begin: a washcloth, mild soap and shampoo, a soft brush, a towel, a clean diaper and clothes.

Pick a warm room and a flat surface, such as a changing table. Undress your baby down to the shirt and diaper. Gently wipe your baby’s eyes and face with water only and pat dry. Next, using baby shampoo, gently wash your baby’s head and rinse. When washing your baby’s body, pay special attention to creases under the arms, behind the ears, around the neck and the genital area.

When your baby is ready for tub baths, the first baths should be gentle and brief. Use warm — not hot — water (test the temperature with your elbow or wrist). When rinsing your baby’s hair, cup your hand across the forehead so suds don’t get in the eyes. After the bath, wrap your baby in a towel immediately, making sure the top and back of his or her head is covered. Hooded baby towels are great for keeping a freshly washed baby warm. Never leave your baby alone during a bath.

**Trimming nails.**

Trimming your baby’s nails for the first time can be unnerving, but keeping nails short can help keep babies from injuring themselves. Find a position that allows you easy access to your baby’s hands. This may mean waiting until your baby is asleep or even performing the task with a partner: one person holding the baby and the other trimming the nails. Use baby nail scissors, which have rounded tips for safety.
Diapering.

Whether you choose cloth or disposable, make sure all diapering supplies (a diaper; fasteners, if needed; warm water and cotton squares, or a diaper wipe; diaper ointment and a changing pad) are within reach before you start. Babies should never be left unattended on a changing table, even for a second.

When removing a boy’s diaper, remember to do so carefully because exposure to air may make him urinate. When wiping a girl, wipe her bottom from front to back to help avoid urinary tract infections. Always wash your hands well after changing a diaper.

Diaper rashes are common in babies. To prevent and heal diaper rash, change diapers frequently, use a diaper ointment with zinc oxide, and let your baby go un-diapered for part of the day (lay him or her down on a few cloths or towels). If the rash doesn’t clear up in two or three days, call your child’s doctor.

Circumcision and umbilical cord care.

Immediately after circumcision, the tip of the penis is usually covered with gauze coated with petroleum jelly to keep the wound from sticking to the diaper. Gently wipe the tip clean with warm water after a diaper change. Redness or irritation of the penis should heal within a few days, but if the redness or swelling increases or if pus-filled blisters form, infection may be present and you should call your baby’s doctor immediately.

Umbilical cord care in newborns is also important. Try to keep the area clean and dry until the cord stump dries up and falls off, usually in 10 days to three weeks. If it becomes dirty, gently wash with soap and water. The infant’s navel area shouldn’t be submerged in water until this happens. Call your baby’s doctor if the navel area becomes reddened or if a foul odor or discharge develops.

Taking your baby’s temperature.

If you need to take your baby’s temperature, your best bet is to use a digital thermometer, which can be used to take rectal (in the bottom) or axillary (in the armpit) readings. Taking a rectal temperature gives the most accurate reading; axillary is the next best choice. Once your child is older than three months, a tympanic (ear) thermometer may also be used, although they are expensive and not as accurate.

To take a rectal temperature, place your baby face down across your lap, supporting his or her head, or lay your baby down on a firm flat surface. While holding one hand against your baby’s lower back to keep him or her still, use the other hand to insert the lubricated thermometer through the anal opening, about one-half to one inch into the rectum (stop if you feel any resistance). Read and record the number on the screen, noting the time of day that the reading was taken.

To take an axillary temperature, remove your child’s shirt and undershirt and place the thermometer in your child’s armpit. Fold your child’s arm across his or her chest to hold the thermometer in place until the reading is complete.
**Sleep and your baby.**

“Does your baby sleep through the night?” is one of the questions new parents face the most. And the bleary-eyed moms and dads almost always answer: “No.” Newborn babies don’t know the difference between day and night yet, and their tiny stomachs don’t hold enough formula to keep them satisfied for very long. They need food about every three or four hours, no matter what time of day or night it is.

A newborn may sleep as much as 16 hours a day, often in stretches of three to four hours at a time. At first, these short stretches may be frustrating for you as they interfere with your own sleep patterns. Have patience. By three months, about 90 percent of babies sleep through the night (between six and eight hours), but if your infant doesn’t, it’s not a cause for worry. Like adults, babies must develop their own sleep patterns and cycles.

For the first weeks of life, most parents place their child’s crib or bassinet in their own bedroom. A separate room just seems too far away, especially if you’re breast-feeding. Most doctors recommend against bringing your infant to sleep in the bed with you for safety reasons. The risk of suffocation is greatest if you are overweight or have been drinking alcohol because you are less alert and could roll over onto your baby.

Always keep safety in mind. Keep blankets and stuffed animals out of the crib or bassinet, as well as any objects with cords, ties or sharp corners. Make sure the crib you are using is up to today’s safety standards.

You can help adjust your baby’s body clock toward sleeping at night by avoiding stimulation during nighttime feedings and diaper changes. Keep the lights low, and resist the urge to play or talk with your baby. This will reinforce the message that nighttime is for sleeping. You can begin to establish some sort of bedtime routine (such as bathing, reading or singing) that should help get your baby to settle down when he or she is a bit older. Even though your newborn may be too young to get the signals yet, setting up the bedtime drill now can keep you on the right track later.

Check with your doctor if you think your baby is sleeping too much, is difficult to rouse or shows little interest in eating.

**Swaddling your baby.**

Swaddling is a technique that keeps your baby’s arms close to his or her body and his or her legs securely bound. Not only does this keep your baby warm, but the surrounding pressure seems to give most newborns a sense of security and comfort.

Spread out the receiving blanket, with one corner folded over slightly. Lay the baby face up on the blanket with his or her head at the folded corner. Wrap the left corner over the baby’s body and tuck it beneath. Bring the bottom corner up over your baby’s feet. Wrap the right corner around your infant, leaving only the neck and head exposed.

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**Back to sleep.**

The American Academy of Pediatrics (AAP) recommends that you always place your infant on his or her back to sleep, not on his or her side or stomach, to reduce the risk of sudden infant death syndrome (SIDS).

Try alternating the position of your baby’s head from night to night to help prevent a flat spot (plagiocephaly) from developing on one side of the head.
Newborns cry a lot. That’s normal.

Babies cry a lot, even when nothing’s wrong. Sometimes your baby’s cries are sending a message, such as he or she has an empty belly, a wet bottom or cold feet, or is tired, bored, overstimulated or in need of cuddling. Many moms will tell you that learning to differentiate between your baby’s many cries is one of the early joys of parenthood.

Still, your baby’s first extended crying period at home will probably be upsetting to you. Young babies typically cry for one to five hours within a 24-hour period, and you can’t always calm them. Fortunately, crying usually decreases gradually after six weeks.

Don’t be too upset when you aren’t able to console your newborn immediately. He or she may just need a good cry. Swaddle your baby, sing a lullaby, walk the floor — just let your baby know you’re there. You can’t spoil a newborn by being too responsive.

Though it may seem impossible now, in a few months it will be difficult to recall even the worst of your baby’s crying jags. Plus, usually during your newborn’s first month, you get a glimpse of the first smile and perhaps hear the first laugh or giggle — welcome additions to your baby’s communication repertoire.

Is it colic?

Your baby cries every afternoon for hours at a time, and the crying has worn you down to the point where you feel like joining in. What could be upsetting your baby?

When a healthy baby cries like this, chances are that it’s colic. Colic is not a physical disorder or disease. Doctors define colic as three or more hours a day of continued crying. The crying is not due to illness, hunger, a wet diaper or other visible causes, and the child cannot be calmed down. The good news is that colic usually goes away by three months of age.

There is no single treatment that always gives relief to infants with colic, but there are some things you can do to try to soothe your baby:

• Walk with your baby or sit in a rocking chair, trying various positions.
• Because a colicky baby swallows a lot of air during crying spells and can become gassy, try burping your baby more often. You could also place your baby across your lap on his or her belly for a backrub.
• Put your baby in a swing or bouncy seat, or take him or her for a ride in the car. The motion may have a soothing effect.
• Try running the vacuum cleaner, the washing machine or a loud fan. Colicky infants often respond to white noise.

Caring for a colicky baby can be extremely frustrating, so be sure to take care of yourself, too. If you need a break from your baby’s crying, call a friend or relative and ask for help. And if you’re feeling overwhelmed or angry, put your baby safely down in a crib and walk away into another room where you can relax and regain your composure. Remember: Never shake a baby, as this can severely injure an infant.
Newborn Care

Keep calm in the face of some kind of gross stuff.

Spitting up.

It’s normal for babies to spit up small amounts of formula or breast milk following a feeding, especially when being burped or bounced in play. This happens because babies’ digestive tracts are immature. Spitting up is not the same as vomiting all or most of a feeding. If your baby seems to be spitting up too much, try keeping him or her in an upright position (but not slouched forward) for 10 to 15 minutes after a feeding. If that doesn’t help, call your child’s doctor. In some cases, there may be an allergy or digestive problem, or it may be gastroesophageal reflux disease (GERD). For babies with GERD, breast milk or formula regularly backs up into the esophagus and sometimes back up and out of the mouth.

Because stomach acid is part of what’s refluxed, the esophagus can become irritated, making eating painful. Some signs of GERD are vomiting and irritability after meals, an inability to sleep soundly, and frequent “wet burps” or “wet hiccups.”

Skin rashes.

Several harmless skin rashes and conditions may be present at birth or appear during the first few weeks.

Milia — tiny, flat yellow or white spots on the nose and chin — are caused by the collection of secretions in skin glands and will disappear within the first few weeks.

Miliaria — small, raised red bumps that often have a white or yellow head — is sometimes called infant acne because of its appearance. Although miliaria often occurs on the face and may be present on large areas of the body, it too will go away within the first several weeks with normal skin care.

Newborn jaundice — a yellowish discoloration of the skin — is a common condition that occurs in half of all babies. It normally doesn’t appear until the second or third day of life and disappears within one to two weeks. Jaundice in healthy babies is caused by an inability of the newborn’s immature liver to clear bilirubin (a waste product produced by the normal breakdown of red blood cells) from the body effectively. A mild or moderate level of jaundice will go away on its own by five to seven days of age. If jaundice is more pronounced, phototherapy — exposure of the baby to ultraviolet light that helps rid the body of the bilirubin — may be prescribed.
Cradle cap.
Seborrheic dermatitis, or cradle cap, often appears in the first few weeks of life as greasy white or yellowish scales on the scalp and sometimes on the eyebrows and behind the ears. Cradle cap is mostly a cosmetic problem. The scales can be quite thick and can make the hair hard to comb. Routine shampooing and massaging of an infant’s scalp with a soft brush twice a week to remove any crusts usually prevents the condition from becoming a problem. It almost always goes away on its own in a few months.

Reflexes.
Infants are born with a number of instinctual responses to stimuli, such as light or touch, known as primitive reflexes. Primitive reflexes gradually disappear as the baby matures. Primitive reflexes include: the sucking reflex, which triggers an infant to forcibly suck on any object put in the mouth; the grasp reflex, which causes an infant to tightly close the fingers when pressure is applied to the inside of the infant’s hand by a finger or other object; and the Moro reflex, or startle response, which causes an infant to suddenly throw the arms out to the sides and then quickly bring them back toward the middle of the body whenever the infant has been startled by a loud noise, bright light, strong smell, sudden movement or other stimulus.

Breathing patterns.
It’s normal for young infants to breathe irregularly. They commonly will have periods during which they stop breathing for about 5 to 10 seconds and then start up again on their own. When he or she is awake, an infant’s breathing rate may vary widely, sometimes exceeding 60 breaths per minute for short periods of time, particularly when the baby is excited or following a bout of crying.

Strange noises.
Although he or she won’t be talking until later, your newborn will produce a symphony of noises — such as grunts, moans and high-pitched squeaks — in addition to the obligatory crying. Sneezing and hiccups occur very frequently and don’t indicate infection, allergies or digestive problems in newborns.

Soft spots.
Because of the separation of your newborn’s skull bones, you’ll be able to feel (go ahead, you won’t harm anything) two fontanels, or soft spots, on the top of the head. Don’t be alarmed if you see the fontanels bulge out when your baby cries or strains. The fontanels will eventually disappear as the skull bones close together.
Bowel movements, gas and constipation.

Babies’ bowel movements change often in terms of color, consistency and frequency. Breast-fed babies tend to have seedy, mustard-yellow stools, and they tend to have them more often. Formula-fed babies tend to have stools that are yellowish tan. The number of stools can vary from six to eight per day to one every other day. As long as your baby is eating well and seems otherwise healthy, these variations are all normal.

Newborns also tend to swallow a lot of air while eating and crying — and what they don’t get out by burping will travel down the gastrointestinal system until it reaches the other end. Gas may also be caused by sensitivity to certain formulas or to a food consumed by a breast-feeding mother. Gas can be very uncomfortable for some babies. If your baby seems especially fussy and gassy, especially after meals, call your baby’s doctor.

Some babies grunt and turn red in the face when having a bowel movement because the process is not yet coordinated. This is not the same thing as constipation. Constipation refers to small, hard balls of stool that are difficult to pass. Formula-fed babies tend to experience constipation more often than breast-fed babies do.

When to call the doctor.

Your baby’s health care provider expects questions from new parents on just about every topic. They’d rather have you call than worry about something needlessly.

You should also call if you see any of these signs:

- Rectal temperature of 100.4 degrees Fahrenheit (38 degrees Celsius) or higher in a baby younger than three months.
- Symptoms of dehydration (crying without tears, sunken eyes, a depression in the soft spot on baby’s head or no wet diapers in six to eight hours).
- A soft spot that bulges when your baby’s quiet and upright.
- Rapid or labored breathing (immediately call 911 if your baby begins turning bluish around the lips or mouth).
- Bloody vomit or stool.
- More than eight diarrhea stools in eight hours. (Breast-fed newborns often have looser stools than formula-fed babies; check with your child’s doctor.)
- Any change in the baby’s color, especially paleness or bluish color of the lips and tongue.
- Baby suddenly becomes “floppy” with loss of muscle tone, or becomes stiff.
- One or both eyes are pink or bloodshot, or have a sticky white discharge or eyelashes that stick together.
- Tenderness, spreading redness or foul odor around the umbilical cord area.
- White patches in the mouth.
- Nose blocked by mucus so baby can’t breathe while feeding and upright.
- A lethargic or difficult-to-rouse baby.
- Forceful vomiting or an inability to keep fluids down.
- Vomiting that lasts for six hours or more, or is accompanied by fever and/or diarrhea.
- Baby stops feeding normally.
- Crying for an abnormally long time.

Emergency situations.

If your concern is urgent, take your child to a hospital emergency room. With young infants, minor conditions can quickly become serious.
Don’t ignore yourself.

Depending upon your labor and delivery experience, you may feel physically drained and sore. Your hormones may be struggling to catch up, too. Your baby’s not on any kind of schedule yet, and your partner may be feeling a little left out.

All new parents feel overwhelmed sometimes and question their parenting skills from time to time. In addition to asking your health care provider for advice, many parents also find it helpful or reassuring to get information or tips from a trusted child health or parenting website, such as those listed at the end of this booklet. A key to your post-baby sanity is your ability to recruit help. While in the hospital, use the expertise around you — nurses and lactation consultants, for example. At home, relatives and friends are great resources.

Tips for keeping it all in perspective:

• Find someone to talk to about your feelings.

• Set aside time to be with your partner to talk about the changes in your lives. Be open about your feelings and worries.

• Let friends and family members help you with child care, household chores and errands.

• Find time to do something for yourself, even if it’s only 15 minutes a day. Try reading, doing something creative, taking a bath or meditating — anything that you enjoy and find relaxing.

• To fight fatigue and depression, you need your rest. You may not be able to get eight consecutive hours of sleep, but try to sleep whenever your baby naps.

• Exercise, even if it’s just walking around the block a few times. The activity and change of scenery can improve your frame of mind and health.

• Eat well, and stay away from caffeine and alcohol.

• Keep a journal. Write down your feelings and emotions as a way of releasing and dealing with them.

• Even if you can only accomplish one goal per day, it’s a step in the right direction. There may be days when you can’t get anything done — and that’s normal for many parents.

• Keep your sense of humor, and remember that it can take some time to adjust to parenthood. You’ll be less stressed if you just try to go with the flow.
Baby blues and postpartum depression.

You’re the proud mother of a beautiful baby. So how can it be that you’re feeling so unhappy? Feeling depressed after giving birth is more common than you might think. There are three forms of depression that can occur after delivery, all of which result from hormonal changes, exhaustion, unexpected birth experiences and a sense of lack of control over your altered life.

• **“Baby blues”** — About 80 percent of new moms experience irritability, sadness, crying or anxiety in the postpartum period. The baby blues typically peak three to five days after delivery and usually resolve within about 10 days after childbirth.

• **Postpartum depression (PPD)** — More serious than the baby blues, this condition affects 10 to 20 percent of new moms. It may cause sadness, weepiness, a lack of interest in almost all activities, anxiety, insomnia and guilt that lasts longer than two weeks. Your baby may be several months old before PPD strikes, and it’s more common in women with a family history of depression.

• **Postpartum psychosis** — Postpartum psychosis is a severe and rare (0.1 to 0.2 percent of women) condition that makes it difficult to think clearly or function, and often causes women to have thoughts about harming themselves or their babies. If you experience any such feelings, call your doctor immediately.

It can be difficult to admit you’re having persistent negative feelings or thoughts about motherhood. But if you think you have PPD, or any form of depression, it’s important to discuss your feelings with your doctor. PPD can have long-term effects on a child’s health and emotional well-being, especially if the condition goes undiagnosed or lasts a long time.
Nondiscrimination notice and access to communication services.

UnitedHealthcare® and its subsidiaries do not discriminate on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

**Online:** UHC_Civil_Rights@uhc.com

**Mail:**
Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

You must send the complaint within 60 days of your experience. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m., or at the times listed in your health plan documents.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

**Phone:** Toll free 1-800-368-1019, 1-800-537-7697 (TDD)

**Mail:**
U.S. Dept. of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us, including letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m., or at the times listed in your health plan documents.
**Multi-language interpreter services.**

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free number listed on your identification card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LUЮ： Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thế hỗ trợ viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تذكير: إذا كنت تتحدث العربية (Arabic)، يمكننا تقديم خدمة مترجم للمساعدة باللغة العربية.

ATABLE: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nivwo gratis ki sou kat identifikasyon w.

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d’identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniamy darmowe usługi tłumaczenia. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tesserina identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

دیدبان: چگونه می توانید به کمک مترجم عمل کنید؟ (Persian فارسی)

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, तो आपके भाषा सहायता सेवाएं, नियुक्ति उपलब्ध हैं। कुप्पा अपने पहचान पत्र पर सुचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yogy koj hais Lus Hmoob (Hmong), muay kew pab txhais lub dawb rau koj. Thov hu rau tus xov tooj hu dawb uus teev muay nyo rau ntawm koj daim yuaj cim qha tus kheej.

រ៉ុប៉ូនហូម៉េ: តើប្រឈមខ្មែរមានកុសម្រាប់កែងហូម៉េ (Khmer) ដែលប្រឈមប្រភេទនៃកុសម្រាប់កែងហូម៉េ ក្នុងរស់ច្រើនទៀតនៅក្នុងប្រភេទនៃកុសម្រាប់កែងហូម៉េ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti longguah nga awanan bayadna, ket sidadaan para kenym. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mno.

DÍÍ BAA’ÁKONÍNIZIN: Diné (Navajo) bizaad bec yáníult’go, saad bec áka’ana’ida’awo’igii, t’áá jíík’eh, bee ná’a’hoó’ó’ó’t’i’. T’áá shóqóodí níínsaatsii níi’íbi ni bęédé béstí bée bée hane’í biki’íi bée bódíinizhii.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac iambarka telefonka khadka bilaashka ee ku yaalla kaakarga aqoonsiga.