



STEPS TO TAKE

COMPREHENSIVE PERINATAL SERVICES

PROGRAM GUIDELINES



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for Enhanced Health Education, Nutrition, and Psychosocial Services

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2017 Edition

We would like to thank all those who contributed many hours, under tight deadlines, to update the Steps to Take Manual. Without their time and expertise, we would not have been able to provide this up-to-date manual for distribution in 2017.

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These Steps to Take Guidelines are to be used with your office protocols which are your facilities' procedures for CPSP (health education, nutrition, psychosocial) services and related case coordination.

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Note about the pagination

Each page is numerated according the section. Each section is coded by an abbreviation and then a page number.

FS = First Steps

HE = Health Education

NUTR = Nutrition

PSY = Psychosocial

GDM = Gestational Diabetes Mellitus

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STEPS TO TAKE

FIRST STEPS



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PSP provides enhanced perinatal care services to pregnant women with Medi-Cal during their prenatal and postpartum period. Enhanced services include nutrition, health education, and psychosocial services in addition to routine obstetric care. These enhanced services have been shown to reduce the incidence of low birth weight births and reduce overall costs when compared to routine obstetric care alone.

The CPSP client receives ongoing orientation, assessment, care plan development, and case coordination, in addition to appropriate nutrition, health education, and psychosocial interventions/referrals from a multidisciplinary team.

The CPSP provider must personally supervise all CPSP services. Personal supervision may occur in person or via electronic means. The provider must directly supervise comprehensive perinatal health workers and document this supervision in the patient's record. Direct supervision must take place in person and on-site. The provider's protocols must define how each type of supervision takes place and is documented.

CPSP enhanced services are provided with the client's input so that each client receives the information, services, and support she needs. It is important to personalize the information and services offered to each client, and to respect her social, cultural, religious, and economic concerns.

The Comprehensive Perinatal Services Program (CPSP) Provider Handbook offers extensive information on the requirements of CPSP and includes useful tools for developing and maintaining your CPSP practice. For more information on the CPSP Provider Handbook, contact the local Perinatal Services Coordinator (PSC) in your county.

Purpose of Steps to Take guidelines

The purpose of these guidelines is to provide CPSP staff members, who are neither registered dietitians nor masters-prepared social workers or health educators, with the information they need to effectively assess situations, provide interventions, and refer appropriately. There are guidelines for many topics common to pregnancy. However, there are not guidelines for all pregnancy-related topics and high-risk issues are purposely not addressed since high-risk clients should be referred to appropriate professional staff.

Due to the wide variety of CPSP programs and staff, it is highly recommended that you modify and adapt these guidelines according to your staff and clients' needs. These guidelines should supplement and enhance your existing CPSP protocols and high-risk situations should be addressed in your on-site CPSP protocols.

First Steps

There are no client handouts in the First Steps section. This section is not written for clients, but for those who deliver CPSP services. This section provides guidance on program elements such as the orientation and care plan, and includes guidelines about how to deliver CPSP services to meet the diverse needs of clients.

Health Education, Nutrition, Psychosocial, and Gestational Diabetes

If you do not have health education, psychosocial, nutrition, or gestational diabetes expertise, the Steps to Take guidelines will help you screen and provide interventions for situations related to these elements of prenatal care. In general, each guideline includes:

- Goals
- Background information
- Steps to take
- Follow up
- Referrals

This document contains guidelines and patient handouts to use when working with CPSP clients. There are five main sections: First Steps, Health Education, Nutrition, Psychosocial, and Gestational Diabetes. There is also a Postpartum Index and Checklist to use when providing postpartum care.

It is helpful for staff new to CPSP to read First Steps.

Client handouts

There are client education handouts for many of the Health Education, Nutrition, Psychosocial, and Gestational Diabetes topics. The guidelines will refer to related client handouts in Steps to Take. When referenced, handouts appear in italics. For example, *Nausea: Tips that Help* is a handout in the Nutrition section. Handouts are available in English and Spanish.

Use these handouts when you discuss a topic with the client. The best way to use them is to read and discuss them with the client. If you send materials home with a client, be sure she can read and understand them, or has someone who can read them for her.

Feel free to use other written materials to supplement the handouts. See the *Low Literacy Skills* guideline in First Steps to learn how to choose effective handouts. You may need to translate handouts into the languages most used by clients.

Use these Steps to Take guidelines with your office protocols, which are your facility's procedures for delivering CPSP health education, nutrition, and psychosocial services, as well as related case coordination.

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Knowing that, there are essential elements to remember every time a CPSP staff person works with a client. These are:

- Believe that each client can help herself
- Focus on the client
- Look for the client’s strengths and build on them
- Keep an open mind
- Support the client’s right to choose

Steps to Take

- Believe that each client can help herself

It is commonly accepted that the health care practitioner can help the client. However, the most effective interventions occur when both the health care practitioner and the client believe in the **client’s ability** to help herself.

Once the client leaves your office, she only has herself to rely upon. When staff show confidence in the client and the client’s abilities, the client is more likely to trust the staff and participate in the plan. For example:

- ◆ Take time to ask the client how she is feeling. Really listen to her as an individual.
- ◆ Look at the client, rather than looking through the chart, typing on the computer, or arranging pamphlets.

Believing that the client can truly help herself leads to the next step: focus on the client.

- Focus on the client

By believing the client can help herself, the focus naturally shifts away from the CPSP staff and toward the client; first by understanding and identifying her goals and then by helping her to achieve them.

CPSP is a client-centered program. Each client has her own unique concerns, way of learning, experience, knowledge, strengths, and risks.

No matter what the issue is, begin by finding out what the client knows, what questions she has, her level of experience, and how she prefers to learn. Then, help her decide what more she needs to learn and provide her with the knowledge and skills she needs to help herself. For example:

- ◆ Encourage the client to bring up her concerns or questions in the beginning.
- ◆ Encourage her to write a list of questions to ask the health care practitioner, so she can better remember them.
- ◆ Provide support and encouragement to a client who, for example, is very nervous at 15 weeks of pregnancy because her last pregnancy ended in a miscarriage at 16 weeks. It may be more appropriate not to spend time on other areas of her health education plan at this time.
- ◆ Design a different health education plan for a client who has never had a baby and prefers to read, as opposed to a woman who has had two babies and finds reading difficult.
- Look for her strengths and build on them

Every client has strengths. However, health care practitioners are trained to look for problems and solve them, so it takes a conscious effort to shift away from looking for risks to also looking for strengths.

When an interaction “focuses on the client,” it is a two-way discussion during which, some of the client’s strengths will become evident. When a CPSP staff person comments on the client’s strengths, the client’s confidence in her ability to help herself increases. For example:

- ◆ Commend a client who called in after spotting for two days. Her strength is that she understood that she should be checked. Use that understanding to teach her about calling right away if she feels any danger signs in the future.
- ◆ Although a client may not know the anatomical names of her reproductive organs, she may have a lot of experience in supporting other women during their pregnancies. Her strength is that she knows what to expect as her body changes.
- ◆ A client may continue to smoke or use other drugs throughout pregnancy. Even if she is risking her health and the health of her baby, she has the right to make those decisions. Praise her for taking an interest in her pregnancy; encourage her to attend all of her appointments and to decrease her smoking/drug use to lessen the risks to herself and the baby.

■ Keep an open mind


When talking with a client, take care to keep your own values and opinions out of the picture, even if some of her attitudes, beliefs, or behaviors seem new or unusual to you. For example:

- ◆ Listen with an open mind to cultural or religious beliefs about food or activities. This information will help when making a plan for the client's care.
- ◆ Even if a client is behaving in ways that you think are not appropriate for a pregnant woman (using drugs, not married, etc.), praise her for showing interest in her baby's health by seeking prenatal care.

■ Support the client's right to choose

Each woman has the right to decide how much she will participate in CPSP. CPSP services are voluntary; a client can turn down any or all parts of these services. For example:

- ◆ A client may choose not to learn all the details of labor and delivery. Accept that she prefers to let nature take its course.
- ◆ A client can choose who she wants to involve in her care. After explaining the client's right to confidential medical records and any legal limitations, it is important to explain what will be discussed in the visits so she can decide if she would like others to be involved in her care. For example, explain the sensitive topics that will be discussed in each visit such as history of past pregnancies, substance use, intimate partner violence, and sexually transmitted infections. Then, the client can knowingly choose if/when she wants to include others in her care.
- ◆ Accept a client's choice to quit school and stay home for the last three months of her pregnancy even though she is in good health.

rientation to other patient services may also be offered later in the pregnancy or postpartum when needed; for example, describing a procedure such as amniocentesis, or explaining how to prepare for her first ultrasound are both examples of orientation on new topics and can be documented using orientation units.

What to Discuss with a New CPSP Client

Inform the client that all services are voluntary and she may accept or decline any services. During your initial orientation, ideally done during the first visit, discuss the topics below with the client.

These topics are covered in the *Welcome to Pregnancy Care* handout in the Health Education section of this manual. You can use this handout as a guide to help you cover the information. Be sure to include your address and phone number on the handout. Topics include:

- Types of service
- Schedule of service
- The team of caregivers
- Where services are provided
- Appointments and procedures
- Emergency procedures
- Clients' rights and responsibilities
- Danger signs to watch for when a client is pregnant

Types of service

- **Medical:** Exams, routine laboratory tests, and other tests needed to check the client's health and the health of her baby
- **Health education:** Assessments and information/classes about pregnancy, childbirth, breastfeeding, infant care, etc.
- **Nutrition:** Assessments and help with eating healthy foods and addressing family issues

Orientation explains what the client can expect from CPSP services and should be provided during the client's first visit to your clinic or office.

- **Psychosocial:** Assessments and counseling regarding personal problems or family issues
- **Referrals:** Outside sources that can provide additional help and services such as Medi-Cal; smoking cessation programs; Women, Infants and Children (WIC); etc.

Schedule of services

- Discuss the purpose of regular prenatal visits and the benefits of prenatal care.
- Review the frequency of prenatal visits; i.e., when and where they will occur.
- Explain that health education, nutrition, and psychosocial services will be offered at least once every trimester, or more often if needed, as part of the client's prenatal care.
- Discuss meeting days and times for health education groups or other services.
- Discuss the importance of postpartum care to provide support for breastfeeding, assess the client's adjustment to being a mother, and answer questions about infant care.

The team of caregivers

- Go over the background and training of clinic or office staff.
- Explain the differences between a nurse practitioner, nurse, nutritionist, health educator, social worker, medical assistant, health worker, etc.
- Review each staff person that provides CPSP services in your clinic or office, including their names, titles, and roles; if you have a photo display board, show the client pictures so she can see the people she will be interacting with.

Where services are provided

Explain where the client will receive her prenatal services:

- In the health care practitioner's clinic or office
- At the delivery hospital
- At other sites for referrals such as WIC
- If you have maps, bus information, or directions, provide them as needed.

Appointments and procedures

Explain how to make and cancel appointments. This should include:

- How to make a prenatal appointment, including what numbers to call and times of day to call.
- How to cancel or reschedule a prenatal appointment, including what phone number to use, whom to call, and the timeframes in which to call (for example, your office/clinic policy may be to call 24 hours in advance to cancel an appointment).
- To call the clinic or office if the client is going to be late for an appointment.
- The consequences if the client is late for an appointment (for example, if the client shows up 15 minutes late for an appointment without notifying the office, the appointment may be rescheduled to a later time).
- How to schedule a tour of the delivery hospital (inform the client of pre-registration requirements at the delivery hospital).
- How to schedule postpartum care appointments.

Emergency procedures

Describe how to use the hospital emergency room and how it differs from the health care practitioner's clinic or office. Provide the following:

- A phone number to call your clinic or office during business hours

- A phone number to call when the clinic or office is closed
- 911 for all emergencies
- Information on where to go if a sudden emergency occurs (which hospital, which entrance, etc.)
- Information on pregnancy danger signs and procedures. Provide this information in writing and review it with the client.

Clients' Rights and Responsibilities

Encourage the client to take an active role in her health care. Tell her she can ask questions if she does not understand something and discuss client rights and responsibilities.

Your clinic or office promises to:

- Treat each client with respect
- Make sure that client information will be kept between the client and the staff
- Keep the client's medical information private and do not give the client's medical information to anyone else unless the client gives your clinic or office written permission
- Inform the client that, in accordance with the law, the clinic or office must report abuse or violence so the client can get extra help. If you do need to file a report, your clinic or office should call the agency that can best help the client.

The client has the right to:

- Look at her medical records with someone from your office
- Help plan and make choices about her care while she is pregnant, in labor, or giving birth
- Accept or refuse any care, treatment, or service

Danger Signs to Watch For When A Client Is Pregnant

Explain the difference between common discomforts and warning signs. Tell her what to do if she has one of the following warning signs:

Call the clinic or office right away if the client experiences:

- Feelings of dizziness
- A fever or chills
- A really bad headache or a headache that goes on for days
- Changes in eyesight, blurred vision, flashes of light, halos, or spots in front of her eyes
- A swollen face or hands
- Difficulty breathing
- A fall, a blow to the stomach, or was in a car accident
- Vomiting or has been having a bad stomach ache
- Too much weight gain too quickly

Don't wait: Call the clinic or office right away if the client has any of the following signs:

- Bleeding from the vagina
- A sudden flow of water or leaking of fluid from the vagina
- A big change in the way the baby moves, or if the baby moves less often
- A sharp pain when urinating (peeing)

Later in the pregnancy, call the clinic or office right away, day or night, if the client has any of the following signs:

- Stomach ache or cramps: With or without diarrhea
- Contractions: The uterus tightens five or more times in one hour

- Pain or pressure: In the belly, thighs, or around her vagina, as if the baby is pushing down
- Change in discharge from her vagina: More mucus than usual, or bloody or watery discharge
- Lower backache: Pain or dull pressure in her back, or back pains that come and go in a regular pattern

Note: If the client's first visit occurs after she feels the baby moving (approximately 18 to 22 weeks), show her how to do kick counts and watch for preterm labor symptoms. Give her the handouts *If Your Labor Starts Too Early* and *Count Your Baby's Kicks* from the Health Education section of this manual.

Orientation Handouts

When you perform an orientation on the first visit, give the client an orientation handout, such as *Welcome to Pregnancy Care* (see the Health Education section of this manual). To emphasize a point, write on the pamphlet. Some items you might write down are: names of staff members or locations of related services (WIC, etc.). When you give handouts to a client, ask her to keep them readily available in case she needs the list of danger signs, phone numbers, or other information. Be sure your name, address, and phone number are on the handout.

How to document orientation

If all of the orientation is provided in one visit, write a short note in the progress notes of the client's chart or on the assessment form, including:

- Date of orientation
- Provider signature and title
- Time spent in minutes

For example:

1/12/16, orientation per protocol,
J. Doe, CPHW, 40 minutes.

If only part of the orientation was provided, document each topic. The orientation can then be completed at a subsequent visit and documented accordingly.

For example:

3/26/16, 15 minutes, orientation on clinic visit procedures, danger signs, and emergency procedures.

J. Doe, RN.

Patient verbalized understanding of danger signs of pregnancy, when to call the doctor, and when to go to the emergency department.

Resources

Prenatal Screening

California Prenatal Screening Program (PNS)

<https://www.cdph.ca.gov/Programs/CFH/DGDS/Pages/pns/default.aspx>

The California PNS provides prenatal screening services to all pregnant women in California as well as follow up services where indicated. Education materials and consent forms are available to help families understand basic prenatal screening and diagnosis information for some birth defects.

The purpose of CPSP assessments is to identify the client's issues, strengths, and learning and resource needs in order to develop a plan for the best pregnancy outcome.

It is best for women to begin care as early in the pregnancy as possible so that the initial assessment occurs early in the first trimester. The initial nutrition, health education, and psychosocial assessments should be completed within four weeks of entry to care. Additional assessments should be conducted in the second and third trimester and postpartum.

CPSP providers complete all assessments in face-to-face interviews. Each assessment area (nutrition, psychosocial, and health education) should be a minimum of 30 minutes or a combined three-part assessment totaling at least 90 minutes (all three of the support disciplines must be assessed).

CPSP providers must conduct assessments that address all elements required by Title 22. The Provider Handbook includes a list of these elements. All assessments and changes to assessment forms need review by the local area Perinatal Services Coordinator (PSC) for compliance with Title 22. PSCs can provide sample assessment forms that include all required elements. Providers must also allow for periodic updates to the assessments to comply with best practices.

After completing an assessment, the CPSP provider and the client develop an Individualized Care Plan (ICP) to address the needs of the client. CPSP assessments and reassessments may identify complex conditions best addressed by a registered dietitian, master's prepared psychosocial practitioner or a master's prepared health educator. It is a best practice to refer clients with complex conditions to these experts for in-depth assessment, intervention, and referrals as needed. Instructions on these procedures are included in your site specific protocols.



See the CPSP Provider Handbook (Chapter 2) for information on assessment guidelines and requirements.

Follow up and completed reassessments are required by regulations. These should be done at each trimester and postpartum.

Assessments and Reassessments

All CPSP services are voluntary. If a client declines the assessment, you must document this in her medical record. Continue to offer assessments or other CPSP services at subsequent visits when you feel she may be ready to participate. Document each invitation to participate in CPSP services and the client's response.

Guidelines for interviewing

- The setting should be private and ideally have a phone for communicating with outside resources.
- Try to put the client at ease. Introduce yourself and explain the purpose of the assessment.
- Adopt a nonjudgmental, relaxed attitude.
- Tell the client that her responses are part of her confidential medical record and will not be shared outside the health care team, with a few exceptions:
 - ◆ If she has a plan to hurt herself or others.
 - ◆ If she has physical injuries as a result of assault or abuse.
 - ◆ If there is suspicion of abuse/neglect of a child, elder, or dependent adult.
- Ask open-ended questions to get information; that is, questions that require more than a "yes" or "no" answer. For example:
 - ◆ Start with, "How do you prefer to learn new things?" instead of, "Do you like to read?"
 - ◆ Try, "What do you know about breastfeeding?" instead of, "Do you plan to breastfeed?"

- ◆ Use, “How does your partner feel about your pregnancy?” instead of, “Is your partner happy about your pregnancy?”
- Focus on the client, not the form. Try not to read the assessment form word for word. Use words and phrases that you feel comfortable with and that are culturally appropriate for the client. Maintain frequent eye contact while completing the form.
- Take special care to fill in an answer to every question. Do not leave any questions blank. If a client does not want to answer, document “client declined to answer.”
- Ask sensitive questions in an accepting, straightforward manner. Clients often report sensing when they are being judged. Be aware of your own attitudes and body language. Most clients are willing to answer, especially if they understand why the question is being asked. Explain that responses are voluntary; she may choose not to answer a specific question.

The ICP is an effective tool for coordinating a CPSP client's perinatal care. The ICP is developed from information obtained during the client's initial assessment and is updated at each trimester and at postpartum. The CPSP practitioner and the client develop the ICP together to document the client's strengths, identify goals and appointments that address her perceived resource needs, and to prioritize her risk conditions.

The ICP may also include referrals to outside agencies. Referrals should include the name of the agency, contact person (if any), and phone number. Follow up on referrals is documented on the ICP during reassessments or any other contact with the client.

All CPSP providers must use an ICP that meets Title 22 requirements. The PSC can provide samples of ICPs that meet the guidelines.

The required elements of the ICP are as follows:

- Risk conditions and problems: The obstetric, nutrition, psychosocial, and health education assessments help determine a client's health risks and resource needs. Conditions prioritized on the ICP should be unique to the client. Risk conditions and problems are identified through the assessment, discussed and prioritized with the client, and documented in the ICP by the practitioner.
- Interventions: Teaching, counseling, referrals, problem solving, and any actions to be taken by the client or staff to address risk conditions/problems are noted on the ICP. The ICP should include who is responsible for carrying out the needed intervention and the associated timelines. Whenever appropriate, involve people who provide her social support, such as her partner or a family member. All proposed interventions should take into consideration the client's cultural background and linguistic needs.



See the CPSP Provider Handbook (Chapter 2) for sample Individual Care Plan (ICP) tools and further information on completing the ICP.

- Client outcomes: At a minimum, update the ICP after each reassessment and indicate the progress achieved to date and any necessary modifications to the plan. Document the results of each planned intervention or referral on the ICP. For example, if the problem was smoking, did she attend the smoking cessation class she was referred to? If not, how is the plan going to be revised? Is she using the deep breathing exercises you taught her? What interventions are helping her achieve her goal to stop smoking? Is the problem now resolved?

Interventions provided and documented in the ICP are based on site-specific protocols. The ICP must document all care coordination and follow up for interventions and referrals.

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As you educate clients, you can help them in the following ways:

- Provide necessary information
- Help clients make informed decisions about their pregnancies (see *Helping a Client Make Decisions*)
- Make linkages to appropriate services (see *Making Successful Referrals and Developing a Community Resource List*)
- Help clients change behaviors to have healthier pregnancies and babies (see *Helping a Client with Behavior Change*)

This section will focus on the first point above, providing information. The goal is to provide information so the client learns what she needs to carry out a healthy pregnancy. Keep in mind, people learn in different ways, so no two clients will assimilate information in the same way.

Learning New Information

Overall, people remember:

- 10% of what they read
- 20% of what they hear
- 30% of what they see
- 50% of what they hear and see
- 70% of what they say or write
- 90% of what they say as they do a thing

As you can see from the list above, the more a person actively uses information, the more they will remember. More passive methods of learning, such as reading or listening, are less effective. Use more active methods such as asking the client to practice a skill or having the client explain what she understands.

Pay attention to the assessment form question about how she likes to learn. One person may like to read instructions, while another may prefer having someone explain instructions. Some people may be terrified of groups, while others prefer group learning.

Teach-back

Ask the client to “teach-back” the main points. With teach-back, you ask the client to teach you/explain the most important part of your message. For example, say:

- “Just to be sure I have explained the danger signs clearly, could you tell me the danger signs you remember and what you will do if you see them?”
- “What suggestion on this handout seemed like something you could do to quit smoking?”
- “Tell me what you will do now to help your nausea.”

Adjust the way you teach to each client’s learning preferences when possible.

Another important factor is the client’s interest in the subject. For example, a client in her first trimester may not care about breast or bottle feeding; however, in her third trimester the same client may be very interested in how she will feed her infant. Find out what the client is interested in and provide information at the relevant time.

Teaching Effectively

You can be a more effective educator by remembering two things: (1) limit and focus the information you give and (2) involve the client.

Following are some suggestions that will help you involve the client with the information you give, from the beginning to the end of your education session.

The beginning

- Establish rapport. Ask the client how she is feeling or make a friendly comment.
- Find out if she has any concerns, and address her concerns.

The middle: getting and giving information

- Ask what the client knows/has heard about this topic.
 - ◆ Use a phrase such as, “What do you know about breastfeeding?” instead of, “Do you plan to breastfeed?”
- Explain jargon or unfamiliar words.
- Give only the most essential information in small “bite-sized chunks.”
- Ask questions to find out what the client understands after explaining a chunk of information.
- When using a handout:
 - ◆ Explain the information in chunks. Name the topic before you give the details of each chunk.
 - ◆ Highlight any important points with a pen, pencil, or colored highlighter.
 - ◆ Ask the client to circle or point out what is important to her.
- When teaching skills, show and tell.
 - ◆ For example, show and tell the client how to use a condom or how to perform prenatal exercises.

The end

- Review the main points.
- Ask the client to show you any skills you’ve taught. For example:
 - ◆ Ask the client to show you how to do kick counts or safe lifting techniques.
 - ◆ Ask the client to role-play with you; for example, how she will ask her partner to smoke outside to avoid second hand smoke.
- Ask the client to “teach-back” the main points. With teach-back, you ask the client to teach you/explain the most important part of your message. For example, say:

- ◆ “Just to be sure I have explained the danger signs clearly, could you tell me the danger signs you remember and what you will do if you see them?”
- ◆ “What suggestion on this handout seemed like something you could do to quit smoking?”
- ◆ “Tell me what you will do now to help your nausea.”
- Ask the client what questions she has.

Open-ended questions

One easy way to involve a client is to use open-ended questions throughout her education. Use open-ended questions whenever you want to find out what a client has learned or knows. Open ended questions start with words like, “what,” “tell me,” or “how.” By using these types of questions, you are not allowing a “yes” or “no” answer. Instead, you are drawing out a longer response. Try not to start questions with words like, “do you,” “is,” “are,” or “can you?” These beginnings lead to “yes” or “no” answers. For example:

- Start with, “How do you like to learn new things?” instead of, “Do you like to read?”
- Try, “What will you do when you want to count your baby’s kicks?” instead of, “Can you count your baby’s kicks?”
- Use, “How does your partner feel about your pregnancy?” instead of, “Is your partner happy about your pregnancy?”

In some cases, you will need to refer a client to an outside resource that specializes in a particular kind of service or focus area. After making a referral, follow up at later visits to assure that the client has followed through. At each referral, be sure to:

- Explain the benefits of the referral and how the referral meets a need she has identified.
- Describe the process of the referral (what has to happen before she can receive services).
- Praise her for taking care of herself.

Try to relieve any embarrassment she might feel as a result of seeing another practitioner. If she has formed an attachment to you, she might be reluctant to see someone else. Let her know you will still see her at upcoming prenatal visits. When you or the client calls the referral agency, find out the following as necessary:

- Who is served? Are there any age limits or other restrictions?
- Are people seen on a drop-in basis or is an appointment required?
- How long will it take to get an appointment?
- Is there a waiting list?
- Is there a cost? What is the cost? Is there a sliding scale for people who have limited resources?
- What are the staff's language capabilities?
- Where are their offices located?
- Which public transportation options are nearby?
- What are their hours and days of service?

You may need to teach the client how to make an appointment. Show her how to ask for the name of the person she's being referred to and how to make notes about what she is told.

Prepare Her For Barriers She May Experience

Ask if she thinks she will have any problems in following through with the referral, such as transportation, childcare, or other barriers. Find out if the client has a calendar and a clock to help her keep appointments. See if she has a map, bus schedule or a corresponding phone application, and be sure she knows how to use it to locate the agency. Consider her literacy skills.

What If She Won't Go?

Do your best to make an appropriate referral and encourage her to accept it. Ask her to share with you any potential barriers that would keep her from following through on the referral. Document your efforts. In most cases, you can't make the client follow through. In cases where the client is a danger to herself or others, see Psychosocial Care: Emotional or Mental Health Concerns.

If a client thinks she doesn't need help or she feels you can't help her with all her problems, she may not want to see someone from an outside agency. Know the limits of your counseling experience or other training and explain those limits to her. Set limits on your time and availability to avoid overdependence. If she becomes overly dependent, she will be less likely to accept outside help and receive an appropriate level of care.

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See the CPSP Provider Handbook (Chapter 6) for information on developing referral resources.

Create a community resource list to use with clients and include these resources in your facility protocols. Your facility protocols should include any referral resources that will help the client meet her needs; referrals should be chosen based on each client's assessment results and client preferences. Build on lists that already exist in your community. Places to check are:

- County Perinatal Services Coordinator (PSC)
- County Health Department's Maternal and Child Health Division
- United Way
- Text4Baby
- Nonprofit or religious organizations such as Catholic Charities, Salvation Army, etc.
- The White Pages of the phone book or the Internet for city, county, state, and federal government offices
- The Yellow Pages of the phone book or the Internet for local community services
- County mental health and substance abuse programs for a list of Medi-Cal providers of these services for pregnant and postpartum women

Potential resources for clients with specific problems or issues are listed at the end of some of the guidelines. Add any resources appropriate for your community. Include contact names, addresses, phone numbers, possible services provided, hours and days of operation, language capabilities of staff, eligibility criteria, access to public transportation, cross streets, intake procedures, and other pertinent information.

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WIC: A Required CPSP Referral

All CPSP providers must refer all pregnant, breastfeeding, and postpartum women, as well as children under age 5, to the WIC program. In addition to the initial referral, CPSP providers must follow up with CPSP clients to inquire about their experience with the WIC program and/or why they chose not to participate. CPSP providers play an important role in supporting and encouraging perinatal women to participate in the WIC program.

What is WIC?

WIC serves women, infants, and children by providing nutrition education, breastfeeding support, referrals to health and social services, and checks for nutritious foods to eligible families. WIC provides supplemental nutrition services in every county in California.

Services provided

The following types of services are provided to eligible women, infants, and children under 5 years of age:

- Nutrition and health education
- Breastfeeding promotion and support
- Nutritious supplemental foods
- Referrals to health care and social services

Who Is Eligible For WIC Services?

Category

Persons in the following categories may be eligible for WIC services:

- Women who are pregnant, breastfeeding women up to one year after delivery, and non-breastfeeding women up to six months after delivery
- Infants from birth to 1 year of age
- Children one to 5 years of age

Income

Women in families with income that is 185% of the Federal Poverty Level or less are eligible for WIC. All women, infants, and children receiving CalFresh (federally known as the Supplemental Nutrition Assistance Program (SNAP) or Food Stamps) or CalWORKS meet the income eligibility criteria for WIC. Most Medi-Cal and Child Health and Disability Program (CHDP) beneficiaries also are income eligible for WIC. In addition, many working families with moderate incomes may be eligible.

Nutrition and health indicators

The WIC program determines the applicant's eligibility based on information provided by the health care provider and the client describing the client's nutritional need.

Federal regulations

Federal regulations specify that pregnant and breastfeeding women and infants are given the highest priority for program enrollment. Please advise clients who are referred to WIC that they must provide the WIC program with the following information at enrollment:

- Income verification, including any of the following:
 - ◆ Adjunctive eligibility documentation: Medi-Cal benefits, CalWORKS, or CalFresh card
 - ◆ Other documentation: Pay stubs, income tax forms, unemployment benefit card
- Residence verification, including but not limited to current:
 - ◆ Utility bills, rent receipts, or bank statements; post office boxes are not acceptable

- Personal identification, including but not limited to current:
 - ◆ Driver's license, Medi-Cal benefits identification card, birth certificate, immunization record, school identification card, California identification card, and other documents

Health care providers should provide the following to the applicant or the WIC program in time for the enrollment appointment:

- Documentation that the participant is receiving CPSP services along with identification (name, address, and phone number) of the CPSP provider
- A WIC referral form or other form that documents the following:
 - ◆ Anthropometric data (height, current weight, pregravid [pregnancy] weight, if applicable)
 - ◆ Biochemical data (hemoglobin or hematocrit)
 - ◆ Expected date of delivery (EDD), if applicable
 - ◆ Any current medical conditions

The client may enroll in the WIC program provisionally without complete information from the medical care provider.

All of the above data must be recorded within 60 days before enrollment of the WIC program (or 90 days in the case of blood work). If it is not, WIC staff is required to disqualify the patient from receiving WIC benefits. Local WIC programs encourage providers to work with them to facilitate the exchange of health information.

WIC Contact Information and Resources

Visit the WIC website for more information and to locate the nearest WIC office:

<https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Program-Landing1.aspx>

1 (888) WIC-WORKS (1 (888) 942-9675) Call to locate the WIC program nearest the applicant's home.

Documentation is used for communication with other members of the health care team and should be clear and complete.

This will be added to the client's medical record, which is a legal document that will follow her for the rest of her life. It is important to document everything correctly, according to medical standards. The requirements for documentation are the same for electronic and for hard copy records.

- Write all entries legibly in black waterproof ink.
- Do not leave any blanks. If the question doesn't apply, write "N/A," meaning "not applicable."
- If the client does not want to answer the question, make a brief note on the form, such as "client declines."
- Use only abbreviations that are approved for use at your site.
- To correct errors, the person who made the original entry should draw a single line with black ink (not thick, felt type) through each line of the incorrect information, leaving the original writing legible, write "error" and initial and date at the end of the crossed out section. Then, write the correct information. Do not attempt to erase, block out or use liquid paper on any error. Do not change another person's note under any circumstances.



See the CPSP Provider Handbook for information on required CPSP documentation and billing procedures.

- Date and sign all entries with your first name or initial, full last name, and CPSP title.
- Note time spent in minutes at the beginning or end of the assessment; indicate only face-to-face time spent with the client, not time spent in phone calls, charting, etc., unless the client is present during these activities.
- Document class attendance (two or more clients) in a progress note. In the note, list the title of the class and refer to an outline on file. Keep all class outlines filed in a designated place in your office/clinic.
- Record all referrals made, including name of agency, contact person, and phone number in the medical record.
- Never chart or document for another person.

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Client caseloads are often made of people from different age groups. At different ages, people are in different stages of emotional development, physical growth, have different ways of thinking and making decisions, and have varying levels of abilities when it comes to getting along with others. Knowing a client's age and paying attention to how she thinks, makes decisions, and relies on others are helpful when choosing the most effective approaches for working with her.

Adolescents (13-18)

Pregnancy interrupts a teen's normal growth, development processes, and a crucial stage of life. It requires the teen's body to expend energy developing a new life instead of devoting that energy to her physical growth. A teen also must face the adult responsibilities of parenthood when she would ordinarily be learning how to make decisions and relate to others.

Thinking and reasoning traits

- An adolescent tends to make decisions based on personal principles that are heavily influenced by peer pressure; decisions are seldom based on fear of punishment or fear of adult disapproval.
- Her view of everything is in relation to herself; she is self-focused and unable to see herself as others see her; the world revolves around her.

Relating to others

- She seeks to establish herself as an individual, while at the same time, trying to connect with her peers in order to be accepted.

Recommended approaches

- Keep a nonjudgmental attitude.
- Focus on "self care" during pregnancy versus "caring for the baby."
- Present subjects in the here and now, as opposed to the future.

- Acknowledge the difficulty of mastering motherhood at this time in her life.
- Use group activities such as classes, parties, games, and outings.
- Use written materials and pictures that are oriented toward teen language and culture.
- Incorporate a variety of teaching methods such as movies, computer, music, etc.
- Use social media and phone resources if they are available (see the Tobacco Use guideline or the SmokeFree.gov resource, which has instant messaging and a mobile phone application to help teens stop smoking. The Text for Baby Campaign also sends messages about the different stages of pregnancy, etc.)
- Link with schools, social service agencies, and pediatric facilities.
- Engage the father of the baby as much as possible.
- Use mentors and peers as appropriate.
- Be flexible.

Adults (19-35)

Pregnancy complements the adult's physical growth, thinking and reasoning patterns, and social relationships. However, the potential for a short interval between pregnancies and the likelihood of working too much outside the home may result in the client lacking the energy and good health needed for a healthy pregnancy.

Thinking and reasoning traits

- An adult makes decisions based on logic and can solve problems and think in an orderly manner.
- She is ready to make commitments and set realistic goals; an adult is anxious to achieve, be responsible, and bring different people and ideas into her life.

Relating to others

- There is a need to share life with someone else, a desire to be private, personal, and in a close relationship.

Recommended approaches

- Assist her in setting goals and making choices and commitments.
- Present information in a logical manner.
- Focus on the sharing aspect of the experience. Encourage the client to include her partner or another support person in her prenatal care experience.
- Be sensitive to existing stress and fatigue.

Mature Adults (36-45)

Pregnancy may challenge the mature adult's place in her life cycle, depending on the planned or unplanned nature of the pregnancy. If this is a first pregnancy, her current lifestyle will soon change dramatically; if it is a subsequent pregnancy, added responsibility may stress the client in new ways. Her age may also place her at higher risk for complications during the pregnancy and for birth defects in the baby. Fatigue comes more quickly and previous pregnancies and/or life experiences may leave her less able to carry pregnancies to term.

Thinking and reasoning traits

- A mature adult is capable of thinking about many things at once and seeing things from different perspectives.
- She is more likely to have a strong sense of "self" and see herself as an individual.

Relating to others

- She is interested in looking at and evaluating previously made goals.

Recommended approaches

- Relate pregnancy needs to her education and life experiences.

- Respect the many questions and concerns she may express.
- Do not assume she is knowledgeable about pregnancy because of her chronological age. Explore beliefs about pregnancy and introduce factual information as appropriate.
- Be sensitive to possible feelings of embarrassment, shock, self-doubt, or conflicting feelings about the pregnancy.

Some clients may need assistance with health-related decisions, such as:

- To attend all prenatal appointments or not
- To wear a seatbelt or not
- To breastfeed or not
- To have a newborn boy circumcised or not
- To have a baby immunized or not
- What contraception to use after the baby is born

You can help the client with the steps involved in making a decision, but in the end, the decision is for the client to make.

In some cases, the client's decisions will be influenced by a family member (such as mother or mother-in-law) or by a group (such as her spiritual support system, co-workers, etc.). Find out who influences her decisions and how strong that influence is. Take that into consideration when you talk with her about her decisions. Many decisions can be worked out by using the following problem solving technique:

1. Ask the client to:
 - ◆ State her choices clearly
 - ◆ List all the benefits and barriers she can think of for each choice
 - ◆ State her values as they relate to each choice

For example, if a client is trying to decide whether to breastfeed or not, she may tell you that she feels strongly about wanting what is best for her baby. She is also concerned about whether she can make enough milk, her modesty, and a need for independence.

2. Clarify information about her choices to help her make a decision

For the client above who is trying to decide whether to breastfeed, you might tell her:

- ◆ Breast size does not determine the quantity of breast milk (frequency of feeding does).
- ◆ Other people can give a bottle to a breastfed baby (the mother can express breast milk for a bottle).
- ◆ A woman's modesty can be protected and her breasts do not have to be exposed during breastfeeding.

Now the client can re-evaluate at her values and beliefs, as well as each factor in her decision. She can understand how strongly she feels about it and has the information she needs to balance with those beliefs.

3. Include "significant others" as appropriate.

Ask the client if she would like to bring a family member or someone important to one or more office visits. Let her know that her supportive relationships are important. For example:

 - ◆ Invite a family member to come along to learn about breastfeeding.
 - ◆ Invite a family member who smokes to come along and learn about ways to help avoid exposure to secondhand smoke.
4. Follow up with the client about her decision next time you see her. If she still is undecided, let her know it can take time to make a decision and repeat steps 1, 2, and 3 above.

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During her time in prenatal care, a client may need to change her behavior. For example, she may want to change her smoking habits, or her habit of missing scheduled prenatal appointments, or the way she handles stress.

Clients do not change their behavior because a CPSP staff person tells them to. CPSP clients are just like CPSP staff; we all change our behavior when we are ready.

People approach a change in behavior in stages. At some points in time, clients are far away from being ready to change. At other stages, change is the next step!

The Transtheoretical Model of Behavior Change (also called the Stages of Change Model) explains how people change.

Why is this model helpful to CPSP staff? Once you assess which stage a client is in, you can then help her to move to the next stage. By taking small steps, you can help the client move toward her desired change in behavior.

The Stages of Change are listed here, and will be followed by a brief explanation of each stage, as well as what CPSP staff can do to help a client in that stage.

Stages of Change:

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse

Think of these stages as parts of a cycle. Ideally clients move little by little toward trying out their desired behavior. However, clients also can move away from the desired behavior.

Assess a client's stage

You can assess which stage the client is in by asking questions that encourage her to explain how she feels about changing her behavior. This only happens during a discussion; it is not something found on the assessment form.

Pre-contemplation

This is the stage furthest away from making a behavior change. In pre-contemplation, clients are not thinking about changing their behavior. Often, they do not want to make a change, because they don't see the behavior as a problem. A client in this stage may say, "I don't think I need to stop smoking. I smoked all through my first pregnancy and my daughter is now 6 years old and has no problems."

To help a client in this stage: Discuss the problem in the abstract. Do not talk about the client's behavior, but talk in a general way about other people who have felt the same way. Talk about statistics. The goal is to give the client some food for thought, so she can move to the next stage, contemplation.

Contemplation:

In the contemplation stage, people begin to think about changing their behavior. A client in this stage may say, "Yes, I know I should stop smoking, BUT..."

To help a client in this stage: Discuss the pros and cons of changing behavior. Help the client to brainstorm ways to overcome each con. The goal is to help the client feel she can overcome the cons, so she can move to the next stage and prepare to change.

Preparation:

In this stage, a client is preparing to take action in the immediate future. She has taken some steps toward changing her behavior. Her preparations may include talking to others to get advice or support, or setting a personal goal such as cutting down to fewer cigarettes.

To help a client in this stage: Applaud her preparations. Then discuss any barriers she foresees in making her desired change. Brainstorm ways that she can overcome these barriers. The goal is to help her make a plan to overcome any barriers and move to the next stage – action.

Action:

In the action stage, the client is changing her behavior. She is trying her new behavior.

To help a client in this stage: Applaud her actions. The goal is to help her to continue her new behavior and to prevent relapse. Discuss any barriers she foresees in continuing her desired change. You might ask, “What is the hardest part about (your new behavior)?” Brainstorm ways that she can overcome the barriers. Reinforce the benefits of her new behavior. You might ask, “What is the best part about (your new behavior)?”

Maintenance:

In the maintenance stage, a client has made the change and continued it for six months.


To help a client in this stage: Continue to give the client encouragement and praise. Remind her of the benefits. Brainstorm solutions to any barriers.

Relapse:

A client may relapse after changing her behavior when she encounters a setback. Depending on the strength of the setback, she may go back to any of the stages, to pre-contemplation, contemplation, or preparation.

To help a client in relapse: Be understanding. Explain that relapse is common, and that it usually takes a person several tries to make a behavior change that is well-integrated into their life. Talk with the client to find out which stage she is now in. Guide her using the suggestions for that stage.

Remember, behavior change occurs over time. Ideally, CPSP clients are seen multiple times throughout their pregnancy and into the postpartum period. In these many visits, CPSP staff have a unique opportunity to help clients move closer to changing their behavior by nudging them along the stages of change.



C PSP is designed to provide individualized services to each client. One important consideration is being sensitive to the client's culture. Culture may be thought of as a way of life belonging to a particular group of people. It includes behaviors, attitudes, values, and beliefs that are shared by that group and passed down from generation to generation. There is linguistic and cultural diversity within a particular ethnic group, and there are differences in the extent to which an individual practices her cultural behaviors or traditions.

One of the most important cultural influences for the client is her ethnic background, but she may be part of other groups that have cultural influence on her life. These include her religion, education, social and economic status, citizenship or immigration status, age, sexual orientation, marital status, her original family and current family structures, where she was raised or lives (urban, rural, suburban), emotional status, current trends, and lifestyle. All of these factors influence her health, beliefs, and practices.

If you are not familiar with a certain culture, let the client know. Show respect for her culture and express your interest in learning more about the beliefs and values associated with that culture. See Cross Cultural Communication on the following pages for techniques for communicating with someone from a culture different from your own.

We all have personal beliefs and tend to make judgments about other people. Avoid negative stereotypes of different groups of people such as ethnic groups, women on welfare, and people addicted to substances. Be aware of your own attitudes and how your personal history might affect your work. Try to view all of your clients as individuals worthy of your help and caring.

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Much of the communication within the clinic is between people of different cultures. The previous page, Cultural Considerations discusses culture. This page will discuss steps you can take to bridge cultural differences when talking to clients and staff.

Steps to Take

These are steps you can take to be prepared to communicate with staff and clients of different cultures.

- Be aware of your stereotypes and prejudices about other people and cultures. Read Cultural Considerations on the previous page.
- Use language support resources, such as translating or interpreting services (see Resources in the Cross Cultural Communications and Dealing with Language Barriers sections).
- Rely on cultural experts. Identify people who are knowledgeable about the culture of your clients. Ask them to assist you with interpreting people's actions, as well as understanding the subcultures and varying behaviors in a population. Find out as much as you can about cultural rules for the groups that come to the clinic for services.

When talking with clients

CPSP staff can keep these seven recommendations in mind to communicate effectively with clients of varying cultures:

1. Be aware of your own biases
2. Evaluate the client for language assistance needs
3. Establish rapport
4. Respect different cultures
5. Collect information respectfully: "Tell me more"
6. Learn about and appreciate different communication styles
7. Find out the role of family

1. Be aware of your own biases

Explore stereotypes and prejudices about other people and cultures you may harbor.

2. Evaluate the client for language assistance needs

If the client needs language assistance, provide an interpreter. See No Language in Common with Staff and Working with Interpreters.

3. Establish rapport

Take a few minutes at the beginning of the visit for "small talk." This will let the client get used to the setting and establishes common ground. Small talk is an important part of communication in many cultures. A client may want to share her feelings about her long trip to the clinic, recent holiday celebrations, or her problems with her mother-in-law. Small talk establishes connection and lets the client get ready for a more directed discussion. For example ask: "How are you feeling today?" or "How has your week gone?"

4. Respect different cultures

Show respect. Be open and willing to understand other people's needs, health beliefs, and health practices.

Explain that Western or conventional medicine is just one kind of health care. Other health care models can be just as effective. Accept the client's health beliefs, attitudes, and health practices. Some of her health beliefs may be based on different cultural practices.

Explain tests and treatments in ways that make sense given the client's worldview.

5. Collect information respectfully: "Tell me more"

A client's cultural background may not be obvious. Invite her to talk about her culture, family situation, and about the people who give her advice.

Ask the client about any alternative health practices, medicines, or herbs she may be taking.

This information is important for her treatment plan. While some alternative health practices may be positive, others could be dangerous.

Using the phrase, “Tell me more . . .” is a respectful way to talk clients. It shows that you are open and willing to understand more about the client. It helps you collect important information for her treatment plan. For example, you might say:

- “Tell me more about what you are doing to prepare for a healthy baby.”
- “Tell me more about the herbal remedies you use to ease your morning sickness.”
- “Tell me more about what you might like to do to relax during early labor.”

See Little Experience with Western Care in the Psychosocial section for more questions you can ask to find out about the client’s beliefs and experiences.

6. Learn about and appreciate different communication styles

Silence

Some people use silence to let an emotion pass, or to think about what to say next. Different cultures have different traditions for “pause time.” Watch the client to see how she uses silence. Do not jump in to fill a silent pause with small talk.

Non-verbal communication

Some kinds of touching, handshakes, eye contact, and hand or feet movements are impolite or offensive in certain cultures. Sometimes gender or age can influence the cultural rules. Some clients may smile or laugh to cover other emotions or to avoid conflict.

Take your clues from the client as to how close she wants to sit, or whether or not she touches you or looks directly at you.

“Yes” means . . .

Some clients may reply “yes” even when they do not necessarily understand or plan to do what is being discussed. In some cultures it may be a way of offering respect. Be sensitive to cues that communication she has shut down. Encourage a give-and-take discussion so the client’s involvement and understanding is evident.

7. Find out the role of family

When appropriate, involve family members in the client’s care (within HIPAA guidelines). HIPAA is the federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information and help the healthcare industry control administrative costs.

Learn the patterns of decision making in the client’s family. In many cultures family members are responsible for making decisions and giving permission for treatment, medication, and hospital stays. Family members can also provide information about the client’s health practices, alternative medicine use, and can be essential to the client’s adherence to her treatment plan.

It may not always be culturally appropriate to include family members or friends in your discussions with the client, even if she has given permission. Look for cues from the client and be sensitive to her non-verbal messages. For example, she may not want to share a Sexually Transmitted Infections (STI) test results with friends and family. Also, it is recommended that family members, friends, or minors should not serve as an interpreter for a client (see Guidelines for Using Interpreters).

Resources

Addressing Language Access Issues in Your Practice: A Toolkit for Physicians and Their Staff Members

<https://innovations.ahrq.gov/qualitytools/addressing-language-access-issues-your-practice-toolkit-physicians-and-their-staff>

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Steps to Take

Prepare your CPSP practice for many languages

- Assess all clients for language needs, including sign language (see the following section, Assess Language Differences).
- If the client needs language assistance, provide a trained interpreter in the language most comfortable for her (see Guidelines for Using Interpreters on the following page).
 - ◆ Maintain a list of well-qualified language interpreters. These may be face-to-face interpreters or an outside telephone interpretation service (see Resources). This list should also include American Sign Language interpreters.
- Identify and record the client's primary language in her medical records.
- Keep a log of staff language capabilities, including American Sign Language. In this log, indicate the trained language interpreters on staff, the languages each staff person can speak, read, and/or write (see Resources for sample log).
- Establish policies and guidelines for serving as interpreters. If possible, have trainings or in-services on how to be an effective verbal interpreter or translator of written materials.
- Provide easy-to-read and culturally appropriate pamphlets in the client's language. English pamphlets should contain pictures and graphics. A friend or relative might be able to translate written English material. If needed, use picture and phrase sheets to help communicate with the client.
- If you do not have a written handout in the client's language, consider using health related applications (apps) for computers, tablets, and smartphones. Apps are helpful if they show actions such as exercises, birth, caring for a baby, etc. Try using educational apps with the volume off, using an interpreter to explain the visuals.

If a client has no language in common with the staff, you need to provide an interpreter.

Assess language differences

- Pay attention to how the client answers the assessment form question about the language she prefers to use during her CPSP visits. Some clients will need an interpreter to respond to this question. Some clients will speak enough English to say they prefer a different language (such as saying in English that they prefer Spanish).
- If the client prefers to receive her CPSP services in English, you will need to assess her level of English literacy (see Low Literacy Skills).
- During your language assessment remember to:
 - ◆ Face the client directly
 - ◆ Speak slowly
 - ◆ Speak softly (speaking loudly implies anger and may cause the client to fear you.)
 - ◆ Watch the client's facial expressions and body gestures. These can help you determine if language interpreter is needed.
- To help identify the client's language, you can show her an "I Speak" card and ask her to point to what language she speaks (see the "I Speak" language identification card in Resources).
- A client may speak English, but if she can't ask questions, explain her needs, or describe what she has learned, she may need an interpreter.
- If the client needs assistance, use an interpreter. See Guidelines for Using Interpreters on the following page. You can use the following types of interpreter services:
 - ◆ Face-to-face interpretation
 - ◆ Over the phone interpretation
 - ◆ Video medical interpretation

Follow Up

After your discussion or educational session, ask the client if she still has the same language preference, or if she needs to change interpreters. Ask if she has ideas that would make it easier for her to understand you (such as speaking more slowly, have more things in writing, etc.).

Resources

Sign language interpreting

California Department of Social Services

<http://www.cdss.ca.gov/Deaf-Access>

A comprehensive site on sign language interpretation that describes the different types of sign language interpretation services; provides a list of sign language services in California and a registry of interpreters for the deaf.

Sample Log

Interpretation resources for non-English speaking clients (see attached sample)

“I Speak” Language Identification Card (see attached “I Speak” card)

www.lep.gov/ISpeakCards2004.pdf

U.S. Department of Commerce, Economics, and Statistics Administration, U.S. Census Bureau (2004 Census Test)

Cards should be used when you need to quickly identify the client’s language. Thirty languages are represented, and the client points to the appropriate language on the card.

Interpretation Resources for Non-English Speaking Clients

Staff Resources

	Name	Language, other than English			Trained language interpreter	Knowledgeable in the following content areas (check all that apply):
		Spoken	Read	Write		
1					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Postpartum <input type="checkbox"/> CPSP Services <input type="checkbox"/> Social <input type="checkbox"/> Other _____
2					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Postpartum <input type="checkbox"/> CPSP Services <input type="checkbox"/> Social <input type="checkbox"/> Other _____
3					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Postpartum <input type="checkbox"/> CPSP Services <input type="checkbox"/> Social <input type="checkbox"/> Other _____
4					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Postpartum <input type="checkbox"/> CPSP Services <input type="checkbox"/> Social <input type="checkbox"/> Other _____
5					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Postpartum <input type="checkbox"/> CPSP Services <input type="checkbox"/> Social <input type="checkbox"/> Other _____
6					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Postpartum <input type="checkbox"/> CPSP Services <input type="checkbox"/> Social <input type="checkbox"/> Other _____
7					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Postpartum <input type="checkbox"/> CPSP Services <input type="checkbox"/> Social <input type="checkbox"/> Other _____
8					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Postpartum <input type="checkbox"/> CPSP Services <input type="checkbox"/> Social <input type="checkbox"/> Other _____
9					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Postpartum <input type="checkbox"/> CPSP Services <input type="checkbox"/> Social <input type="checkbox"/> Other _____
10					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Postpartum <input type="checkbox"/> CPSP Services <input type="checkbox"/> Social <input type="checkbox"/> Other _____
11					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Postpartum <input type="checkbox"/> CPSP Services <input type="checkbox"/> Social <input type="checkbox"/> Other _____
12					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Postpartum <input type="checkbox"/> CPSP Services <input type="checkbox"/> Social <input type="checkbox"/> Other _____



Interpretation Resources for Non-English Speaking Clients

Outside Resources

		Name	Phone Number	Notes
	Face-To-Face Interpreters			
1				
2				
3				
4				
5				
	Telephone Interpreters			
1				
2				
3				
4				
5				
	Video Medical Interpreters			
1				
2				
3				
4				
5				

2004 Census Test		United States Census 2010
LANGUAGE IDENTIFICATION FLASHCARD		
<input type="checkbox"/>	ضع علامة في هذا المربع إذا كنت تقرأ أو تتحدث العربية.	1. Arabic
<input type="checkbox"/>	Խոսողո՞ւմ ե՞նք 'նշո՞ւմ կատարե՞ք այս քառակուսում, եթե խոսում կամ կարդում եք Հայերեն:	2. Armenian
<input type="checkbox"/>	যদি আপনি বাংলা পড়েন বা বলেন তা হলে এই বাক্স দাগ দিন।	3. Bengali
<input type="checkbox"/>	ល្អបញ្ជាក់ក្នុងប្រអប់នេះ បើអ្នកអាន ឬនិយាយភាសា ខ្មែរ ។	4. Cambodian
<input type="checkbox"/>	Motka i kahhon ya yangin ûntûngnu' manaitai pat ûntûngnu' kumentos Chamorro.	5. Chamorro
<input type="checkbox"/>	如果你能读中文或讲中文，请选择此框。	6. Simplified Chinese
<input type="checkbox"/>	如果你能讀中文或講中文，請選擇此框。	7. Traditional Chinese
<input type="checkbox"/>	Označite ovaj kvadratić ako čitate ili govorite hrvatski jezik.	8. Croatian
<input type="checkbox"/>	Zaškrtněte tuto kolonku, pokud čtete a hovoříte česky.	9. Czech
<input type="checkbox"/>	Kruis dit vakje aan als u Nederlands kunt lezen of spreken.	10. Dutch
<input type="checkbox"/>	Mark this box if you read or speak English.	11. English
<input type="checkbox"/>	اگر خواندن و نوشتن فارسی بلد هستید، این مربع را علامت بزنید.	12. Farsi

DB-3309

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU

<input type="checkbox"/>	Cocher ici si vous lisez ou parlez le français.	13. French
<input type="checkbox"/>	Kreuzen Sie dieses Kästchen an, wenn Sie Deutsch lesen oder sprechen.	14. German
<input type="checkbox"/>	Σημειώστε αυτό το πλαίσιο αν διαβάζετε ή μιλάτε Ελληνικά.	15. Greek
<input type="checkbox"/>	Make kazyè sa a si ou li oswa ou pale kreyòl ayisyen.	16. Haitian Creole
<input type="checkbox"/>	अगर आप हिन्दी बोलते या पढ़ सकते हैं तो इस बक्स पर चिह्न लगाएँ।	17. Hindi
<input type="checkbox"/>	Kos lub voj no yog koj paub twm thiab hais lus Hmoob.	18. Hmong
<input type="checkbox"/>	Jelölje meg ezt a kockát, ha megérti vagy beszél a magyar nyelvet.	19. Hungarian
<input type="checkbox"/>	Markaam daytoy nga kahon no makabasa wenno makasaoka iti Ilocano.	20. Ilocano
<input type="checkbox"/>	Marchi questa casella se legge o parla italiano.	21. Italian
<input type="checkbox"/>	日本語を読んだり、話せる場合はここに印を付けてください。	22. Japanese
<input type="checkbox"/>	한국어를 읽거나 말할 수 있으면 이 칸이 표시하십시오.	23. Korean
<input type="checkbox"/>	ໃຫ້ໝາຍໃສ່ອ່ງນີ້ ຖ້າທ່ານອ່ານຫຼືຢາກພາສາລາວ.	24. Laotian
<input type="checkbox"/>	Prosimy o zaznaczenie tego kwadratu, jeżeli posługuje się Pan/Pani językiem polskim.	25. Polish

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<input type="checkbox"/>	Assinale este quadrado se você lê ou fala português.	26. Portuguese
<input type="checkbox"/>	Însemnați această casuță dacă citiți sau vorbiți românește.	27. Romanian
<input type="checkbox"/>	Пометьте этот квадратик, если вы читаете или говорите по-русски.	28. Russian
<input type="checkbox"/>	Обележите овај квадратик уколико читате или говорите српски језик.	29. Serbian
<input type="checkbox"/>	Označte tento štvorček, ak viete čítať alebo hovoriť po slovensky.	30. Slovak
<input type="checkbox"/>	Marque esta casilla si lee o habla español.	31. Spanish
<input type="checkbox"/>	Markahan itong kuwadrado kung kayo ay marunong magbasa o magsalita ng Tagalog.	32. Tagalog
<input type="checkbox"/>	ໂທດາທຳນຽມນີ້ໃນສ່ວນທີ່ທ່ານຮ້າກຳລັງອ່ານຫຼືເວົ້າໂພງ.	33. Thai
<input type="checkbox"/>	Maaka 'i he puha ni kapau 'oku ke lau pe lea fakatonga.	34. Tongan
<input type="checkbox"/>	Відмітьте цю клітинку, якщо ви читаете або говорите українською мовою.	35. Ukrainian
<input type="checkbox"/>	اگر آپ اردو پڑھتے یا بولتے ہیں تو اس خانے میں نشان لگائیں۔	36. Urdu
<input type="checkbox"/>	Xin đánh dấu vào ô này nếu quý vị biết đọc và nói được Việt Ngữ.	37. Vietnamese
<input type="checkbox"/>	באצייכנו דעם קעסטל אויב איר לייענט אדער רעדט אדיש.	38. Yiddish

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Be Prepared for Clients Who Need An Interpreter

- Assess clients for language needs, including sign language interpretation. (See Resources for the “I Speak” card or for sign language interpreting resources.)
- Provide interpreters to all clients who have language needs or request language interpretation.
- Maintain a contact list of approved, well-qualified medical language interpreters. These may be face-to-face interpreters or telephone interpretation vendors.
- Identify and record the client’s primary language on her medical records.
- Learn basic words and phrases in other languages in order to greet clients and to follow what interpreters are saying.
- Expect to spend more time with a client when using an interpreter.

Choosing An Interpreter

- Ideally, the interpreter should be bicultural, trained in cross-cultural interpretation, trained in the health care field, and able to understand perinatal terms.
- Try to use a female interpreter.
- Family members and minors are not appropriate interpreters. The client may want a family member or friend to participate in a discussion or help interpret, but confidentially may become an issue; for example delivering STI test results or discussing abusive relationships. Also, family and friends may change an interpretation to “protect” the client from difficult topics or to present the client’s information in a way that “looks good” for the family.
- Occasionally there may be problems with using an interpreter who is older or younger than the client, of a different social class or educational

level, or from a particular region or country of origin. If more than one interpreter is available for a particular language, find out the client’s preferences on issues such as gender, age, country of origin, etc.

Steps to Take

Working with All Interpreters

- If this is your first meeting with the client, introduce yourself first to the client, then introduce yourself to the interpreter. Finally, introduce the interpreter to the client.
- Ask the interpreter to explain his or her role to the client.
- Position yourself:
 - ◆ An interpreter should be next to the client but a bit behind the client. This gets the interpreter out of the line of sight.
 - ◆ Sign language interpreters should be positioned next to you, so the client can see the sign language interpreter’s hands.
- Speak directly to the client, not to the interpreter. Look at the client, not at the interpreter.
- Ask the client to speak directly to you.
- Speak in the first person to the client. (Example: “Do you have an upset stomach?”)
- Speak slowly and at an even pace. Speak in short sentences. Pause often and let the interpreter interpret.
- Ask one question at a time.
- Avoid interrupting the interpretation.
- If you don’t want it interpreted, don’t say it.
- If you want to talk to the interpreter, first tell the client that you will be talking to the interpreter.
- Explain technical terms such as C-section, IV, preterm, etc.

- If the concept is complex, it may work better to explain the whole thing to the interpreter and then let her explain it to the client.
- Watch the client for nonverbal cues, such as avoiding eye contact, crossing arms, and looking down.
- Ask the client questions such as, “Tell me about . . .”
- Review important points by saying, “Let me tell you what I have heard, to be sure I understand clearly . . .”
- Frequently check with the client using the “teach back” method to be sure she understands your main points. Ask the client to teach you/explain the most important part of your message. (See *Educating Effectively* for a more detailed description of the teach back method.)

Working with an Untrained Interpreter

There may be times when you will not be able to obtain the services of a trained interpreter. This is not ideal, but it may be the only way to talk with the client.

Speak with the Untrained Interpreter

Follow the guidelines for working with all interpreters and add these steps:

- Try to assess the interpreter’s level of English language skills and her ability to interpret.
- Ask the interpreter to interpret everything you say.
- If the interpreter and the client get into a conversation, ask the interpreter to inform you of what was discussed.
- Interrupt the interpreter if you think the interpreter is getting off the subject or not completing the interpretation.

Working with a Telephone Interpreter

Working with a telephone interpreter is different than working with an interpreter in person. You don’t have direct contact with the interpreter and you may have

to pass the phone back and forth between you and the client, unless you have a speakerphone.

A telephone interpreter is a trained interpreter qualified to provide appropriate interpretation services. Telephone interpreters work off site and can be contracted by your office or clinic to provide their services. Most services are open 24 hours a day, seven days a week.

Make a phone call

- Dial the toll free number provided by your office or clinic.
- Provide your agency’s account number.
- Request the language you need.

Speak with the telephone interpreter

Follow the guidelines for working with all interpreters, adding these steps:

- Face the client and talk directly to her. Ask the client to speak directly to you. Explain the reason for your call to the client (the interpreter will interpret).
- Explain that you will make a statement to the client and then the interpreter will make a statement to the client.

Resources – See “Dealing with Language Barriers”

For free or low-cost phone interpretation services, please work with your local community-based organizations.

Background

Learning disabilities are not the same as low literacy skills. Clients with learning disabilities, such as dyslexia and slow-learning, may benefit from many of the same techniques described in this section.

How to Assess Low Literacy

If a client has very low literacy skills or is unable to read, note this information in the chart where all staff will see it. Discuss her literacy skills during any case conferences, as it may affect how other services are provided.

- Assess literacy for all clients, no matter how much formal schooling they've had. A person who finished 10th grade will likely read at a 4th grade level. The only way to know is to ask a person to read. People with low literacy skills may be rich or poor, born locally or in another country, a fast learner, or a slow learner, etc.
- Ask the client to read two or three sentences from Welcome to Pregnancy Care in the Health Education section about danger signs of pregnancy. Explain that this is to be sure she understands them. Ask her to say them, in her own words, or read from the list.
- If she reads without difficulty, continue on with the orientation or assessment. Consider how she prefers to learn, her experiences and interests in using written materials.
- If she reads slowly or with difficulty, ask her questions about the content. If she cannot discuss the content easily and completely, use the guidelines for low literacy. Explain that people learn in different ways and she probably knows what works best for her.
- Explain that when written materials are offered, they will illustrate the information and will not have many pages of reading. Invite her to give

In general people with reading skills below the fifth grade level are considered “functionally illiterate” and lack many skills to function effectively in today’s society.

feedback on which ones work well for her and what is most helpful.

- If she uses excuses such as “want to read it later” or “can’t see such small print,” use the low-literacy guidelines. Explain, as above, that people learn in different ways.
- When working with a client in another language, use the same approach in assessing literacy. Also consider regional variations of the same language.

Follow Up

When a client returns for follow-up visits, review any questions she may have about written materials given to her. It may be useful to review the written material together again. For critical topics such as danger signs or kick counts, conduct a complete review of the material. Especially for women with low literacy or no literacy skills, ask her to tell you her understanding and what she will do if danger signs occur.

Guidelines for low literacy readers and non-readers

- Ask about times when she was successful at learning and enjoyed it.
- Consider referring her to group sessions where emphasis is on talking, visual aids, discussion and demonstrations.
- Teach the smallest amount possible to do the job; only give information that is necessary to get the point across.
- In one-on-one sessions, use demonstrations and visual aids when possible.

- Ask the client to talk about the topic in her own words to see if she understands.
- Review important points a number of times.
- Try to limit new ideas to three to four items at any one time.
- Help clients decrease anxiety, which acts as a barrier to learning.
- Reward clients with encouragement at every opportunity.
- For any written material provided:
 - ◆ Explain the purpose of the pamphlet
 - ◆ Review the pamphlet with the client
 - ◆ Underline or highlight specific information on which she should focus
 - ◆ Ask her to explain or demonstrate the content to check her understanding of it
- Ask if she has someone who helps her read written materials and how they can help with health education. Ask what kind of materials she prefers for this purpose, what language she would like the materials in, how much narrative or writing she would like in the materials, etc.
- Encourage her to speak up if she's asked to read information by other providers (such as WIC, the lab) that she does not understand. Role-play a brief conversation between the client and another provider (such as a nurse). Have the client practice telling people she needs more verbal explanations.
- Use materials with only relevant, important points. Use concrete examples as much as possible. Try to lower her anxiety and reward her with encouragement as often as possible.
- Consider using audio tapes for important information, such as danger signs. These can be made in a number of languages, if needed.

- If the woman asks about improving her reading skills, make referrals to local literacy classes. Check the library, any community college or adult school, or high schools for possible classes. See Resources.

Choosing easy to read materials

The easiest materials to read contain the following:

- Conversational style and active voice (such as “take a prenatal vitamin every day” as opposed to “daily supplements are recommended to ensure . . .”)
- Short and clear sentences
- Few medical terms or jargon
- Words that are two syllables or less
- Very little narrative
- Large type
- Upper and lower case letters
- Headings (subtitles) and “chunk” related information in small sections
- Follow a clear order
- Simple line-drawing visuals for showing what the reader should do (not what she shouldn't). Do not show detached body parts.

Resources

For more information about educational materials for clients with low literacy, see:

California Literacy Resources: <http://www.literacynet.org/slrc/home.html>

California Literacy, Inc.: http://cahealthliteracy.org/hlrc_plainlan.html#iasd

For referrals for literacy classes or resources for clients see the National Literacy Directory at: <http://familieslearning.org/our-solutions/national-literacy-directory.html>.

Some clients have had little experience with Western health care. They've never been to a clinic or hospital, and have always used the services of traditional healers. These women may have a lot of experience and knowledge about pregnancy, birth, and infant care. They may have had babies at home with a midwife or they may have never been pregnant or given birth.

Western health care is based on diagnosing and treating diseases, which are caused by germs and biochemical factors.

Other beliefs about health may include factors such as supernatural forces, God's will, religion, imbalances, bad conduct, or eating certain foods.

How to Assess the Need

Ask about the client's past use of Western health care services during the initial health education assessment. If she has little or no experience with them, find out what beliefs and experiences she has had with other non-Western health care. Ask questions like:

- What kinds of things do you do when you get sick?
- What did your family do for you when you were little and got sick?
- Are there healers in your community who help sick people? Are there women who help care for the new mother and baby?
- Have you used their services?
- Have you been pregnant before or had a baby at home?
- Have you seen a baby being born? What was the setting like, who helped, how did the woman cope with birthing pains and recuperation?
- Are there things that are harmful for women during pregnancy or after birth that you want to avoid, such as foods, showers, certain activities or movements?

Steps to Take

Based on the client's beliefs and past experiences, determine how you can help her understand Western health care services. Describe Western health care as one approach, not necessarily the only approach. Western health care services can be used in conjunction with many traditional approaches.

Follow Up

At each visit ask if she has any questions about the care she is receiving. This may be her only opportunity to learn about Western-type prenatal care. The more she learns the more fully she can participate.

Ask postpartum clients what they wish they had known about their hospital or clinic experiences ahead of time. They may have ideas for helping future clients who have little experience with Western health care.

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STEPS TO TAKE

HEALTH EDUCATION

**Healthy Mom,
Healthy Baby**



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These Steps to Take Guidelines are to be used with your office protocols. Office protocols are your office procedures for health education, nutrition, psychosocial services and related case coordination.

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Pregnancy and expectant parenthood create new learning needs and challenges for each woman, her partner, members of her family, and her support system. These needs may include health information, perinatal care facts, the practice and mastery of new skills, or changes in current health habits.

The goals of health education are to:

- Provide clients with information
- Assist clients in making informed decisions about their pregnancies
- Help clients change behaviors to have healthier pregnancies and babies

The following health education guidelines were designed to provide information on basic topics from early pregnancy to postpartum care. The topics covered are limited to less complicated, more common health needs. The medical provider is responsible for the client's health education needs, particularly educational needs for complex conditions.

All health education interventions should be preceded by a health education assessment. The health education assessment will help identify the client's knowledge, past experiences, sources of support, health practices, and personal goals. The assessment will also indicate how the client best learns, what she'd like to know more about, and what motivates her to learn. This information will help you develop an educational plan to meet the client's needs.



See the CPSP Provider Handbook for a description of required parts of a health education assessment, what's needed in basic health education, complex health education conditions that call for specialized attention, and requirements for individuals who provide health education in CPSP.

Assessment Guidelines

Complete an initial health education assessment for every client within 4 weeks of entry into care. If the client declines the assessment, document this in the chart. Offer assessments at future visits. Some clients may need to be offered the assessments several times.

Offer reassessments at least once every trimester and at the postpartum visit. High-risk clients may need more interventions and may be seen more frequently.

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An effective health education plan should include basic topics that cover everything from early pregnancy through postpartum.

At a minimum, health education services and written materials should be available on the topics listed below.

Some clients may need education on all of these topics. Others may be very experienced and need less attention. Clients may also ask for education on topics that are not included here.

The timing to address these topics will vary, depending on:

- How far along in pregnancy the client is when she begins her prenatal care
- What she has learned from past experiences
- Her current needs

During her prenatal and postpartum time, each client should understand the topics below. When discussing a topic, the client and health worker will agree upon objectives. Objectives are goals for the client. The client and the health worker should also be able to identify the client's strengths and concerns and find ways to resolve any problems.

Listed below are topics and sample objectives. These are generally listed in order from early pregnancy to postpartum care.

Discomforts and Danger Signs of Pregnancy

- List at least 3 common discomforts and 3 danger signs, and explain the difference between discomforts and danger signs needing immediate attention
- Identify actions to take and support networks to use if a danger sign appears during daytime, evenings, or weekends

Pregnancy Changes/Fetal Growth

- Describe the importance of prenatal exercises (including Kegels) and how to perform at least 3 exercises

Immunizations Recommended During Pregnancy

- Describe the needed immunizations during pregnancy

Preterm Labor/Kick Counts

- List preterm labor symptoms and describe what to do if these symptoms occur
- Demonstrate how to do kick counts

Drugs, Smoking, and Alcohol During Pregnancy

- Identify risks associated with use of alcohol, tobacco, over-the-counter drugs, and street drugs
- Reduce, eliminate, or seek treatment for any non-recommended substance
- Identify the risks associated with exposure to secondhand smoke and identify ways to avoid it

Sexuality, Birth Control, STIs, and HIV

- Develop a plan for future children and, if applicable, describe all relevant contraceptive methods
- Identify how STIs (Sexually Transmitted Infection), including HIV (Human Immunodeficiency Virus), are transmitted, their negative health impact, and how to prevent infection
- State that a benefit of early detection of HIV infection in pregnant women is medical treatment
- Discuss intimacy and sexuality during pregnancy and postpartum

Cautions and Workplace/Home Safety

- Identify at least 4 potentially dangerous activities or foods to avoid while pregnant
- Discuss any reproductive hazards at home or work

Labor and Delivery

- Identify 5 routine hospital procedures used during labor and delivery, such as IVs, episiotomy, external monitoring, etc.
- Discuss symptoms of labor and changes in different stages of labor
- Describe steps to take if she is faced with the possibility of being induced before or after 39 weeks of pregnancy
- Identify at least 2 reasons for having a cesarean section (C-section)
- Discourage elective C-sections
- Identify a support person for labor and delivery
- Identify a plan for getting to the hospital for delivery and returning home with the baby

Self-care After Delivery

- Identify at least 2 strategies for taking care of physical and emotional needs during the postpartum period

Adapting to Parenthood

- Discuss life/family adjustments needed to accommodate the new baby
- Make a decision about circumcision (in the case of a baby boy) before delivery
- List items to obtain for the baby
- Describe changes to make at home for the baby

Infant Safety and Early Detection of Illness

- Discuss the schedule for routine immunizations through age 2
- Identify danger signs in the newborn and what to do if these occur
- Describe safety precautions required for infants, including the need for a car seat before leaving the hospital, and the recommended sleeping position (on back)
- Identify a pediatric care provider for the baby

Client Rights and Responsibilities

- Encourage each client to take an active role in her health care. Tell her she can ask questions if she does not understand something. Discuss the *Welcome to Pregnancy Care* handout.
- Encourage your client to talk about any activities or practices that might affect her health. This information will provide her health care provider with a full understanding of her health status.
- If she is going to deliver her baby at a teaching hospital, discuss the practice of having medical students examine her. Tell her that she can decline to participate in any extra examination, study, or interview.
- Encourage her come up with a list of questions in advance so she will be prepared to ask questions.

Danger Signs of Pregnancy/ Emergency Procedures

- Practice or role-play with your client what she will do if she experiences a danger sign. Talk about who to call, where to go, daytime vs. evening or weekend. These danger signs are covered in the *Welcome to Pregnancy Care* handout.
- Ask your client to identify a family member or friend who will assist her in an emergency. She may need help getting to the hospital or caring for her other children.

Services Offered

- Describe the reasons for, and how she will experience, routine medical procedures such as blood samples, urine samples, listening to the baby's heartbeat, pelvic exams, etc.
- Describe the purpose of each component of prenatal services and related services such as WIC, hospital tours, childbirth preparation classes, prenatal classes, referrals to community agencies, etc.

Schedule of Services

- Describe the purpose of regular prenatal visits and the benefits of prenatal care.

The Clinic Team

- Briefly explain the background and training of clinic staff. Describe the differences between a nurse, a nutritionist, a health educator, a social worker, and a health worker.

Hospital Orientation

- Orient her to the labor and delivery hospital (see the Hospital Orientation guideline)

Emergency Procedures

- Describe how to use the hospital emergency room and how it differs from the health care provider's office or clinic

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Help us give you the best care

- Be honest about your medical history and the way you live. Don't leave anything out when telling your medical history. The little things that you don't tell us may affect your pregnancy and your baby's health.
- Ask questions when you don't understand
- Follow the advice given by the staff. Let us know if you might not be able to follow the advice for some reason.
- Let us know if there is a change in your health

Remember:

- Come to all of your appointments
- Be on time
- Call us if you are going to be late
- Call 24 hours in advance if you need to cancel an appointment
- Tell us if you change your address or phone number
- Let us know if you have any ideas about making our services better

Important Numbers:

Our office phone number: _____
When we are closed, call: _____

Name of family members or friends who can assist you in an emergency:

Name: _____
Home phone: _____
Mobile: _____
Work: _____
Name: _____
Home phone: _____
Mobile: _____
Work: _____

Emergency Hospital

Address: _____
Cross Street: _____
Phone: _____

Delivery Hospital

(if different from Emergency Hospital)

Address: _____
Cross Street: _____
Phone: _____

Childbirth Preparation Classes

Address: _____
Cross Street: _____
Phone: _____

WIC (Women, Infant, Children Supplemental Nutrition Program)

Address: _____
Cross Street: _____
Phone: _____

Breastfeeding Help

Address: _____
Cross Street: _____
Phone: _____

Dentist

Address: _____
Cross Street: _____
Phone: _____

Community Agencies

Local resources: _____



Welcome to Pregnancy Care

We are here to help!

There are many kinds of people who may help you during your pregnancy: doctors, nurse midwives, nurses, health educators, community health workers, social workers, nutritionists, job counselors, Medi-Cal workers, and family planning counselors.

Our clinic name, address, and phone:

We have many services

We can work together to keep you and your baby healthy.

The services we offer:

- Check-ups once a month or more, the whole time you are pregnant
 - Immunizations you need for a healthy pregnancy and newborn
 - Tests to check your health and the health of your baby
 - Classes and one-on-one information about pregnancy, childbirth, baby care, and breastfeeding
 - A tour of the hospital where you will have your baby
 - Referral to community agencies that can provide additional help and services
 - Information about where to go for financial help, health insurance like Medi-Cal or Healthy Families, food programs like WIC or food banks
 - Help with cutting down or quitting smoking, drinking, or using drugs
 - Help eating healthy foods while you are pregnant
 - Counseling on problems or family issues you may have
 - Postpartum care to assure that you recover well after the baby is born
- On our staff, here are some of the people who may be helping you:
-

Client Rights

We promise to:

- Treat you with respect
- Make sure that what you say to us stays private
- ◆ We will keep your medical information private
- ◆ We will not give your medical information to anyone else unless you give us permission in writing
- ◆ However, you should know that the law says we must report abuse or violence so that you can get extra help. If we do need to report, we will call the agency that can best help you.

- Explain any tests you will need and how we do things at this office

- Answer questions you might have about your baby and your care

You have the right to:

- Look at your medical record with someone from our office
- Help plan and make choices about your care while you are pregnant, in labor, or giving birth
- Accept or refuse any care, treatment, or service

Danger or Warning Signs

Call your health care provider right away if:

- You feel dizzy
- You have a fever or chills
- You have a really bad headache, or your headache goes on for days
- You have any changes in your eyesight such as: blurred vision, flashes of lights, halos, or spots in front of your eyes
- Your face or hands swell
- It is hard to breathe
- You fall, suffer a blow to the stomach, or are in a car accident
- You vomit or have a bad stomach ache
- You gain too much weight too quickly

Don't wait! Seek medical treatment right away if you:

- Have any bleeding from your vagina
- Have a sudden flow of water or if water leaks from your vagina
- Feel a big change in the way your baby moves, or if your baby moves less often
- Have a sharp pain when you urinate (pee)

Later in your pregnancy, call your health care provider right away, day or night, if you have:

- **Stomach ache or cramps** (with or without diarrhea)
- **Contractions** - Your uterus tightens 5 or more times in 1 hour
- **Pain or pressure** in your belly, thighs, or around your vagina, as if the baby is pushing down
- **Change in the discharge from your vagina** - there may be more mucus, or the discharge may be bloody or watery
- **Lower backache** - pain or dull pressure in your back, or back pains that come and go in a regular pattern

Ayúdenos a proporcionarle la mejor atención posible

- Sea honesta sobre sus antecedentes médicos y su estilo de vida. No omita nada cuando nos cuente sobre sus antecedentes médicos. Los detalles que no nos cuente pueden afectar su embarazo y la salud de su bebé.
- Haga preguntas cuando no entienda algo.
- Siga los consejos que le dé el personal. Avisenos si es posible que no pueda seguir los consejos que recibió, por cualquier motivo.
- Avisenos si hay algún cambio en su salud

Recuerde:

- Acuda a todas sus citas.
- Llegue a tiempo.
- Líámenos si va a llegar tarde.
- Líámenos con 24 horas de anticipación si necesita cancelar una cita.
- Avisenos si cambia su dirección o número de teléfono.
- Avisenos si tiene alguna idea sobre cómo podemos mejorar nuestros servicios.

Números de teléfono importantes:

Número de teléfono de nuestra oficina: _____

Cuando nuestra oficina está cerrada, llame al: _____

Nombre de familiares o amigos que la pueden ayudar en caso de emergencia:

Nombre: _____
Número de teléfono: _____
Teléfono móvil: _____
Trabajo: _____
Nombre: _____
Número de teléfono: _____
Teléfono móvil: _____
Trabajo: _____

Hospital para casos de emergencia

Dirección: _____
Calle transversal más cercana: _____
N° de teléfono: _____

Hospital en el que dará a luz

(Si no es el mismo que el hospital para casos de emergencia)

Dirección: _____
Calle transversal más cercana: _____
N° de teléfono: _____

Clases de preparación para el parto

Dirección: _____
Calle transversal más cercana: _____
N° de teléfono: _____

WIC (Programa de Nutrición Suplementaria para Mujeres, Bebés y Niños)

Dirección: _____
Calle transversal más cercana: _____
N° de teléfono: _____

Ayuda para dar pecho

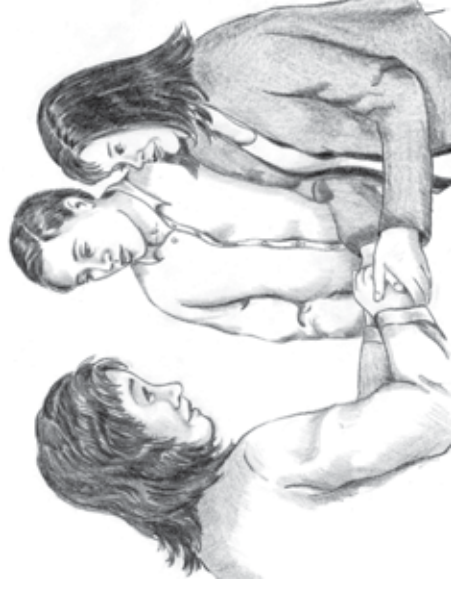
Dirección: _____
Calle transversal más cercana: _____
N° de teléfono: _____

Dentista

Dirección: _____
Calle transversal más cercana: _____
N° de teléfono: _____

Agencias comunitarias

Recursos locales: _____



Bienvenida al Cuidado Prenatal

¡Estamos aquí para ayudarla!

Hay muchos tipos de personas que la pueden ayudar durante su embarazo: médicos, enfermeras parteras, enfermeras, educadores de la salud, trabajadores comunitarios de la salud, trabajadores sociales, nutricionistas, consejeros de trabajo, trabajadores de Medi-Cal y consejeros de planificación familiar.

Nombre, dirección y teléfono de nuestra clínica:

Brindamos muchos servicios

Podemos trabajar juntos para mantenerla saludable a usted y a su bebé.

Los servicios que ofrecemos son:

- Exámenes una vez por mes o más, durante todo su embarazo.
 - Inmunizaciones que necesita para un embarazo saludable y recién nacido.
 - Pruebas para comprobar su estado de salud y la salud de su bebé.
 - Clases e información personalizada sobre el embarazo, el parto, cuidado de bebés y cómo dar pecho.
 - Un recorrido del hospital donde nacerá su bebé.
 - Remisiones a agencias comunitarias que le pueden brindar ayuda y servicios adicionales.
 - Información sobre dónde obtener ayuda económica, un seguro de salud, como Medi-Cal o Healthy Families, y programas de alimentos, como WIC o bancos de comida.
 - Ayuda para reducir o dejar de fumar, tomar alcohol o usar drogas.
 - Ayuda para comer alimentos saludables durante su embarazo.
 - Consejería sobre problemas o asuntos familiares que la preocupan
 - Cuidado postparto para asegurar que se recupera bien después del nacimiento del bebé.
- Las siguientes personas son miembros de nuestro personal que la pueden ayudar:
-
-

Derechos de los clientes

Prometemos:

- Tratarla con respeto.
- Asegurar que lo que nos dice se mantenga privado
- ◆ Mantendremos privada su información médica.
- ◆ No revelamos su información médica a nadie a menos que usted nos dé permiso por escrito.
- ◆ No obstante, la ley dice que tenemos la obligación de reportar casos de maltrato o violencia para que pueda obtener ayuda adicional. Si tenemos que reportar algo, llamaremos a la agencia que mejor la pueda ayudar
- Explicar cualquier prueba que necesite y cómo hacemos las cosas en esta oficina.
- Responder a las preguntas que tenga sobre su bebé y su atención

Tiene derecho a:

- Examinar sus registros médicos con alguien de nuestra oficina.
- Ayudar a planificar y tomar decisiones sobre su atención cuando está embarazada, durante el trabajo de parto o el parto.
- Aceptar o rechazar cualquier atención, tratamiento o servicio

Señales de peligro o advertencia

Llame su proveedor de atención médica inmediatamente si::

- Se siente mareada.
 - Tiene fiebre o escalofríos.
 - Tiene un dolor de cabeza muy fuerte, o su dolor de cabeza dura más de un día.
 - Tiene cambios en la vista, como por ejemplo, la visión borrosa, destellos de luz, aureolas o puntos delante de sus ojos.
 - Tiene hinchazón de la cara o las manos.
 - Le cuesta respirar.
 - Se cae, sufre un golpe en el vientre o tiene un accidente de automóvil.
 - Vomita o tiene dolor de vientre muy fuerte.
 - Aumenta mucho de peso demasiado rápido.
- ¡No espere! ¡No espere! Busque tratamiento médico inmediatamente:**
- Observa cualquier cantidad de sangrado de la vagina.
 - Siente un flujo repentino de agua o tiene descarga de agua de su vagina.
 - Siente un cambio importante en los movimientos de su bebé, o si su bebé se mueve con menos frecuencia.
 - Siente un dolor agudo cuando orina (hace pipí).

Cuando su embarazo está más avanzado,

llame su proveedor de atención médica inmediatamente, a cualquier hora, si tiene:

- **Dolor de vientre o cólico** (con o sin diarrea).
- **Contracciones**, si el útero se tensiona 5 o más veces en 1 hora.
- **Dolor o presión** en su vientre, muslos o cerca de su vagina, como si el bebé estuviera haciendo fuerza para abajo.
- **Cambios en la descarga de su vagina** – puede haber más mucosidad, o la descarga puede ser acuosa o contener sangre.
- **Dolor de la parte baja de la espalda** – dolor o presión sorda en la espalda, o dolores de espalda que van y vienen con un ritmo regular.

Goal

Help your client:

- Understand where to go at the hospital
- Understand what she can expect to happen when she goes to deliver her baby
- Know what to bring to the hospital and what to do after she arrives at the hospital
- Consider making a birth plan

Steps to Take

For all clients:

- Ask about her expectations, what she has heard or knows about hospitals
- Show a video of the hospital, or of a birth in a hospital setting, if possible
- Schedule at least 1 tour of the hospital for her, and follow up by asking her to explain what she expects during labor and delivery. A second tour may be helpful. Encourage her to bring family members or friends on the tour so they can be supportive during labor and delivery.
- Describe a birth plan (a plan to help the client think about how to prepare for her labor, delivery, and postpartum care options). Ask the client if she would like to make a birth plan. If she would, give the client a sample birth plan worksheet (see “Resources”) and review it with her.

What the hospital orientation should include:

- Where to park/drop off. If she is non-English speaking and plans to take a cab, write out a note that can be given to a cab driver with the hospital name and address (such as the hospital brochure).
- How long it might take to travel to the hospital
- Entrance to use at night (if applicable)

- Information on how to get an interpreter (if needed)
- Personal items to bring to the hospital (as well as what not to bring)
- Forms and cards necessary for admission
- Demonstration of a fetal monitor and different birthing positions in the labor room
- Bathroom facilities – where to wash/use the toilet, shower, or bathe
- Information about beverages/ice available during labor (and how to get them)
- Information about who can be with her (such as her husband, mother, sister or friend)
- Visiting policies for other family and friends
- Any policies about videotaping or taking pictures
- Visiting policies on using cell phones, laptop computers, and internet wireless availability
- Information about rooming in and choices she will need to make, such as circumcision and how to feed the baby
- Information about the hospital staff who will help her deliver her baby
- Information on how her blood pressure and temperature will be monitored before, during, and after the delivery of her baby
- In-hospital education about postpartum care of the mother, how to care for her baby, etc.
- Length of stay (for vaginal and cesarean section births)
- Breastfeeding support (lactation consultant, home visiting nurse)
- Hospital security procedures and how she can be sure her baby will be safe
- Infant car seats, the California law requiring car seat usage, how she will travel with her infant, how to get a car seat, and how to use a car seat

- Times of day clients are usually discharged
- If available, classes that are offered at the hospital before the baby's birth, such as childbirth preparation classes

Follow Up

Ask clients who had a hospital tour what they thought of the hospital. Address any unanswered questions.

Resources

Sample birth plans:

March of Dimes

<http://www.marchofdimes.com/pregnancy/your-birth-plan.aspx>

Baby Center

http://assets.babycenter.com/ims/Content/my_birth_plan.pdf

The Bump

http://images.thebump.com/tools/pdfs/birth_plan.pdf

Half of all women who go into preterm labor have none of the identified risk factors. Every client should know the warning signs, and what to do if she experiences a warning sign.

Goal

Help your client:

- Understand the warning signs of preterm labor at or before the 20 week prenatal visit
- Describe what to do if she experiences any of the warning signs

Background

Preterm labor occurs if a woman begins labor between 20 and 36 weeks. It is also called premature labor. If noticed in time, preterm labor can often be stopped with medications, bed rest, or medical procedures to prevent a preterm delivery.

If preterm labor is not noticed in time, uterine contractions can cause the cervix to open earlier than normal, leading to preterm birth. Preterm birth can cause breathing, feeding, and temperature-regulating problems for the baby. Preterm babies may die. Complications related to prematurity are the leading cause of death for babies in the United States. Preventing preterm births should be a major focus of prenatal care.

Steps to Take

For all clients:

At or before the 20th week of pregnancy, discuss the warning signs of preterm labor and what the client should do if she experiences any of them.

- Give the handout *If Your Labor Starts Too Early*
- Review each warning sign on the handout. Sometimes the signs of preterm labor may be

Who is at Risk?

Low risk women:

- Begin prenatal care in the first trimester
- Come to prenatal appointments regularly
- Avoid using tobacco, alcohol, or other drugs
- Eat a healthy balance of foods for appropriate weight gain

High-risk women have 1 or more of the following risk factors:

- A history of preterm labor in a previous pregnancy
- Preterm labor, a serious infection (especially UTIs), or abdominal surgery during current pregnancy
- Tobacco, alcohol, or drug use during current pregnancy
- Pregnancy with twins or other multiples
- Abnormalities of the cervix or uterus, such as incompetent cervix, uterine malformations, or fibroids
- Bleeding in the second or third trimester of the current pregnancy
- Underweight or obese before pregnancy
- Domestic violence or any abuse during pregnancy
- Placenta previa (the placenta is in front of the cervix)

very mild and hard to detect. Emphasize to the client that she must go to the hospital if she has 5 or more contractions per hour, for more than 1 hour, whether they hurt or not.

- It may help to have the woman make a fist, and then tighten and relax her arm muscle, as an example of how the uterus might feel during a contraction
- Emphasize that the client should watch for any of the warning signs, and call if any warning signs occur (watch and call). Be sure she knows what number to call on weekdays, and on nights and weekends.

- Rehearse who she will call, where she will go, and how she will get there if she has warning signs of preterm labor
- Explain that if she experiences preterm labor warning signs she must be examined by a health care provider, who will feel the cervix to see if it is changing. Because contractions may not affect the cervix one day, but can cause dilation the next, she must be checked each time she has warning signs.
- Emphasize the importance of calling.
Some clients hesitate to call their health care providers. Some women want to see if the symptoms will go away on their own. Others may feel that the symptoms are too mild to “make a fuss” over or that they are too busy to lie down for an hour to evaluate the signs. Others may want to try their own remedies in the comfort of their homes.
- Ask your client if she has any hesitation about calling. If she does, show respect for these feelings, but continue to encourage her to call her health care provider.

Braxton Hicks Contractions

There are contractions that are warning signs of preterm labor. (These contractions occur 5 times or more in an hour, and do not go away after about an hour of rest).

However, there are other contractions called Braxton Hicks contractions, which are not warning signs of preterm labor. Braxton Hicks contractions commonly occur during the last part of pregnancy. Unlike the contractions that are a warning sign of preterm labor, Braxton Hicks contractions usually go away after about an hour of rest.

Ask your medical provider for guidance on when to explain Braxton Hicks in your practice. Ask if every client should receive this information, and when during the pregnancy it should be explained.

For clients who are at higher risk:

- At each visit, discuss the warning signs using *If Your Labor Starts Too Early*
- Review what the client should do if she has a warning sign
- Show each woman how to lie back with her hands on her abdomen to feel for contractions
- Encourage her to continue healthy behaviors and keep the watch and call idea in mind

Follow Up For All Clients

Ask each client how she will watch for preterm labor signs. Encourage her to continue healthy behaviors and keep the watch and call idea in mind.

Resources

American College of Obstetricians & Gynecologists

- Resource Center – provides information on any pregnancy-related topic to requesting individuals. Email: resources@acog.org
www.acog.org/About_ACOG/ACOG_Departments/Resource_Center
- Full text of patient education materials available online. Many are available in Spanish.
<http://www.acog.org/-/media/For-Patients/fq181.pdf>
<http://www.acog.org/Patients/Patient-Education-Pamphlets-Spanish-List>

March of Dimes

- Background information on preterm labor, including FAQs, in-depth information and a brief summary.
<http://www.marchofdimes.com/pregnancy/preterm-labor.aspx>

Remember: Half of the women who go into preterm labor have none of the identified risk factors. Emphasize “watch and call” with every client.



If Your Labor Starts Too Early

If you go into labor before it's time to have the baby, you need medical care right away.

How can you tell if you are going into labor before it is time? You can watch for these warning signs:

Warning Signs

- **Stomach ache or cramps in your belly**
 - ◆ You may/may not have diarrhea
- **Contractions**
 - ◆ Your uterus tightens 5 or more times in 1 hour
- **Feeling like the baby is pushing down**
 - ◆ You may feel pain or pressure in your lower belly, thighs, or around your vagina
- **Change in the discharge from your vagina**
 - ◆ There may be more mucus or the discharge may be bloody or watery
- **Lower backache**
 - ◆ You may feel pain or a dull pressure in your back, or have back pains that come and go in a regular pattern

Here's what you can do:

If you feel any of these warning signs, do this test:

- Drink 2 to 3 glasses of water
- Lie down and turn on your left side
- Feel for contractions. Place your hands lightly on your bare belly. If you can feel your muscles get tight and then soft, this is a contraction.
- Count the number of contractions you feel
- Do this for up to 1 hour

Call your health care provider right away if you answer "yes" to one or more of these questions:

- Am I having 5 or more contractions in one hour?
- Do I have bleeding or discharge from my vagina?
- Have any of the warning signs listed on this page lasted for 1 hour?

If you answer "no" to these questions and your symptoms get better, relax for the rest of the day.



Our office phone number:

When we are closed, call:



Si empieza el trabajo de parto demasiado temprano

PASOS A SEGUIR

Si empieza el trabajo de parto antes de tiempo, necesita obtener atención médica de inmediato.

¿Cómo puede saber si está empezando el trabajo de parto antes de tiempo? Puede tener en cuenta las siguientes señales de advertencia:

Señales de advertencia

- **Dolor de vientre o calambres en su vientre**
 - ◆ Puede o no tener diarrea.
- **Contracciones**
 - ◆ Su útero se tensa 5 o más veces en 1 hora.
- **Sentir que el bebé está empujando hacia abajo**
 - ◆ Puede sentir dolor o presión en la parte inferior de su vientre, muslos o alrededor de su vagina.
- **Cambios en la descarga de su vagina**
 - ◆ Puede haber más mucosidad, o la descarga puede ser acuosa o contener sangre.
- **Dolor de la parte baja de la espalda**
 - ◆ Puede sentir dolor o una presión sorda en su espalda, o tener dolores de espalda que van y vienen con un ritmo regular

Lo que puede hacer es:

Si observa alguna de estas señales de advertencia, realice la siguiente prueba:

- Tome 2 a 3 vasos de agua.
- Acuéstese sobre su lado izquierdo.
- Observe si tiene contracciones. Coloque sus manos suavemente sobre su vientre descubierto. Si puede sentir que sus músculos se tensionan y después se relajan, es una contracción.
- Cuente el número de contracciones que siente.
- Hágalo por hasta 1 hora

Llame de inmediato a su proveedor de atención de la salud si contesta “sí” a 1 o más de las siguientes preguntas:

- ¿Estoy teniendo 5 o más contracciones en 1 hora?
- ¿Tengo sangrado o descarga de mi vagina?
- ¿Alguna de las señales de advertencia enumeradas en esta página duraron 1 hora?

Si contesta “no” a estas preguntas y sus síntomas mejoran, descanse durante el resto del día.



El número de teléfono de nuestra oficina:

Cuando nuestra oficina está cerrada, llame al:

Goal

Help your client:

- Be aware of the baby's movements each day
- Understand how to do kick counts
- Understand when to call the clinic or hospital

Background

If a woman is pregnant for the first time, she will usually feel the baby moving (quickening) between 18 and 22 weeks. Women who have been pregnant before may notice movement earlier. This fetal movement helps show the wellbeing of the unborn baby.

By 22 weeks of pregnancy, the unborn baby should be felt moving often.

After 28 weeks of pregnancy, no fetal movement over a 2-hour period is a sign of possible trouble. She should be checked by a health care provider.

Steps to Take

For all clients:

- Discuss the importance of fetal movement
- There are several methods for doing kick counts. Discuss the method used in your practice.
- Discuss the *Count Your Baby's Kicks* handout with the client. Show her the method for doing kick counts.
 - ◆ The method discussed in the handout is "Count to 10". In the handout, the woman is advised to feel for kick counts. After eating, she should sit or lie down on her left side. She should count up to 10 movements. For normal pregnancies, this usually occurs within 1 hour and at most will take place within 2 hours.

After 28 weeks of pregnancy, if there is no fetal movement over a 24-hour period, notify the health care provider immediately.

- Practice kick counts with the client
- Tell her she can start counting kicks at her 7th month or at 28 weeks
- Review when and how to call during business hours, and during evenings and weekends

Follow Up

At each prenatal visit, ask the client whether she is doing kick counts each day. Remind her to talk to her provider if the pattern of movement changes.

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Count Your Baby's Kicks

Counting how often your baby moves or “kicks” is a good way to check on your baby’s health.

You can start during your 7th month, or at 28 weeks.

Here’s how to do kick counts:

- Try just after you eat a meal. Your baby is most active after you eat.
- Sit with your feet up or lie down on your left side
- Check what time you start
- Put your hands on your belly
- Count how many times your baby moves. A “move” is any kick, wiggle, twist, turn, roll, or stretch.
- Count up to 10 moves
- Once the baby has moved 10 times in an hour, you can stop counting and go about the rest of your day



“Yesterday morning I did kick counts for 2 hours and didn’t feel my baby move. I called my doctor and told her. She called the emergency room to tell them I was coming to get my baby checked. When I got to the hospital, they told me my baby was having trouble. They said it was a good thing I came in. They saved my baby and now I have my healthy son.”

– Silvia, 25 years old

If your baby doesn’t move 10 times in the first hour, don’t worry.

Your baby may be sleeping.

Here’s what you can do:

- Drink something cold
- Eat something
- Walk around for 5 minutes
- Then repeat kick counts for 1 hour

What if you do not feel 10 moves in the second hour?

Call your health care provider right away. Your provider will tell you what to do.

Health care provider’s phone number:

When we are closed, call:

Cómo contar las patadas de su bebé

Una buena manera de observar la salud de su bebé es contar la frecuencia con la que se mueve o “patea”.

Puede empezar a hacerlo durante el 7º mes del embarazo, o a partir de las 28 semanas.

Para contar las patadas, haga lo siguiente:

- Intente hacerlo inmediatamente después de comer. Su bebé está más activo después de que usted coma.
- Siéntese con sus piernas levantadas o acuéstese sobre su lado izquierdo.
- Registre el horario en que empieza.
- Coloque las manos sobre su vientre.
- Cuente cuántas veces se mueve su bebé. Se considera que se “mueve” cada vez que da una patada, se menea, retuerce, da vueltas, rueda o se estira.
- Siga contando hasta llegar a 10 movimientos.
- Una vez que el bebé se haya movido 10 veces en una hora, puede dejar de contar y seguir con el resto de su día.

Si su bebé no se mueve 10 veces en la primera hora, no se preocupe. Puede estar durmiendo. Lo que puede hacer es:

- Tomar algo frío.
- Comer algo.
- Caminar por 5 minutos.
- Luego vuelva a contar patadas durante 1 hora más.

¿Qué pasa si no siente 10 movimientos durante la segunda hora?

Llame a su proveedor de atención de la salud de inmediato. Su proveedor le dirá qué hacer.

Número de teléfono del proveedor de atención de la salud:

 Cuando nuestra oficina está cerrada, llame al:



“Ayer por la mañana conté las patadas durante 2 horas y no sentí ningún movimiento. Llamé a mi doctora y le conté. Ella llamó a la sala de emergencias para avisar que iba a ir para que revisen a mi bebé. Cuando llegué al hospital, me dijeron que mi bebé tenía problemas. Dijeron que hice muy bien en ir al hospital. Le salvaron la vida a mi bebé y ahora tengo un hijo saludable.”

– Silvia, 25 años de edad

Goals

Help your client understand:

- How STIs are transmitted
- Why STIs are a special concern for pregnant women
- Symptoms to watch for
- How to prevent transmission

Background

STI stands for sexually transmitted infection. STD stands for sexually transmitted disease. STI and STD are used somewhat interchangeably in the United States. STI is the newer term, but many in the United States continue to use the term STD.

STIs are infections people get from having sex with someone who has an STI.

In the U.S., STIs are the second-most widespread contagious disease after the common cold! Teens are especially at risk. Two-thirds of all STIs occur in people under 25 years of age.

STIs occur more frequently in women than men.

Who is at Risk?

Low Risk:

- A woman with only 1 sex partner. This partner only has sex with her (a monogamous relationship) and does not currently have an STI or HIV.

High-Risk:

- A woman who has had a recent STI
- A woman whose sex partner has had an STI in the past 2 years
- A woman who has more than 1 sex partner
- A woman whose sex partner has other sex partners

What are the Risks?

Women often have no symptoms, so they may not know they need treatment. Without treatment, STIs can be transmitted to a partner or a unborn baby.

Risks for pregnant women infected with an STI include spontaneous abortion, transmission to the unborn baby, and even death of the unborn baby. Other risks for the infant include brain damage, liver or lung damage, blindness, retardation, and skeletal problems.

The STIs that can be passed to the unborn baby during pregnancy or delivery, or cause complications such as preterm delivery and low birth weight include:

- Bacterial vaginosis
- Chlamydia
- Gonorrhea
- Hepatitis B
- Human papilloma virus (HPV)
- Herpes simplex virus 1
- Herpes simplex virus 2
- HIV
- Syphilis
- Trichomoniasis

STIs are caused mainly by bacteria or viruses.

Bacterial STIs (like syphilis, gonorrhea) can be cured. If not treated, a baby may be born with syphilis and is at risk for brain damage, heart disease, skeletal problems, and other health problems.

STIs caused by viruses (like HIV, herpes, hepatitis B) cannot be cured. However, some of their symptoms are treatable. For women with HIV there is medicine that can reduce the chance that HIV will be transmitted to the baby during her pregnancy. There is a vaccine that can prevent hepatitis B and this vaccine can be given to pregnant women. For a woman with herpes on her cervix at the time of delivery, a cesarean delivery can

reduce the risk of transmission to her baby. There are also medicines for a woman with active herpes toward the end of her pregnancy.

Signs of STIs are:

- Burning or itching around the vagina
- Pain in the pelvic area
- Strange discharge from the vagina (It may smell bad or be colored or bubbly)
- Bleeding from the vagina
- Pain during sex
- Sores, bumps, or blisters around the vagina or mouth
- Burning during urination (peeing)
- REMEMBER: Sometimes there are no symptoms of an STI

Steps to Take

For all clients:

- Discuss STIs during the initial assessment
- Use the more common term, “STD”, when you talk with her
- Review the handout *What You Should Know About STDs*. Emphasize the main point of this handout, which is, “It is very important to get tested to get any care you need to protect your health and the health of the baby”.
- Review the handout, *You Can Protect Yourself and Your Baby from STDs*. Emphasize the main point of this handout which is, “Whether or not you have an STD, it is important to know how to protect yourself and your baby”. For low risk clients, emphasize that they can use condoms if their situation changes. For high-risk, see below.
- Encourage her to talk openly with her partner in case he or she has other sex partners. Also encourage her to know her sex partner’s history of any STIs.

For high-risk clients:

- Review the handout, *You Can Protect Yourself and Your Baby from STDs*. Emphasize the main point of this handout which is, “Whether or not you have an STD, it is important to know how to protect yourself and your baby”.
- Recommend using condoms or abstinence
- For those clients who have symptoms of an STI or whose partner has an STI, follow up at each visit.
 - ◆ Help the client get tested and treated
 - ◆ Refer sex partner(s) for STI testing
 - Give her the County Health Department STD clinic phone number or refer her to a primary health care provider or a community clinic
 - Ask if she’d like to bring her partner to her next visit to discuss STIs

Helping a client to work with her partner:

- If a client or her partner has an STI, the client will have to talk with her partner about protecting her and the baby from STIs. Talking about any behaviors involving sex, such as starting to use condoms, can be hard. When a client feels she cannot ask a partner to use condoms, explore ways she feels she could assert herself more. Role-playing can be helpful. As she improves her skills in protecting her health, such as talking with her partner, trying a condom once, or trying a non-intercourse activity to reduce her risk, provide positive feedback. Ask if she’d like to bring the partner to her next visit to discuss STIs.

Follow Up

If the client has discussed using condoms during sexual activity, ask about success in trying them. Support her efforts and ask if she’s had any problems.

If a client cannot get her sex partner to use condoms and she depends on him for money, housing, or for immigration status, she has many factors to consider. If she understands how STIs are transmitted, what effect they can have on her baby and how to prevent transmission, she must decide how to handle the risk.

Referrals

Local County STD clinic

Phone: _____

Resources

California Department of Public Health, STD Control Branch

<https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STD.aspx>

STDs & Pregnancy Pamphlet

CDC Fact Sheet, Centers for Disease Control and Prevention

www.cdc.gov/std/pregnancy/STDfact-Pregnancy.htm

General STD Information

- Division of STD Prevention (DSTDP)
Centers for Disease Control and Prevention
www.cdc.gov/std
- American Social Health Association
1-800-783-9877
www.ashastd.org

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What You Should Know About STDs

What are STDs?

STDs (Sexually Transmitted Diseases) are diseases people get from having sex with someone who has an STD.

You may have heard of gonorrhea, syphilis, herpes, or chlamydia. HIV, the virus that causes AIDS, is also an STD.

STDs can spread when:

- You have sex without a condom
- You have sex with more than 1 partner
- Your sex partner has sex with other partners

STDs can spread to your unborn baby.

If you do not get treatment, these diseases can cause many problems for you and your baby:

- You could have a miscarriage
- The baby might be born too early or too small
- The baby may have birth defects or other health problems
- You could get very sick

Call your health care provider right away if you:

- Have burning or itching around the vagina
- Have pain in the pelvic area
- Have a strange discharge from your vagina (it may smell bad or be colored or bubbly)

You should also call your health care provider if you:

- Bleed from the vagina
- Experience pain when you have sex
- See sores, bumps, or blisters around your vagina or mouth
- Experience burning when you urinate (pee)

You or your partner may not have any signs of an STD.

Even if you don't see any signs, STDs can still spread. You may have signs that go away. But the STD stays in the body. **Remember, you can get tested for STDs.**



You can get tested for STDs.

This is very important when you are pregnant. If you get tested, you can get any care you need right away to protect your health and the health of your baby.

¿Qué son las ETS?

Las ETS (Enfermedades de Transmisión Sexual) son enfermedades que se contraen al tener relaciones sexuales con alguien que tiene una ETS.

Probablemente haya escuchado hablar sobre la gonorrea, la sífilis, el herpes o la clamidia. El VIH, el virus que causa el SIDA, también es una ETS.

Las ETS se contagian cuando:

- Tiene relaciones sexuales sin un condón.
- Tiene relaciones sexuales con más de 1 compañero.
- Su compañero sexual tiene relaciones sexuales con otras personas.

Las ETS se pueden pasar a su bebé aun no nacido.

Si no obtiene tratamiento, estas enfermedades pueden causar muchos problemas para usted y su bebé:

- Podría tener un aborto espontáneo.
- Su bebé puede nacer demasiado temprano o demasiado pequeño.
- El bebé puede tener defectos de nacimiento u otros problemas de salud.
- Usted podría enfermarse de gravedad.

Llame su proveedor de atención médica inmediatamente si:

- Siente ardor o picazón alrededor de la vagina.
- Siente dolor en la zona de la pelvis.
- Tiene descarga extraña de su vagina (puede tener feo olor o un color inusual o tener burbujas).

También debe llamar a su proveedor de atención de la salud si:

- Tiene sangrado de la vagina.
- Siente dolor cuando tiene relaciones sexuales.
- Observa lesiones, bultos o llagas alrededor de su vagina o boca.
- Siente ardor al orinar (hacer pipí).

Es posible que ni usted ni su compañero tengan señales de tener una ETS.

Las ETS igual se pueden contagiar aunque no vea ninguna señal. Puede tener señales que se van. Pero la ETS permanece en el cuerpo. Recuerde: puede hacerse las pruebas de ETS.



Puede hacerse pruebas para detectar las ETS.

Esto es muy importante durante el embarazo. Si le hacen las pruebas, puede obtener cualquier atención que necesite de inmediato para proteger su salud y la de su bebé.

Goal

Help your client:

- Understand that the HIV test is a routine part of prenatal care
- Understand that pregnant women with HIV benefit from early detection and medical treatment
- Know how to prevent HIV transmission

Background

If a woman has HIV, she can pass it to her baby when she is pregnant or breastfeeding.

In California, prenatal care providers must offer HIV testing, information, and counseling to all pregnant women during prenatal care. Testing must be offered, but the patient may refuse it. Patient refusal does not need to be in writing, but it must be documented in the medical record.

Patients do not need to provide written consent for the test.

When offering testing, the clinician is required to discuss all of the following:

- Intent to perform the test
- The routine nature of the test
- The purpose of testing
- The risks and benefits of testing
- The risk of perinatal transmission
- Approved treatments
- The right to refuse the test

The handout *What You Should Know about HIV* covers these 7 required points.

Health care providers must document HIV test results in the medical record where other test results are recorded. Prenatal care providers are permitted to transmit test results to Labor and Delivery without written patient consent.

Pregnant women who arrive at Labor and Delivery with no record of an HIV test result will be informed that a rapid HIV test will be done. The patient has a right to refuse. The purpose is to prevent HIV transmission to the baby by using drugs during and after delivery for the woman and baby.

There is no cure for HIV, but women can take anti-retroviral drugs to prolong their lives and maintain their health. These drugs can reduce the chance that HIV will be transmitted to the unborn baby to about 1% if a woman follows her treatment during pregnancy, during labor, and after birth.

Most often, the virus is spread when people have sex or share needles with someone who has HIV.

There are 2 main ways to prevent HIV transmission: (1) use condoms every time during sex (penis, vagina, mouth, and anus), and (2) don't share needles.

Steps to Take

For all clients:

Find out what the patient knows or has heard/experienced about HIV or AIDS. Find out if she understands how the HIV virus is transmitted.

Review the handout *What You Should Know about HIV* with each patient. It covers the 7 points which must be discussed (see "Background" above).

Ask if she has already taken the HIV test. Offer HIV testing, information, and counseling.

- Some clients refuse the HIV test when it is first offered. More of these clients end up having HIV than do other pregnant women who do not refuse the test. Offer HIV testing again in the third trimester to all women who refuse.

For clients needing more information on preventing HIV transmission, review the handout, *You Can Protect Yourself and Your Baby from STDs*.

For clients who have already taken the test:

- If the result was negative, explain that the negative test result shows that she was not infected 3 to 6 months ago. It takes 3 to 6 months after infection for the test to show a positive result. Encourage uninfected pregnant women who are at risk to avoid further exposure to HIV and to be retested for HIV during the third trimester.
- If the result was positive, discuss with the medical provider at your site
 - ◆ Encourage treatment. Explain to the client that she can lead a healthy life and reduce the risk of infecting the baby to about 1% if she follows the treatment while pregnant, during delivery, and after birth.
 - ◆ Discuss practicing “safer sex” (not exchanging body fluids, avoiding intercourse, and using condoms and other protection, etc.) and how to avoid sharing needles
 - ◆ Refer right away to a program for HIV-infected pregnant women. This will help her learn about drug treatments and other services specifically for HIV-infected pregnant women, and about preventing transmission to others.

For clients who are exposed to HIV:

Demonstrate prevention techniques. This may include condom use, how to apply spermicide, how to use dental dams or other devices for oral sex, or how to clean needles with bleach. When possible, have samples and models. The handout *You Can Protect Yourself and Your Baby from STDs* includes information on how to use a condom.

If needed, make referrals:

- Refer sex partners for HIV testing, when possible. Refer to on-site testing, or call the numbers listed in “Resources.”
- Refer to hotlines in “Resources” for more information. Give numbers to the client so she can make the calls herself, or call with her during her visit.

Follow Up

Some clients refuse the HIV test when it is first offered. More of these clients end up having HIV than do other pregnant women who do not refuse the test. At future visits, encourage patients to take the HIV test so that if they are positive they can benefit from the medication.

Resources

California HIV/AIDS Service Referral (CA Department of Public Health, Office of AIDS)

1-800-367-2437

www.cdcpin.org

English, Spanish

Monday - Friday, 9 am – 4 pm

Testing, prevention, care, treatment, and support services in California

Testing & Prevention (CDC)

1-800-232-4636

English, Spanish

24 hours / 7 days a week

Treatment (US DHHS)

1-800-448-0440

English, Spanish

Monday – Friday, 9 am – 2 pm

HIV Health InfoLine (Project Inform)

1-800-822-7422

Monday - Friday, 10 am – 4 pm

After Hours Emotional & Crisis Support

1-800-628-9240

24 hours, nationwide

County Public Health Departments

For information on the following services:

Infectious Disease Specialists

Pediatric AIDS Specialists

Drug and Alcohol Recovery Programs

Local AIDS Foundations

Family Planning



What You Should Know About HIV

HIV is the virus that causes AIDS.

Most often, the virus is spread when people have sex or share needles with someone who has HIV. If a woman has HIV, she can pass it to her baby when she is pregnant or breastfeeding.

What you need to know:

- You can get HIV when you have sex using the penis, vagina, mouth, or anus
- You can help protect yourself. Use condoms every time you have sex. Use condoms no matter how you have sex.
- HIV can spread if you share needles
- Don't share needles to do drugs, get vitamin shots, tattoos, or piercings

Every pregnant woman should take the HIV test.

In California, it is the law to offer all pregnant women the opportunity to be tested for HIV. It is routine to test pregnant women for HIV. You have the right to refuse the test by telling the health care provider you do not want it at that time.

Taking the HIV test is a routine part of prenatal care.

Why? You could have HIV and not know it. You could pass it on to your baby during pregnancy, labor and delivery, or breastfeeding. When you get the HIV test, you find out if you have HIV. The test results are private.

If you had a negative test in the past, it is best to take the test again to be certain. It can take up to 6 months after getting the HIV infection before it shows up on the test.



If you do have HIV, you can get the care you and your baby need.

- There are very helpful medicines now. The sooner a pregnant woman starts the treatment, the better her health will be.
- Treatment can greatly lower the chances of your baby getting HIV. The medicines prevent transmitting HIV in almost 99% of cases. Without medicine, there is a 1 in 4 chance of passing it to the baby. The sooner treatment is started, the better the results will be.
- You can feed your baby with formula to prevent spreading the infection through breast milk

El VIH es el virus que causa el SIDA.

En la mayoría de los casos, el virus se contagia cuando personas tienen relaciones sexuales o comparten jeringas con alguien con VIH. Si una mujer tiene VIH, puede pasárselo a su bebé cuando está embarazada o da pecho.

Necesita saber lo siguiente:

- Puede contraer VIH cuando tiene relaciones sexuales que entran en contacto con el pene, la vagina, la boca o el ano
- Usted puede ayudar a protegerse. Use condones cada vez que tenga relaciones sexuales. Use condones independientemente de cómo tenga relaciones sexuales.
- El VIH se puede contagiar si comparte jeringas
- No comparta jeringas para inyectarse drogas, darse inyecciones de vitaminas, hacerse tatuajes o perforaciones en el cuerpo

Todas las mujeres embarazadas se deben realizar una prueba de VIH.

En California, hay una ley que dice que se debe ofrecer la oportunidad de realizarse una prueba de VIH a todas las mujeres embarazadas. La prueba de VIH es una parte de la atención de rutina para mujeres embarazadas. Tiene derecho a negarse a hacerse la prueba. Dígame a su proveedor de atención de la salud que no se la quiere realizar en este momento.

La prueba de VIH es parte de la atención prenatal de rutina.

¿Por qué? Usted podría tener VIH y no saberlo. Se lo podría pasar a su bebé durante el embarazo, el trabajo de parto y el parto, o cuando le da pecho. Cuando se realiza la prueba de VIH, podrá saber si tiene VIH. Los resultados de la prueba son privados.



Si tuvo un resultado negativo anteriormente, es mejor volver a realizarse la prueba para estar segura. Pueden pasar seis meses después de infectarse con VIH antes de que se detecte en la prueba.

Si tiene VIH, puede obtener la atención que usted y su bebé necesitan.

- Ahora hay medicamentos que ayudan mucho. Cuanto antes empiece el tratamiento una mujer embarazada, mejor será su salud.
- El tratamiento puede reducir en gran parte las posibilidades de que su bebé tenga VIH. Los medicamentos previenen la transmisión del VIH en casi el 99% de los casos. Sin el medicamento, hay una posibilidad entre cuatro que pasará el virus a su bebé. Cuanto antes se inicie el tratamiento, mejor serán los resultados.
- Puede alimentar a su bebé con fórmula para evitar contagiarle la infección a través de la leche materna



You Can Protect Yourself and Your Baby from STDs

STEPS TO TAKE

STDs are dangerous for you and your baby.

STDs are diseases you could get when you have sex with someone who has an STD. You can get an STD from someone even if he or she doesn't have any symptoms. You may have heard of HIV, chlamydia, gonorrhea, and herpes, but there are many more STDs.

Here just a few of the problems STDs can cause:

- Your baby could be born too early or too small
- Your baby's eyes or lungs could be damaged
- Your baby could have lifelong health problems
- Your baby could die

Here are ways to protect yourself and your baby.

Use a latex condom every time you have sex if:

- You have more than 1 sex partner
- You think your partner may have other partners
- You know your partner has sex with other people
- You don't know if your partner has an STD or HIV

Ask your health care provider to show you how to use a condom.

- There are condoms for both men and women
- It's easy to learn

Don't share needles to inject anything.

- If you do share needles, use bleach to clean them between uses
- Ask your health care provider how to clean needles
- Find out if there are needle exchange programs near you
- Don't share other equipment or works used for injection

Get tested! While not all STDs are curable, there are medicines that can help:

- Tell your health care provider if you have had STDs in the past
- Get tested for STDs and HIV. The earlier STDs are found the better!
- If you have an STD, get treated. Make sure your partner gets checked and treated, too.

For more information, call: _____



How to Use a Condom

Condoms can help protect against infection. For best results, they must be used correctly.

- Use a new condom each time
- Condoms should be put on before sexual contact and left on until all contact is finished
- Squeeze air out of the tip and unroll the condom all the way
- After ejaculation, hold the condom while pulling out. Take care not to spill the liquid. Then take the condom off the penis and throw it away.
- Only use water-based lubricants (no lotion, Vaseline, baby oil, etc.)



PASOS A SEGUIR

Las ETS son peligrosas para usted y su bebé.

Las ETS son enfermedades que podría contraer cuando tiene relaciones sexuales con alguien que tiene una ETS. Puede contraer una ETS de alguien por más que no tenga ningún síntoma. Probablemente haya escuchado hablar sobre el VIH, la clamidia, la gonorrea y el herpes, pero hay muchas más ETS.

Estos son algunos de los problemas que pueden causar las ETS:

- Su bebé podría nacer demasiado temprano o demasiado pequeño
- Su bebé podría tener una lesión en los ojos o los pulmones
- Su bebé podría tener problemas de salud durante toda la vida
- Su bebé podría morir

Las siguientes son maneras de protegerse y proteger a su bebé.

Use un condón de látex cada vez que tenga relaciones sexuales si:

- Tiene relaciones sexuales con más de una pareja sexual
- Piensa que su pareja sexual puede llegar a tener otras parejas
- Sabe que su pareja sexual tiene relaciones sexuales con otras personas
- No sabe si su pareja tiene una ETS o VIH

Pídale a su proveedor de atención de la salud que le muestre cómo usar un condón.

- Hay condones para hombres y para mujeres
- Es fácil aprender a usarlos

No comparta jeringas para inyectarse cualquier cosa.

- Si comparte jeringas, use lejía para limpiarlas después de cada uso
- Pregúntele a su proveedor de atención de la salud cómo limpiar las jeringas
- Averigüe si hay programas de intercambio de jeringas en su zona

Puede Protegerse y Proteger a su Bebé de las ETS

- No comparta otros equipos o implementos que usa para inyectarse

¡Hágase la prueba! Si bien no todas las ETS se pueden curar, hay medicamentos que la pueden ayudar:

- Dígale a su proveedor de atención de la salud si tuvo una ETS anteriormente
- Hágase pruebas de ETS y VIH. ¡Cuanto antes se detecten las ETS, mejor!
- Si tiene una ETS, obtenga tratamiento. Asegúrese de que su pareja también se haga las pruebas también.

Para obtener más información, llame al: _____



Cómo Usar un Condón

Los condones pueden proteger contra las infecciones. Se deben usar correctamente para obtener los mejores resultados.

- Use un condón nuevo cada vez que tenga relaciones sexuales
- Los condones se deben colocar antes de que se inicie el contacto sexual y no se deben quitar hasta que se haya terminado todo el contacto
- Apriete la punta para sacar el aire y desenrolle el condón del todo
- Después de la eyaculación, sostenga el condón cuando retira el pene. Tenga cuidado de no derramar el líquido. Saque el condón del pene y bótelo a la basura.
- Use solamente lubricantes con base de agua (no lociones, Vaseline, aceite de bebé, etc.)

Goals

Help your client:

- Understand that pregnant women are more vulnerable to some infections and diseases
- Understand that some normal activities may be harmful during pregnancy
- Find ways to avoid those activities

Background

An unborn baby can be harmed by a number of things that do not harm children or adults. Cleaning cat boxes, certain types of insect bites, taking hot baths, or eating certain foods can cause miscarriages, major disabilities in infants, and other serious health problems. All clients should be aware of these special risks for pregnant women so they can avoid them.

Steps to Take

For all clients:

Review the handout *Pregnant? Steps for a Healthy Baby* with each client. Ask which items on the handout apply to her. If you need more information about any topic, refer to the section titled “More Information” on the next page.

NOTE: If the client indicates that her or her partner have recently traveled outside of the United States, she may be at risk of Zika. Refer to the new Zika section on pages 49-50 for specific information about the Zika virus and the “Steps to Take” with all pregnant clients.

For clients at risk (other than Zika):

- Help her find ways to avoid risky behavior. For example, a client may want to discuss how to change the cat litter, or a client may need to think about the cheeses she eats to learn which ones are safe.

- If she is exposed to hazards at work, provide her with the handout *Keep Safe at Work*
- If there are food safety issues, review the Food Safety guidelines in the “Nutrition” section for preventing food-borne illnesses through safe food preparation, handling, and storage
- Make a note of the risk in her care plan. For example, “Discussed not eating queso fresco; review next trimester.”

Follow Up

At each trimester reassessment, ask how the client is handling any risk you have discussed. If needed, help her find ways to continue avoiding hazards.

Resources

Mother to Baby Fact Sheets

English and Spanish

1-866-626-6847

Text: (855) 999-3525

<http://mothertobaby.org>

US Food and Drug Administration

For pregnant women:

www.fda.gov/Food/ResourcesForYou/HealthEducators/ucm117561.htm

US Department of Health and Human Services

“Pregnancy Do’s and Don’ts”

English and Spanish

1-800-994-9662

Monday-Friday, 12pm - 9 pm

<http://www.womenshealth.gov/publications/our-publications/pregnancy-dos-donts.pdf>

More Information About Normal Activities That May Be Harmful While Pregnant:

Toxoplasmosis

Cat feces, raw meat, fish, eggs, or raw milk can contain a parasite “*Toxoplasma gondii*” which causes toxoplasmosis in humans. In a pregnant woman, the parasite can cause infection in the baby. Contagion can occur at any time during the pregnancy, but it can be most harmful in the early months. Some babies born with a toxoplasmosis infection will have medical conditions affecting the brain, eyes, heart, and other organs. About 20% of women with toxoplasmosis infection during pregnancy transmit the infection to their unborn babies. Most women have no symptoms of toxoplasmosis infection, but if infection is suspected, a blood test can be used to detect its presence. If a client wants to get tested, she should ask her health care provider. Women can also be tested to see if they’ve already had toxoplasmosis infection earlier in life.

Listeriosis

Soft cheese, raw milk, or raw or undercooked meat can contain bacteria that causes listeriosis. Hot dogs, cold cuts, deli meat, pâté, and smoked seafood can also carry the bacteria. If a pregnant woman is infected, she may have a fever, sore throat, and pain. A blood test can show if she is infected. She could pass the illness on to her unborn baby through her blood. This infection can cause miscarriage, stillbirth, or serious illness in newborns. See the Food Safety Guidelines in the “Nutrition” section. Avoid soft cheeses, like queso fresco, brie, or feta unless the labels show they are pasteurized. Hard cheeses, solid at room temperature, are considered safe. Hot dogs, luncheon meats, and deli meats must be reheated until steaming hot.

Mercury

The mercury content in fish is generally low. However, if a pregnant woman eats a diet high in fish, she may eat enough mercury to harm her unborn baby. Pregnant and breastfeeding women should not eat shark, king mackerel, tilefish, or swordfish due to high mercury levels. A pregnant woman should eat 2-3 servings of fish a week in 2 to 3 meals. See *Food Safety Guidelines* for more information on fish safety and review the “Nutrition” handout, *Lower Your Chances of Eating Foods with Unsafe Chemicals in Them*.

High Body Temperature

Studies have shown that body temperature at 101°F or above can cause birth defects. Pregnant women should not use hot tubs or saunas for more than 10 minutes, especially in the first trimester. In case of a fever, she should contact her health care provider right away. She should also avoid exercising heavily for long periods of time, especially in hot weather or during a fever.

Douches

Douching is not necessary for normal hygiene and can cause problems. Having more vaginal secretions during pregnancy is normal and does not mean that a woman needs to douche. Some pregnant women like to wash more often with a washcloth and water. This is not harmful.

X-rays

X-rays during pregnancy can expose the unborn baby to harmful levels of radiation, causing possible birth defects or childhood leukemia. If x-rays are needed, the client must be sure to tell her dentist or health care provider that she is pregnant, to limit the unborn baby’s exposure to x-rays. Walking through checkpoints at airports does not pose a health risk.

Chemicals

Exposure to chemicals can cause problems for the unborn baby, including birth defects, low birth weight, etc. Pregnant women should try to minimize their exposure to chemicals. They should get plenty of fresh air when around chemicals such as aerosol sprays, cleaning fluids, oven cleaners, paint, paint thinner, paint removers, glue, antifreeze, varnish, and flea bombs. Pregnant women can help prevent chemicals from entering their bodies by wearing protective clothes or gloves to cover their skin, and not eating or drinking around chemicals.

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Immunizations Are Not Just for Infants, They Are for the Entire Family!

Ideally, all women of child-bearing age should be up-to-date on their immunizations before they become pregnant. Immunization status should be assessed at the first prenatal visit. Although some vaccines, particularly live virus vaccines, are not recommended during pregnancy, certain immunizations are specifically indicated during pregnancy. In addition, all routine immunizations may be given to a mother while breastfeeding.

Influenza (Flu)

Pregnant women are at increased risk of severe influenza, so it is important that they are appropriately protected. Influenza during pregnancy can cause low birth weight, premature birth, stillbirth, hospitalization, and death. Women who are pregnant or planning a pregnancy should receive the influenza vaccine as soon as it's available each fall or winter to protect themselves and their families. Infants are at increased risk of severe influenza but cannot be immunized until 6 months of age, so it is important that those around them are immunized. Thus, parents and other family members should receive the flu vaccine at least several weeks prior to the infant's birth.

Tetanus, Diphtheria, and Pertussis (Tdap)

Pertussis (whooping cough) is a very serious disease that can cause babies to turn blue, stop breathing, and die. To protect infants too young to be vaccinated, the Centers for Disease Control and Prevention (CDC) recommend that pregnant women receive a dose of Tdap at the earliest opportunity during the third trimester of each pregnancy, regardless of the patient's prior history of receiving Tdap (or Td).

Tdap vaccine not only helps protect the mother from getting and spreading pertussis to her baby after birth, but also provides the baby with direct protection

against pertussis because the mother's protection from the vaccine is passed to the baby during pregnancy. Vaccinating patients with Tdap during pregnancy, rather than postpartum, will prevent more infant hospitalizations and deaths from pertussis. To provide the best protection for the baby, Tdap should be given as early as possible between weeks 27 and 36 of pregnancy. The level of pertussis antibodies decreases over time, so Tdap should be given during every pregnancy in order to transfer the greatest number of protective antibodies to each baby.

Rubella

All women of child-bearing age should be protected against rubella with 2 doses of the measles, mumps, rubella (MMR) vaccine. Rubella infection during pregnancy can cause miscarriage or a pattern of birth defects such as deafness and mental retardation (congenital rubella syndrome). Physicians providing prenatal care should check for immunity to rubella through a blood test. Women who are not immune to rubella should be immunized with MMR vaccine shortly after delivery and before discharge from the health care facility.

Chicken Pox

All women of child-bearing age should be immune to chicken pox, either by having the disease or through 2 doses of the varicella vaccine. This vaccine is a live virus vaccine, so it is not recommended during pregnancy. If it is determined during pregnancy that the woman is not yet protected against chickenpox, she should receive the vaccine shortly after delivery and before discharge from the healthcare facility. The second dose should be administered 4-8 weeks after the first dose.

Hepatitis B

Providers are required by California law to test pregnant women for hepatitis B infection. Uninfected pregnant women who have clinical hepatitis or report risk factors should be re-tested before delivery.

Risk factors include recent intravenous drug use, an HBV infected sex partner, more than one sex partner in the past 6 months, or recent treatment for an STD. Finally, if a pregnant woman does not have evidence of a negative HBV result at delivery, the birth hospital should test the woman and provide post-exposure prophylaxis to the infant if test results are not available before discharge..

HBV infected women should also be tested for HBV DNA (viral load) and referred to a specialist if HBV DNA $\geq 20,000$ IU/mL. These women may benefit from antiviral treatment during pregnancy to prevent transmission to the infant.

All infants born to mothers known to be infected with HBV should receive HBV vaccine and Hepatitis B Immune Globulin within 12 hours of birth. These infants should also complete the HBV vaccine series and receive post-vaccination serologic testing to ensure that they are immune and not an ongoing risk of household transmission of HBV.

For more information and resources, see:
www.pregnancyshotsca.org



Your Baby Needs to be Immunized



Get your baby's shots on time — every time!

Shots can protect your baby from dangerous childhood diseases.

Your baby could get very sick or even die from these diseases. To be protected, your baby needs a series of shots at 2, 4, and 6 months of age, and between 12 to 18 months of age.

Protect your baby from these diseases:

- Hepatitis B
- Hib (meningitis)
- Diphtheria
- Tetanus (lockjaw)
- Pertussis (whooping cough)
- Polio
- Chicken pox
- Measles
- Mumps
- Rubella (German measles)
- Pneumococcal disease
- Rotavirus disease (severe gastroenteritis)
- Hepatitis A
- Influenza

Do shots really work?

Yes. When we give children a small amount of vaccine, they can grow up without getting these diseases. Check with your baby's healthcare provider. Make sure your child has gotten all the shots he or she needs.

Are shots safe?

Almost all children have only a mild reaction to shots. Your child may be sore where the shot was given, or have a slight fever or rash.

A serious problem from shots is very rare. Call your health care provider right away if your child has a very high fever, a rash all over his or her body, or a lot of swelling where he or she was given the shot.

Schools need a record of your child's shots.

By law, children in California must have certain shots before they go to school or day care.

Your child needs a record of these shots. Most of the time, you will get a yellow card with the dates your child got the shots. Keep this card and all your child's health records in a safe place.

For more information, see: www.shotsforschool.org.



Vacune a su bebé a tiempo ¡todo el tiempo!

Las vacunas pueden proteger a su bebé de enfermedades peligrosas de la niñez.

Su bebé se puede poner muy enfermo o hasta morir de estas enfermedades. Para estar protegido, su bebé necesita una serie de vacunas a los 2, 4, y 6 meses, y entre los 12 a 18 meses.

Proteja a su bebé de estas enfermedades:

- Hepatitis B
- H (meningitis)
- Difteria
- Tétano
- Pertusis (tosferina)
- Polio
- Varicela
- Sarampión
- Paperas
- Rubéola (Sarampión Alemán)

¿Son efectivas las vacunas?

Sí. Cuando les damos a los niños una pequeña cantidad de la vacuna, pueden crecer sin tener estas enfermedades. Verifique con el médico de su niño. Asegúrese de que haya vacunado a su niño con todas las vacunas.

¿Son seguras las vacunas?

Casi todos los niños tienen una leve reacción a las vacunas. Su niño puede estar adolorido en el área en que le pusieron la vacuna, o tener una leve fiebre o erupción en la piel.

Un problema serio de las vacunas es raro. Llame a su médico de inmediato si su niño tiene fiebre alta, le sale erupción en todo el cuerpo o tiene mucha hinchazón en donde se le puso la inyección.

Las escuelas necesitan verificación de las vacunas de su niño.

Por ley, los niños en California deben tener todas sus vacunas antes de poder asistir a la escuela o a una guardería.

Su niño necesita verificación escrita de todas estas vacunas. La mayoría del tiempo, usted recibirá una tarjeta amarilla con las fechas en que su niño recibió las vacunas. Guarde esta tarjeta y todos los datos de la salud de su niño en un lugar seguro.



Pregnant? Steps for a Healthy Baby

You can help prevent miscarriage, birth defects, or illness:

1. **Take a prenatal vitamin with 400 micrograms of folic acid each day.** Most multi-vitamins have 400 micrograms of folic acid.
2. **Protect yourself from mosquito bites and sexual transmission of Zika.**
3. **Notify your prenatal care provider if you have recently traveled out of the country .**
4. **Get flu and whooping cough shots.** These shots are safe for you and your baby. Get flu vaccine as soon as it's available during flu season and the whooping cough shot as early as possible during your third trimester, even if you got it before pregnancy. The protection you get from these shots passes to your baby in the womb. This will help protect your baby during early life, when she is most at risk for serious complications and death from these diseases.
5. **What about other vaccines?** To further protect your baby, ask your medical provider about any other vaccines you or your family might need. For example, it's a good idea for everyone who has contact with your baby (parents, grandparents, siblings, babysitters, etc.), to also get their flu shot. Make sure they are up to date on other shots, like whooping cough and measles.
6. **Do not drink alcohol.** That includes beer, wine, wine coolers, and hard liquor. There is no safe amount.
7. **Do not smoke.** For help quitting, ask your doctor or call 1-800-NO-BUTTS. Also, avoid secondhand smoke.
8. **Do not use any street drugs, including marijuana. If needed, get counseling.** You can ask your doctor for help to get treatment.
9. **Check with your doctor before taking any drugs, medicine, or herbs.** Natural products and herbs are not always safe. You should also tell your doctor about any prescription or over-the-counter medicines you take.
10. **Limit caffeine from coffee, sodas, and energy drinks.** Do not drink more than 1 cup each day.
11. **Brush and floss your teeth.** Make a dental appointment! Dental appointments are safe and important during pregnancy.
12. **Cook your meat until it is well done.** Do not eat raw meat, seafood, or eggs. Do not eat hot dogs, luncheon meats, or deli meats unless they are reheated until steaming hot.
13. **Do not share forks, cups, or food with children.**
14. **Avoid raw milk (not pasteurized) and foods made from raw milk.** Do not eat soft cheeses such as queso fresco, feta, or brie unless the labels show they are pasteurized.



Pregnant? Steps for a Healthy Baby

15. **Do not eat shark, swordfish, tilefish, or king mackerel.** They have higher amounts of mercury. For other fish, do not eat more than 2-3 servings per week. For more information on fish, visit: <https://www.epa.gov/choose-fish-and-shellfish-wisely> or call 1-800-532-3749.

For help, call:
1-866-626-6847 (Teratology Information Specialist)
<http://mothertobaby.org>
16. **Wash your hands with soap and water often.**

Be sure to wash when:

 - Leaving the bathroom
 - Eating or preparing food
 - Taking care of children or pets
 - Changing diapers
 - Being around people who are sick
 - Getting saliva (spit) on your hands

If there is no soap and water, use alcohol-based hand gel (at least 60% alcohol).
17. **Avoid people who are sick.** Stay away from people who are sick with fevers, rashes, coughs, or sore throats.
18. **Avoid exposure to chemicals and fumes.** Get plenty of fresh air and wear protective clothing like gloves. Never mix cleaning fluids.
19. **Avoid exposure to lead in products such as paint, batteries, and imported pottery.** Find out more about job safety if you work with pesticides or in salons, shops for dry cleaning, auto repair, printing, graphic design, plumbing, carpentry, battery plants, funeral homes, factories, or laboratories. Ask your clinic for the handout, *Keep Safe at Work*.
20. **Do not change cat litter or work in the garden.** If you must, wear gloves. Wash your hands after taking off the gloves.
21. **Stay away from rodents and their droppings.** If you have wild rodents in or around your home, try to get rid of them. If you have a pet rodent, like a mouse or guinea pig, have someone else care for it until your baby is born.
22. **Do not douche.** Douching may cause problems for your pregnancy.
23. **Avoid raising your body temperature for more than 10 minutes,** like in a hot tub, a very hot bath, a sauna, or from heavy exercise. It is recommended not to exercise heavily for more than 40 minutes. If you have a fever, ask your doctor about medicine to lower it.
24. **Avoid x-rays unless ordered by your doctor or dentist.** Be sure to tell health care workers you are pregnant.
25. **Get help if you feel unsafe with your partner.** For domestic violence help, talk to your doctor or call 1-800-799-7233.
26. **Always wear a seatbelt.** The lap strap should go under your belly. The shoulder strap should go between your breasts and to the side of your belly. Make sure it fits snugly.



¿Está embarazada? Pasos para tener un bebé saludable

Usted puede ayudar a prevenir un aborto espontáneo, defectos de nacimiento o enfermedades:

- 1. Tome una vitamina prenatal con 400 microgramos de ácido fólico todos los días.**
La mayoría de los complejos vitamínicos (multi-vitamins) contienen 400 microgramos de ácido fólico.
- 2. Protéjase de las picaduras de mosquito y de la transmisión sexual del virus del Zika.**
- 3. Avise a su proveedor de atención de la salud prenatal si estuvo fuera del país en el último tiempo.**
- 4. Vacúnese contra la gripe y la tos ferina. Estas vacunas son seguras para usted y para el bebé.** Dese la vacuna contra la gripe tan pronto esté disponible durante la temporada de gripe y dese la vacuna contra la tos ferina lo antes posible durante el tercer trimestre, incluso si ya se la dio antes del embarazo. La protección que obtendrá de estas vacunas pasa a su bebé en el útero. Esto ayudará a proteger a su bebé en sus primeros tiempos de vida, cuando hay más riesgo de que estas enfermedades le causen complicaciones graves e incluso la muerte.
- 5. ¿Hay otras vacunas?** Para proteger aún más a su bebé, pregúntele a su proveedor de atención de la salud sobre otras vacunas que podrían necesitar usted y su familia. Por ejemplo, sería bueno que todas las personas que tengan contacto con el bebé (padres, abuelos, hermanos, niñeras, etc.) también se vacunen contra la gripe. Asegúrese de que tengan al día las otras vacunas, como la de tos ferina y sarampión.
- 6. No tome alcohol.** Esto incluye la cerveza, vino, cócteles con vino y bebidas alcohólicas. No hay una cantidad segura de alcohol.
- 7. No fume.** Para obtener ayuda para dejar de fumar, pregúntele a su médico o llame al 1-800-NO-BUTTS. Evite además el humo de segunda mano.
- 8. No use drogas de la calle, incluida la marihuana.** Obtenga consejería de ser necesario. Puede pedir a su médico ayuda para obtener tratamiento.
- 9. Consulte con su médico antes de tomar cualquier droga, medicamento o hierba.** Los productos naturales y hierbas no siempre son seguros. También debe informarle a su médico sobre cualquier medicamento bajo receta o de venta libre que tome.
- 10. Limite la cafeína que ingiere del café, refrescos y bebidas energizantes.** No tome más de 1 taza por día.
- 11. Cepíllese los dientes y use hilo dental.**
¡Arregle una cita con el dentista! Las visitas al dentista son seguras e importantes durante el embarazo.
- 12. Cocine la carne hasta que esté bien cocida.** No coma carne, pescado o huevos crudos. No coma salchichas, carnes frías o fiambres a menos que los caliente hasta que estén humeando.
- 13. No comparta tenedores, tazas o comida con niños.**
- 14. Evite la leche cruda (sin pasteurizar) y las comidas hechas con leche cruda.** No coma quesos blandos, como por ejemplo queso fresco, feta, o brie, a menos que las etiquetas indiquen que son pasteurizados.
- 15. No coma tiburón, pez espada, lofolátilo o caballa gigante.** Tienen mayores



¿Está embarazada? Pasos para tener un bebé saludable

PASOS A SEGUIR

concentraciones de mercurio. No coma más de 2 o 3 porciones de otros pescados por semana. Para obtener más información sobre el pescado, visite <https://www.epa.gov/choose-fish-and-shellfish-wisely> o llame al 1-800-532-3749.

16. Lávese las manos con frecuencia, con jabón y agua tibia.

Lávaselas siempre que:

- Salga del baño.
- Coma o prepare comida.
- Cuide a niños o mascotas.
- Cambie pañales.
- Esté cerca de personas enfermas.
- Tenga saliva en las manos.

Si no hay jabón y agua, use alcohol en gel (con por lo menos un 60% de alcohol).

17. **Evite a las personas enfermas.** Manténgase alejada de personas enfermas con fiebre, sarpullido, tos o dolor de garganta.
18. **Evite exponerse a productos químicos y gases.** Respire aire fresco en abundancia y use vestimenta de protección, como por ejemplo guantes. No mezcle nunca los líquidos de limpieza.
19. **Evite exponerse al plomo en productos como pintura, baterías y productos de cerámica importados.** Si trabaja con pesticidas o en una peluquería, tienda de lavado a seco, reparación de automóviles, imprenta, diseño gráfico, plomería, carpintería, plantas de baterías, funerarias, fábricas o laboratorios, obtenga más información sobre la seguridad en el lugar de trabajo. Pida en su clínica una copia del folleto Manténgase segura en el trabajo (*Keep Safe at Work*).

Para obtener ayuda, llame al Especialista en información sobre malformaciones o anomalías congénitas (tertalogía) al: 1-866-626-6847 <http://mothertobaby.org>

20. **No cambie la arena higiénica del gato ni trabaje en el jardín.** Si tiene que hacer estas cosas, use guantes. Lávese las manos después de quitarse los guantes.
21. **Manténgase alejada de los roedores y sus heces.** Si tiene roedores salvajes en su casa o cerca, intente eliminarlos. Si tiene un roedor de mascota, como por ejemplo un ratón o conejillo de indias, pídale a otra persona que lo cuide hasta que nazca su bebé.
22. **No use duchas vaginales.** Las duchas vaginales pueden causar problemas para su embarazo.
23. **Evite elevar la temperatura de su cuerpo por más de 10 minutos,** como por ejemplo en un jacuzzi, baño en tina muy caliente, sauna o por hacer mucho ejercicio físico. Se recomienda que no haga ejercicios intensos por más de 40 minutos. Si tiene fiebre, pregúntele a su médico qué medicamento puede tomar para bajarla.
24. **Evite las radiografías a menos que las ordene su médico o dentista.** No se olvide de decirles a los profesionales de atención de la salud que está embarazada.
25. **Si no se siente segura con su pareja, obtenga ayuda.** Para obtener ayuda con la violencia en el hogar, hable con su médico o llame al 1-800-799-7233.
26. **Use siempre un cinturón de seguridad.** La parte inferior del cinturón debe estar debajo de su vientre. La parte superior debe estar entre sus senos y al costado de su vientre. Verifique que esté bien ajustado.

Background

Zika is a virus that spreads to people primarily through mosquito bites in areas of the world with Zika. Two specific types of mosquitos can spread the Zika virus, and both types are found in certain areas of California. Zika is also sexually transmitted, and since most people with Zika don't have symptoms, they can still spread the virus to their sexual partners without knowing it. The greatest risk from Zika is to a pregnant woman's unborn baby. If a pregnant woman gets Zika, by being bitten by an infected mosquito or by having unprotected sex with someone who has the virus, she can pass the virus to her unborn baby, which can cause miscarriage, stillbirth and severe birth defects. There is no specific vaccine or medicine for Zika.

Steps to Take

Advise All Pregnant Clients:

- Protect yourself from mosquito bites and sexual transmission of Zika.
- If possible, don't go to areas with risk of Zika. (A complete list of countries with risk of Zika can be found on the CDC World Zika Map.)
- If you must go to areas with risk of Zika, prevent mosquito bites by using EPA-registered insect repellents, which are safe and effective for pregnant and breastfeeding women when used as directed.
- If you or your partner must go to an area where Zika is spreading, practice safer sex by using condoms (male or female) and dental dams—from start to finish, every time during all types of sex (vaginal, anal and oral)—or do not have sex during travel or after you return. Both male and female sexual partners can transmit Zika to a pregnant woman.

- If a male partner is exposed (goes to an area with Zika): practice safer sex or do not have sex for at least 6 months after returning from an area with Zika.
- If a female is exposed: practice safer sex or do not have sex for at least 8 weeks after returning from an area with Zika.
- If a male and female travel together and both are exposed: practice safer sex or do not have sex for at least 6 months after returning from an area with Zika.
- After the baby is born, women should practice safer sex and avoid pregnancy by using an effective form of birth control for at least 8 weeks after returning from an area with Zika, or for 6 months if a male sexual partner was exposed.

Share the CDPH Zika + Pregnancy Poster with your clients, which can serve as a take-home tool and provide additional information about preventing mosquito bites.

Follow Up & Referrals

Refer to a health care provider according to your protocols:

- If your client has been to an area with Zika or had sex with someone who has been to an area with Zika.

Discuss the following with your client:

- Instruct your client to talk to their prenatal care provider about their possible Zika exposure, whether or not they feel sick; follow up with your client and provider according to your protocols.
- Instruct your client to ask their prenatal care provider about getting tested for Zika. If she has frequent visits to areas with Zika, she may need testing at least once per trimester. Follow up with your client and provider according to your protocols.

- For more information on Zika testing, review the CDC's [Zika Screening and Testing Tool for Pregnant Women](#).

Resources

CDC Microcephaly During Pregnancy
<https://www.cdc.gov/zika/pdfs/whattoknow-doctor-suspects-microcephaly.pdf>

CDC World Zika Map
<https://www.cdc.gov/zika/geo/countries-territories.html>

CDC Zika Screening Tool for Pregnant Women
<https://www.cdc.gov/zika/pdfs/zikapregscreeningtool.pdf>

CDPH Zika + Pregnancy Poster
(English: <https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/ZikaandPregnancyLetter11-16.pdf>)

(Spanish: <https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/ElZikayElEmbarazoafiche.pdf>)

More Information

Microcephaly is associated with Zika virus infection that is passed from a pregnant woman to her unborn baby.

Microcephaly is a birth defect where the baby is born with a small head. This could mean that the baby will have problems learning, moving and speaking. Not all babies infected with Zika will have microcephaly, but problems could develop later in the infant. Other birth defects from Zika infection could include: hearing loss, vision problems, seizures or joint problems. See the CDC Microcephaly During Pregnancy document for more information about microcephaly and potential risks for a pregnant woman and her unborn baby.

Cardiovascular disease (CVD) is the leading cause of maternal death in the United States and California.

- CVD accounts for more than 33% of all pregnancy-related deaths in the US and 25% of pregnancy-related deaths in California.
- A few of these women had a known diagnosis of cardiovascular disease prior to death
- Most women that died had symptoms either during pregnancy or after childbirth.
- If a woman develops complications during pregnancy such as preeclampsia and gestational diabetes, the risk of developing high blood pressure or heart disease over her lifetime may be increased.
- Any woman can develop heart disease in pregnancy or postpartum, and a woman is at higher risk if she :
 - ◆ Has a history of heart disease
 - ◆ Is over 40 years old
 - ◆ Has preeclampsia or high blood pressure
 - ◆ Is African American
 - ◆ Is obese

Steps to Take:

1. Review and discuss the handout: "Signs & Symptoms of Heart Disease During Pregnancy and Postpartum." The symptoms to watch for in late pregnancy and up to five months postpartum are:
 - Extreme swelling or weight gain
 - Extreme fatigue
 - Fainting
 - Persistent cough
 - Chest pain or fast heart beat

- Severe shortness of breath (especially when lying down)
2. Review and discuss the section of the handout that discusses what to do if the symptoms don't go away
 3. If the client develops persistent chest pain, severe shortness of breath, or feels extremely sick, tell her to go to the Emergency Department.
 4. During the postpartum period discuss ways to help your client lower their risk of heart disease if they had complications during pregnancy using the handout infographic "Did you have complications during pregnancy?"
 - For new mothers and mothers with kids over one year: review the section of the handout "Did You Have Complications During Pregnancy?" that discusses ways she can lower her risk of heart disease "

Reference:

<https://www.cmqcc.org/projects/cardiovascular-disease-pregnancy-postpartum>

<https://www.cmqcc.org/resources-tool-kits/infographics>

Resources and More Information:

www.myheartsisters.com

www.womenheart.org

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DID YOU HAVE COMPLICATIONS DURING PREGNANCY?

♥ You may be at a higher risk for heart disease over your lifetime

Which pregnancy complications can increase your risk for heart disease as you age?



HIGH BLOOD PRESSURE

5-10% of all pregnant women



GESTATIONAL DIABETES

7-14% of all pregnancies



PRETERM BIRTH

11.5% of babies were born preterm in 2012.

Can include:

- ♥ Gestational hypertension
- ♥ Preeclampsia
once known as Pregnancy Induced Hypertension (PIH) and Toxemia
- ♥ Eclampsia
- ♥ HELLP syndrome



Mothers who had gestational diabetes are more likely to have the condition again in a future pregnancy.



Babies born before 37 completed weeks of pregnancy are preterm, or premature.



If you had **PREECLAMPSIA**, you have **2x** the risk of stroke, heart muscle damage, or blood clot and **4x** the risk of developing high blood pressure for the rest of your life!



If you had **GESTATIONAL DIABETES**, you are **50%** more likely to develop Type II diabetes within 5 years, putting you at higher risk for heart disease.



Women with **PRETERM BIRTH AND PREECLAMPSIA** have an **8-10x** higher chance of death from heart disease.

If you had complications in pregnancy, you can lower your risk:

New Mothers



See your health care provider 3-6 months after birth to check your overall physical health. Discuss your pregnancy and any complications you experienced.



Get a copy of your pregnancy and post-delivery medical records to share with your providers for the rest of your life. Don't wait – records may be destroyed.



Breastfeed as long as possible. Women whose total lifetime breastfeeding is 6-12 months were 10% less likely to develop heart disease (and it's good for baby too).

If you had one of these complications, speak with your provider when planning your next pregnancy to optimize your health.



REMEMBER!

It's a **MYTH** that **ALL** pregnancy related high blood pressure and gestational diabetes complications go away after the baby is born!

Get more information and stay heart healthy.
www.cmqcc.org

Mothers With Kids Over One Year



Get annual checkups and be screened for heart disease. At this visit, your provider should check your overall physical condition.



Ask your provider what your test results mean and how you can lower your heart disease risk.

These screening numbers show desirable results.

Blood Pressure	< 120/80 mm hg	Fasting Blood Glucose	< 100 mg/dl
Total Cholesterol	< 200 mg/dl	Body Mass Index	< 25 kg/m ²



Try a mobile app to automatically retrieve and store your medical records, so you always have them handy.



Eat healthy! A diet low in salt, fat, cholesterol and sugar can help you lower your risk for obesity, diabetes and heart disease.



Maintain a healthy weight. Body Mass Index (BMI) is an estimate of body fat based on height and weight. Less than 25 is healthy.



Get active for 30 minutes a day, or as recommended by your provider.



If you smoke, make a plan to quit. Your provider may have resources to support you.



Take medications as directed. Sometimes a healthy diet and exercise is not enough to lower your risk for heart disease, so your provider may prescribe medications to help.



SISTER TO SISTER
The Women's Heart Health Foundation



CMQCC
CALIFORNIA MATERNAL
QUALITY CARE COLLABORATIVE





¿TUVO COMPLICACIONES DURANTE SU EMBARAZO?



Usted puede correr mayor riesgo de enfermedades del corazón por el resto de su vida

¿Cuáles son las complicaciones del embarazo que pueden aumentar el riesgo de enfermedades del corazón con el paso de los años?



PRESIÓN ARTERIAL ALTA

5-10% de todas las mujeres embarazadas



DIABETES GESTACIONAL

7-14% de todos los embarazos



NACIMIENTO PREMATURO

11.5% de todos los bebés nacieron prematuros en el 2012

Puede incluir:

- ♥ Hipertensión gestacional
- ♥ Preeclampsia, anteriormente conocida como hipertensión inducida por el embarazo o toxemia
- ♥ Eclampsia
- ♥ Síndrome HELLP (por sus siglas en inglés) que incluye hemólisis, enzimas hepáticas elevadas y un conteo bajo de plaquetas.



Las madres que tuvieron diabetes gestacional tienen más probabilidad de volver a tenerla en un futuro embarazo.



Los bebés que nacen antes de las 37 semanas completas de embarazo son prematuros.



Si tuvo PREECLAMPSIA, tiene 2 veces más riesgo de tener un ataque al cerebro, daño en los músculos del corazón o un coágulo de sangre, y 4 veces más riesgo de desarrollar presión arterial alta por el resto de su vida.



Si usted tuvo DIABETES GESTACIONAL, tiene 50% más probabilidad de desarrollar diabetes tipo II dentro de 5 años, lo que aumenta su riesgo de enfermedades del corazón.



Las mujeres con PARTO PREMATURO Y PREECLAMPSIA tienen de 8-10 veces más probabilidad de morir por enfermedades del corazón.

Si tuvo alguna complicación en su embarazo, usted puede disminuir su riesgo:

Nuevas mamás



Consulte con su proveedor de atención médica de 3 a 6 meses después del parto para que le evalúa su salud física general. Cuénteles sobre su embarazo y cualquier complicación que haya tenido.



Obtenga una copia de los registros médicos de su embarazo y posparto para poder compartir con sus proveedores el resto de su vida. No espere para hacerlo, ya que pueden destruir los registros.



Amamante el mayor tiempo posible. Las mujeres que han amamantado por un total de 6 a 12 meses de toda su vida tienen 10% menos probabilidad de desarrollar enfermedades del corazón (y también es bueno para el bebé).

Si usted tuvo una de estas complicaciones, consulte con su proveedor de atención médica al planear su siguiente embarazo para mantenerse lo más saludable posible.



¡RECUERDE!

Es un MITO que TODA presión arterial alta relacionada con el embarazo y TODAS las complicaciones de la diabetes gestacional desaparecen después de que nace el bebé.

Obtenga más información y mantenga su corazón sano.

www.cmqcc.org (en inglés)

Mamás con niños mayores de un año



Hágase un chequeo anual y pruebas de detección para las enfermedades del corazón. En su visita anual, su proveedor debe evaluarle su condición física en general.



Pregúntele a su proveedor qué significan los resultados de sus pruebas y cómo puede reducir su riesgo de las enfermedades del corazón.

Estos son los resultados deseables de las pruebas de detección:

Presión arterial < 120/80 mm hg Glucosa en la sangre, en ayunas < 100 mg/dl
Colesterol total < 200 mg/dl Índice de masa corporal < 25 kg/m²



Pruebe una aplicación móvil que pueda automáticamente recuperar y almacenar sus registros médicos para que siempre los tenga a la mano.



¡Coma sano! Una dieta baja en sal, grasa, colesterol y azúcar puede ayudar a reducir el riesgo de obesidad, diabetes y enfermedades del corazón.



Mantenga un peso saludable. El índice de masa corporal (IMC) es un cálculo de la grasa corporal que se basa en la estatura y el peso. Lo saludable es tener un índice menor de 25.



Manténgase activa por 30 minutos al día o lo que le recomiende su proveedor.



Si fuma, haga un plan para dejar de fumar. Su proveedor puede tener recursos para ayudarle.



Tome los medicamentos siguiendo las indicaciones. A veces, no es suficiente seguir una dieta saludable y hacer ejercicio para reducir el riesgo de las enfermedades del corazón. Por eso, quizás su proveedor le recete medicamentos que le pueden ayudar.



SISTER TO SISTER
The Women's Heart Health Foundation



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STEPS TO TAKE

Signs and Symptoms of Heart Disease During Pregnancy and Postpartum

Signs & Symptoms of Heart Disease

Heart disease is the leading cause of death among women in the U.S. who are pregnant or gave birth in the last 5 months (postpartum).

During Pregnancy and Postpartum

Symptoms to watch for in late pregnancy and up to five months postpartum:



- Extreme swelling or weight gain
- Extreme fatigue
- Fainting
- Persistent cough
- Chest pain or fast heart beat
- Severe shortness of breath (especially when lying down)

NOTE: While some of these symptoms are common in late pregnancy, they may be a sign of heart disease especially if they are severe and do not go away after treatment.



If you have any of these symptoms and they don't go away:

- Contact your OB, midwife, family medicine doctor, or your primary care provider
- Describe your symptoms clearly and explain how sick you feel
- If your symptoms arise postpartum, be sure to tell the provider that you recently had a baby
- If your provider says your symptoms are normal, ask what symptoms should cause you to call or come back



Go to the Emergency Department

If you have persistent chest pain or severe shortness of breath, or otherwise feel extremely sick. If possible, take someone with you.

Any woman can develop heart disease in pregnancy or postpartum, but you are at higher risk if you:

- Have prior heart disease
- Are over 40 years old
- Have preeclampsia or high blood pressure (hypertension)
- Are African-American (4X greater risk and 8-10X more likely to die of heart disease)
- Are obese



Bottom line

- Trust your instincts when you feel something is wrong
- When you see a healthcare provider, bring your partner, friend or family member who can support you and help explain these symptoms are not normal for you
- Seek a second opinion if you don't feel listened to or your symptoms are not taken seriously

Get online support and information: www.myheartsisters.com | www.womenheart.org



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Señales & Síntomas

de enfermedades del corazón durante el embarazo y posparto

En los Estados Unidos, las enfermedades del corazón son la principal causa de muerte en las mujeres que están embarazadas o que han dado a luz en los últimos 5 meses (posparto).

Esté atenta a los siguientes **síntomas** hacia el final de su embarazo y hasta 5 meses después de dar a luz:



NOTA: Aunque algunos de estos síntomas son comunes al final del embarazo, también pueden ser una señal de una enfermedad del corazón, especialmente si son graves y no desaparecen después de tener un tratamiento.



Si usted tiene cualquiera de los síntomas anteriores y éstos no desaparecen:

- ♥ Comuníquese con su obstetra, partera, médico general o proveedor de atención médica principal.
- ♥ Descríbale claramente sus síntomas y dígame lo mal que se siente.
- ♥ Si sus síntomas aparecen después del parto, asegúrese de que su médico sepa que usted dio a luz hace poco.
- ♥ Si su médico u otro proveedor de atención médica le dice que sus síntomas son normales, pregúntele cuáles síntomas requieren que usted le llame de nuevo o vuelva a su consultorio.



Vaya a la sala de emergencias si usted tiene un dolor de pecho persistente, mucha dificultad para respirar, o se siente extremadamente enferma por alguna otra razón. De ser posible, trate de que alguien le acompañe.

Cualquier mujer puede desarrollar una enfermedad del corazón durante el embarazo o el posparto, pero usted corre un riesgo más alto si:

- ♥ Ya tenía una enfermedad del corazón
- ♥ Tiene más de 40 años
- ♥ Es afroamericana (4 veces más riesgo y 8 a 10 veces más probabilidad de morir de una enfermedad del corazón)
- ♥ Tiene preeclampsia o presión arterial alta (hipertensión)
- ♥ Es obesa



Conclusión

- * Confíe en sus instintos si siente que algo anda mal.
- * Cuando consulte a su proveedor de atención médica, vaya con su pareja, amigo o amiga o algún familiar que le pueda apoyar y ayudarle a explicar a su médico que estos síntomas no son normales para usted.
- * Busque una segunda opinión si siente que su proveedor de atención médica no le escucha o que no toma en serio sus síntomas.

Obtenga apoyo e información en el internet: www.myheartsisters.com | www.womenheart.org | www.womenheart.org/espanol

Definition

Labor induction is the use of drugs or other methods to start (induce) labor. Oxytocin (sometimes called Pitocin) is the most common drug used to induce labor. There are other ways labor may be induced without the use of drugs.

Goal

Help your client:

- Understand what labor induction is
- Define elective induction
- Describe steps to take if she is faced with the possibility of being induced before or after 39 weeks of pregnancy

Background

The rate of labor induction in the United States more than doubled since 1990 from 9.5% to 23.1% in 2008¹.

Labor induction occurs when the doctor uses medications or other methods to start contractions before labor begins on its own. This may be done for medical reasons or for convenience. Inducing labor for reasons of convenience is called elective induction.

Previously, many labor inductions were performed before 39 weeks gestation electively, for non-medical reasons, despite long-standing recommendations against this by health experts. Babies born before 39 weeks are more likely to suffer from symptoms of prematurity and require admission to a special care nursery or neonatal intensive care unit (NICU). There is also evidence showing that elective labor induction increases the risk of C-section births for women who are in labor for the first time.

Elective labor induction has little to no benefit to a pregnant woman and her baby. The medications used to induce labor increase the chance that both mother and baby will have complications during the birthing process. These complications may include the following:

A pregnant woman should plan to have her baby naturally if she has no medical reason to be induced. If possible, it is best to stay pregnant for at least 39-40 weeks.

- The pregnant woman may have very strong contractions during labor
- The unborn baby may have an abnormal heart rate
- The woman may be more likely to have a C-section if her labor fails
- The mother and baby may have to stay in the hospital longer
- Longer hospital stays increase health care costs
- The mother and baby may become ill or even die

Steps to Take

For all clients:

- Review the patient handout, *What You Need to Know about Labor Induction*
- Point out the questions on the handout and tell the client that if her health care provider recommends labor induction, she should ask these questions
- Remind the client that she should not choose an elective induction because of pressure from her health care provider

For clients whose health care provider recommends labor induction:

- Review the questions on the handout, *What You Need to Know about Labor Induction*
- Remind the client that she should not choose an elective induction because of pressure from her health care provider

¹ US Census, Statistical Abstract of the United States, 2012

- Help a client whose labor will be induced for medical reasons to prepare for the possibility of a complication. Preparing in advance can help the client handle complications as they arise.

Resources

March of Dimes

Why the Last Weeks of Pregnancy Count (Bilingual Brochure, #09-2428-09)

www.marchofdimes.com/catalog/Category.aspx?categoryid=210&page=1&sort=

American College of Obstetricians and Gynecologist Resources

Information Sheet: Induction of Labor (FAQ154)

Downloadable print information

1-800-410-2264

www.acog.org

- Select “For Patients”
- Look under “Labor, Delivery and Postpartum Care” heading
- Labor Induction is FAQ154

Agency for Healthcare Research and Quality

Thinking About Having Your Labor Induced? A Guide for Pregnant Women

Downloadable print and audio information

www.effectivehealthcare.ahrq.gov

- Search for 353

American College of Obstetricians & Gynecologists (ACOG)

1-800-762-2264

1-800-410-2264 (ACOG Resources)

www.acog.org

Medical reasons for inducing labor:

There are valid medical reasons for labor induction. These include:

- Pregnancy is past 42 weeks
- High blood pressure caused by pregnancy
- Infection in the womb (uterus)
- Placenta begins to separate from the womb before the baby is born
- Baby dies before it is born (stillbirth)
- Water bag breaks early
- Water surrounding the baby is too low
- Baby is not growing well
- Baby’s blood type does not match the mother’s blood type
- Client has diabetes, kidney disease, chronic lung disease, chronic high blood pressure, or blood disorders that may lead to miscarriage or premature birth

Elective Induction

These inductions are not done for medical reasons, but are done for convenience. Some common reasons for elective induction include:

- The woman wants to have her baby when family and friends are in town
- The woman plans the time her baby is born around her work schedule
- A woman may want to have her baby early because she is tired of being pregnant
- The woman wants to have her baby early when her doctor can deliver the baby
- The doctor may choose to do the delivery early due to his/her busy schedule



What You Need To Know About Labor Induction

What is Labor Induction?

Labor induction happens when a pregnant woman is given medicines or other methods to start her labor before she goes into labor on her own.

For medical reasons, your doctor may choose to induce you when:

- The pregnancy has lasted more than 42 weeks
- You have high blood pressure
- Your water bag breaks early
- The water surrounding your baby is too low
- The baby is not growing well
- You have a health problems, like diabetes, that may harm you or your baby

Some women ask their doctors to induce them for non-medical reasons, such as:

- To have the baby early because she is tired of being pregnant
- To have the baby when family and friends are in town
- To plan the time the baby is born around her work schedule
- To have the baby early to plan around her doctor's busy schedule

It is not a good idea to be induced when there are no problems with the pregnancy.

Inducing labor may make a difference in your baby's health. Because it can be hard to know the date you became pregnant, inducing labor may mean that your baby is born too early. Babies that are born too early may have breathing problems and need extra care. When inducing labor does not work, you may need to have a C-section.

If your doctor suggests that you be induced, ask these questions:

- Why do I need to have my labor induced?
- What are the possible risks to me and my baby if my labor is induced?
- Can I wait to have the baby naturally without being induced?
- Are there any other options?

A pregnant woman should plan to have her baby naturally if she has no medical reason to be induced. If possible, it is best to stay pregnant for at least 39-40 weeks.



Lo que Necesita Saber Sobre la Inducción del Parto

¿Qué es la Inducción del Parto?

La inducción del parto ocurre cuando a una mujer embarazada le dan medicamentos o emplean otros métodos para iniciar su parto antes de que se desencadene naturalmente.

Su médico puede decidir inducirle el parto por razones como las siguientes:

- El embarazo ha durado más de 42 semanas
- Tiene la presión sanguínea elevada
- Se le rompe la fuente antes de tiempo
- No tiene suficiente líquido alrededor de su bebé
- El bebé no está creciendo bien
- Tiene problemas de salud, como por ejemplo diabetes, que pueden dañarla o dañar a su bebé

Algunas mujeres piden que sus médicos les induzcan el parto por motivos que no son médicos, como por ejemplo:

- Para tener al bebé temprano porque está cansada de estar embarazada
- Para tener al bebé cuando están sus familiares y amigos presentes
- Para coordinar el nacimiento del bebé con sus días de trabajo
- Para tener al bebé temprano para que su médico pueda estar en el parto

No es una buena idea inducir el parto si no hay

problemas con el embarazo.

La inducción del parto puede afectar la salud de su bebé. Debido a que puede ser difícil saber la fecha en que quedó embarazada, la inducción del parto puede hacer que su bebé nazca demasiado temprano. Los bebés que nacen demasiado temprano pueden tener problemas para respirar y quizás necesiten atención adicional. Cuando la inducción del parto no funciona, es posible que tenga que tener un parto por cesárea.

Si su médico sugiere que le induzcan el parto, pregunte lo siguiente:

- ¿Por qué me tienen que inducir el parto?
- ¿Cuáles son los posibles riesgos para mí y para mi bebé si me inducen el parto?
- ¿Puedo esperar a tener el bebé naturalmente sin inducción?
- ¿Hay alguna otra opción?

Es importante que las mujeres embarazadas sigan embarazadas por lo menos por 39 semanas, y que no se induzca el parto si no hay una necesidad médica.

Goal

Help your client:

- Be aware of health hazards in her work environment
- Plan for ways to avoid such hazards

Background

An unborn baby is most vulnerable to harmful substances during the first 3 months of pregnancy. Birth defects involving the organs or limbs are most common in that period. Later in pregnancy, harmful substances can cause brain damage, low birth weight, or small-for-gestational age (SGA) babies. In most cases, the degree of damage depends on the amount of harmful substance the unborn baby was exposed to.

Steps to Take

For all clients:

- Discuss the handout *Keep Safe at Work* to see if she is exposed to any hazards at work. Help her plan how to avoid these.
- Ask about her work safety. Lifting objects that are bulky or very heavy may be a problem. Working more than 40 hours a week and standing more than 3 hours a day at work may also be a problem. Advise her to discuss her work safety with her health care provider.
- When in doubt about exposure to a substance, tell the client to avoid it at least for the first trimester, until you can get more information on the substance as it relates to pregnancy

Chemicals and other hazards at work can harm an unborn baby.

For at-risk clients:

For clients who are exposed to harmful substances at work:

- Advise her to inform her supervisor of her pregnancy and to ask about risks at her job. She can ask her supervisor for the Material Safety Data Sheets for the chemicals she works with. She can then discuss these data sheets with her health care provider.
- Ask if there is a safety office or employee relations office at her job, or perhaps a union representative, who can provide more information about the materials used at work
- Ask if she uses all the safety equipment that is available, or if she feels additional safety equipment (masks, gloves) is needed
- Discuss ways she can limit contact with hazardous materials by changing how she does her job
- Make a list of questions she should ask her health care provider about possible safety concerns
- Print out and review this handout with her – *If I'm Pregnant, Can the Chemicals I Work With Harm My Baby?* (see "Resources").
- If she wants more information, refer her to *Mother to Baby*, which is listed on the handout, *Keep Safe at Work*

For clients who consider leaving work on disability:

If a client considers leaving work on disability because she is exposed to unsafe conditions, review her legal rights with her.

- **Pregnancy Disability Leave.** This disability leave is provided by the client's employer. If pregnancy-related symptoms or problems force a woman to

work less or to stop work, she has a right to get the same disability benefits or leave as employees who are disabled by something other than pregnancy. An employee disabled by pregnancy is entitled to up to 4 months disability leave.

<https://www.dfeh.ca.gov/resources/frequently-asked-questions/employment-faqs/pregnancy-disability-leave-faqs/>

- **California State Disability Insurance.** Eligibility requirements include having a Social Security number, having SDI payments deducted from paychecks, and having a doctor determine that the woman is too disabled to work. Length of eligibility depends on the doctor's recommendations. For more information, call the Employment Development Department (look under "State Government" listings in front of the white pages in the phone book) or visit [http://www.edd.ca.gov/disability/State_Disability_Insurance_\(SDI\)_Eligibility.htm](http://www.edd.ca.gov/disability/State_Disability_Insurance_(SDI)_Eligibility.htm).
- **Legal advice related to pregnancy, disability, and discrimination.** Call the Advice and Counseling Hotline of Equal Rights Advocates at 1-800-839-4372 (available at limited times during the week).

Follow Up

If a client is exposed to dangerous substances, ask her at each visit how she is limiting her exposure to the substance. If referrals have been made, ask if she followed through and what recommendations she received.

Provide support for clients who need to make major changes in their jobs or home practices to avoid harmful substances.

Who is at Risk?

All pregnant women are at risk when they use chemicals. They should:

- Never mix cleaning liquids
- Get plenty of fresh air (open windows, use a fan) when using cleaning products or paints
- Limit the amount of time spent working with chemicals that produce fumes
- Not eat or drink around chemicals, or let them get on their skin
- Wear clothing and gloves that cover their skin
- Take care with pesticides, such as flea bombs and insect repellent

Women who work in these settings are at higher risk of exposure to harmful substances:

- A medical setting
- Manufacturing or a factory
- With paints or nail polish
- With strong solvents that end in "ene" (For example, "benzene" or "toluene")
- Agriculture, with pesticides
- As a printer
- As a chemist
- As a laboratory technician
- A dry-cleaning plant
- A toll booth
- As a housekeeper
- If someone she lives with comes home with chemicals on their clothes

Resources

Mother to Baby

Fact sheets on medications, herbal products, infections, vaccines, maternal medical conditions, illicit substances, and other common exposures such as paint, pesticides, hot tubs, etc.

English and Spanish

1-866-626-6847

Text: (855) 999-3525

<http://mothertobaby.org>

California Department of Public Health

Hazard Evaluation System and Information Service

Handout: *If I'm Pregnant, Can the Chemicals I Work With Harm My Baby?*

<https://www.cdph.ca.gov/Programs/CCDCPHP/DEODC/OHB/HESIS/CDPH%20Document%20Library/pregnant.pdf>

UC Davis Safety Services

"SafetyNet #108 - Pregnancy and Reproductive Hazards in the Workplace: Chemical and Radiological Hazards"

<http://safetyservices.ucdavis.edu/snfn/safetynets/snml/sn108/sn108>

Physical and Shift Work in Pregnancy: Occupational Aspects of Management

National Guideline Clearinghouse, USDHHS, AHRQ
<http://www.guideline.gov/content.aspx?id=48219>

National Pesticide Information Center

Oregon State University and the U.S. Environmental Protection Agency

Monday - Friday, 7:30 am to 3:30 pm

1-800-858-7378

Website is available in English, Spanish, Chinese, and Vietnamese.

www.npic.orst.edu

www.npic.orst.edu/health/preg.html

Occupational Safety and Health Administration (OSHA)

1-800-321-OSHA (6742) / TTY 1-877-889-5627

www.osha.gov

Facts About Pregnancy Discrimination

The U.S. Equal Employment Opportunity Commission

www.eeoc.gov/facts/fs-preg.html

Disability Insurance

Statewide Toll-Free Number

English 1-800-480-3287 / Spanish 1-866-658-8846

Monday – Friday, 8 am - 5 pm

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STEPS TO TAKE

Keep Safe at Work

Find out about your safety if you work:

- In a medical setting
- In manufacturing or a factory
- With paints or nail polish
- With strong solvents that end in “ene” (For example, “benzene” or “toulene”)
- In agriculture, with pesticides
- As a printer
- As a chemist
- As a laboratory technician
- In a dry-cleaning plant
- In a toll booth
- As a housekeeper



Are you lifting or standing a lot?

Lifting objects that are bulky or very heavy may be a problem. Working more than 40 hours and standing more than 3 hours a day at work may also be a problem. If you are lifting or standing a lot, discuss this with your health care provider.

Take care when you use chemicals:

- Never mix cleaning liquids
- Get plenty of fresh air when you clean or paint. Open windows. Use a fan.
- Limit the amount of time spent working with strong smelling chemicals
- Do not eat or drink around chemicals, or let them get on your skin
- Wear clothing and gloves that cover your skin
- You also need to protect yourself if someone you live with comes home with chemicals on their clothes

Get plenty of fresh air (open windows, use a fan) when using:

- Aerosol sprays
- Cleaning fluids or oven cleaners
- Paints, paint thinners, paint removers
- Varnishes
- Antifreeze
- Glue

Check with your doctor before using:

- Pesticides used in farming, industry, and at home (even flea bombs)
- X-rays at high levels
- Gases used to put patients to sleep (if you breathe them in)
- Mercury (if you breathe in or swallow it). It is used in doctor or dentist offices, or in labs.
- Toluene (if you breathe it in). Some glues, gasoline, and some paint thinners have toluene in them. If you sniff glue, it can cause health problems for you and your baby. Your baby can be born with birth defects or have other life-long problems.
- Lead (if you swallow it). You may use lead if you make batteries or work with paints, ceramics, and glass. You may also use lead in pottery glazing and printing.

If you need more information:

Mother to Baby
English and Spanish
1-866-626-6847
Text: (855) 999-3525
<http://mothertobaby.org>



Manténgase Segura en el Trabajo

Obtenga información sobre su seguridad si trabaja:

- En un entorno médico
- En una industria o en una fábrica
- Con pinturas o esmaltes para uñas
- Con solventes fuertes que terminan en “ene” en inglés (como por ejemplo “benzene” (bencina) o “toluene” (tolueno))
- En agricultura, con pesticidas
- En una imprenta
- Como química
- Como técnica de laboratorio
- En una planta de lavado a seco
- En una casilla de peaje
- Como empleada doméstica



¿Está de pie o levanta cosas a menudo?

Puede ser un problema levantar objetos grandes o muy pesados. También puede ser un problema trabajar más de 40 horas por semana y estar de pie más de 3 horas por día en el trabajo. Si está de pie mucho tiempo o levanta muchas cosas, hable sobre este tema con su proveedor de atención de la salud.

Tenga cuidado cuando usa productos químicos.

- No mezcle nunca los líquidos de limpieza
- Respire aire fresco en abundancia cuando limpie o pinte. Abra ventanas. Use un ventilador.
- Limite la cantidad de tiempo que pasa trabajando con productos químicos con olor fuerte
- No coma ni beba alrededor de productos químicos, ni deje que le toquen la piel
- Use vestimenta y guantes que le cubran la piel
- También necesita protegerse si alguien que vive con usted vuelve a su casa con productos químicos en la ropa

Respire aire fresco en abundancia (abra ventanas, use un ventilador) al usar:

- Rociadores en aerosol
- Productos de limpieza o limpiadores de horno
- Pinturas, diluyentes, disolventes
- Barnices
- Anticongelante
- Pegamento

Consulte con su médico antes de usar los siguientes:

- Pesticidas que se usan para agricultura, industria y en el hogar (incluso bombas anti pulgas)
- Rayos X en niveles altos
- Gases que se usan para dormir pacientes (si se inhalan)
- Mercurio (si lo inhala o traga). Se usa en consultorios de médicos o dentistas, o en laboratorios.
- Tolueno (si lo inhala). Algunos pegamentos, gasolina y algunos diluyentes de pintura contienen tolueno. Si inhala pegamento, puede causar problemas de salud para usted y su bebé. Su bebé puede nacer con defectos de nacimiento o tener otros problemas que duran toda la vida.
- Plomo (si lo traga). Puede usar plomo si fabrica baterías o trabaja con pinturas, cerámica y vidrio. También puede usar plomo para vidriar cerámica.

Si necesita más información:

Mother to Baby
Inglés y español
1-866-626-6847
Text: (855) 999-3525
<http://mothertobaby.org>

Goals

Help your client:

- Understand and identify oral health problems common to pregnant women
- Understand the possible relation between oral disease, such as periodontal or gum infection, and having a preterm and/or low birth weight baby
- Understand that dental caries (tooth decay) is a transmissible infectious disease and realize that she can lower the chances of transmitting the bacteria that cause dental caries to her baby
- Learn how to prevent dental and gum diseases

Background

Pregnancy is an especially important time for women to take care of their oral health. Pregnancy provides a “teachable moment” and may be the only time some women are eligible for dental benefits. Dental caries is the single most common chronic disease of childhood, and its prevalence can persist as individuals mature, including in pregnant women. Pregnancy can also contribute to certain conditions that may result in the need for dental care. Women should be aware of the following oral conditions during pregnancy:

- Tooth decay (caries)
- Gum disease (gingivitis)
- Loose teeth (tooth mobility)
- Dry mouth (xerostomia)
- Too much spit (excessive salivation)
- Loss of tooth surface (acid erosion of teeth)

Important information about dental caries (tooth decay):

Dental caries is the most common oral health problem and is caused by specific bacteria. Infants are not born with these bacteria. Mothers with active

Some women may have never been to the dentist or may have had very little or no dental care during their lives. Make every effort to refer these pregnant women to a dentist for a regular dental check-up and teeth cleaning.

tooth decay will have more decay-causing bacteria in their mouths than mothers with no tooth decay. Most infants get these bacteria from their mothers before their third birthday and are more likely to get cavities before the age of five. Therefore, a pregnant woman can reduce her child’s risk of developing early tooth decay by improving and maintaining her own oral health as soon as possible.

Gingivitis (gum disease)

Gingivitis is defined as inflammation of the gingiva (gums) causing redness, swelling, and bleeding. This is one of the most common oral health problems seen during pregnancy. Its prevalence has been reported to range from 50% to 70% of all pregnant women. Most cases of gingivitis are caused by poor daily dental home care. Hormonal changes that happen during pregnancy can make the gingivitis worse.

If untreated, gingivitis may lead to periodontitis, a more serious chronic infection of the gums, ligaments, and bone supporting the teeth. Advanced periodontitis will cause tooth mobility, leading to tooth loss. Periodontitis may also contribute to preterm and/or low birth weight deliveries as well as cardiovascular disease, stroke, and other medical conditions. Diabetic patients with periodontitis may have a difficult time controlling their blood glucose levels. Poorly controlled diabetes before and during pregnancy can cause birth defects, miscarriage, or other complications.

Here are typical signs of gingivitis. The gums:

- Have a bright red color
- Are swollen
- Bleed easily when brushing and flossing

- Have a smooth and shiny surface
- May be sensitive or tender

Tooth Mobility (loose teeth)

Generalized tooth mobility may be seen in pregnant women. Tooth mobility may depend on how unhealthy the gums are and on small changes in the bone supporting the teeth during pregnancy. This condition usually goes away after delivery. However, tooth mobility may also be associated with advanced periodontitis and may not go away after pregnancy. An examination by a dentist is needed to diagnose and treat the condition appropriately.

Xerostomia (dry mouth)

Some pregnant women may complain of dry mouth (xerostomia). Hormonal changes may contribute to this condition, which should go away after delivery.

Excessive Salivation (Too much spit)

This is a rare condition. It usually begins at 2 to 3 weeks of gestation and may stop at the end of the first trimester. In some cases, it can continue until the day of delivery. It may be caused by the inability of nauseous pregnant women to swallow normal amounts of saliva.

Acid Erosion of Teeth (loss of tooth surface)

This is a rare condition that may cause the enamel of teeth to wear away. Repeated vomiting of gastric contents associated with morning sickness, esophageal reflux, and bulimia may cause it.

Steps to Take

Dental Caries

Advise your client to do the following to prevent dental caries (tooth decay):

- Brush teeth with fluoride toothpaste at least twice a day, especially before going to bed
- Use a soft toothbrush
- Limit foods and drinks containing sugar to mealtimes only

Refer a pregnant woman for a dental visit if she has not been to a dentist in the past 6 months or if she has signs or symptoms of oral disease.

- Rinse with 0.05% sodium fluoride mouth rinse and/or chlorhexidine prescribed rinse
- Choose gum/lozenges containing xylitol 4-5 times a day, after eating
- Visit the dentist at least once a year, or as often as the dentist recommends, for cleaning, examination, and preventive treatments such as fluoride and dental sealants
- Dental care can improve her overall health and the health of her baby/other children

Gingivitis

Advise your clients to do the following to prevent gingivitis:

- Use a soft toothbrush
- Floss every day. Be sure to floss below the gum line, not just between the teeth.
- Follow prenatal nutrition guidelines to eat a healthy diet. Healthy oral tissue depends on a balanced diet with lots of fruits and vegetables. Remember that a balanced diet is good for the mother's overall health, as well as for her oral health and her baby's health.
- Take a daily prenatal vitamin and mineral supplement that includes folic acid. Low levels of folic acid in pregnant women have been linked to increased chances of cleft lips and palates in the newborn, as well as other medical complications. For more information, refer to the folic acid handouts in the "Nutrition" section.
- Do not smoke or use tobacco products
- Visit the dentist for a complete oral examination and tooth cleaning

Tooth Mobility

- If your client indicates she has loose teeth, refer her immediately to a dentist

Dry Mouth

Advise your client to:

- Drink more water and/or non-sugared, non-carbonated, and non-caffeinated beverages
- Use sugarless or xylitol candies, mints, and gums, 4-5 times a day, after eating
- Use a fluoride mouth rinse for 1 to 2 minutes at least once daily, especially before bedtime. Avoid using mouth rinses with alcohol, such as Listerine (it has 22% alcohol).
- Not smoke or use tobacco products and not drink alcohol
- Avoid excessively dry, spicy, or salty foods
- See the doctor or dentist. Dry mouth may be a symptom of a hidden medical condition.

Excessive Salivation

Let her know that there may not be much she can do about this. Advise your client to:

- Eat frequent, small, and balanced meals
- See the doctor or dentist. This may be a symptom of a hidden medical condition.

Acid Erosion of Teeth

Advise your client to:

- Read the “Steps to Take” handouts about nausea. Anything that helps reduce morning sickness/nausea will help avoid acid erosion of the teeth.
- Right after vomiting, rinse mouth with one teaspoon of baking soda in a cup of water, or with an over-the-counter mouth rinse and spit out. This will help protect teeth from the damaging action of stomach acid.
- Use a soft toothbrush and fluoride toothpaste, and use fluoride mouth rinse immediately before

Ask the women if she has any concerns/fears about getting dental care while pregnant. Based on her response, be ready to inform her that dental care is safe during pregnancy and address her specific concerns.

going to bed to help strengthen the surface of the teeth (remineralize) damaged by acid.

- Avoid drinking regular or diet carbonated sodas. They contain phosphoric and citric acids that can wear away tooth enamel if taken in large or frequent amounts

Other Considerations

Dental treatment during pregnancy:

- Professional dental care, including examinations, cleanings, and treatment, is safe and effective during pregnancy. Women should be encouraged to schedule a dental examination if one has not been performed in the past six months, or if a new condition has developed or is suspected. Urgent care can and should be provided without delay throughout pregnancy. Cosmetic or non-urgent care may be delayed until after delivery.
- Advise your client that dental emergencies, such as pain and infection, should be treated right away. Untreated gum or tooth infections and increased stress can harm the mother and may endanger the baby. All tooth decay should be treated as soon as possible.
- Assure your clients of the safety of X-rays, which are particularly important for dental emergencies and are safe during pregnancy if used selectively and with a lead apron and neck collar.
- Refer pregnant women to a dentist for additional advice and preventive treatment, such as fluoride and dental sealants. A sealant is a plastic resin that is usually applied to the chewing surfaces of the back teeth—premolars and molars. This plastic resin bonds into the depressions and grooves (pits

and fissures) of the chewing surfaces of back teeth. The sealant acts as a barrier, protecting enamel from plaque and acids.

Systemic vs. Topical Fluoride

Systemic prenatal fluoride supplements are not recommended for pregnant women. Recent research has proven that use by mothers is not effective in preventing cavities in their babies' teeth. However, a woman's own teeth will benefit from systemic and topical fluoride.

Systemic fluoride is fluoride that is swallowed by the individual, although any form of fluoride that bathes the teeth for any period of time also has topical effects.

Examples of systemic fluoride are:

- Fluoridated water
- Dietary fluoride supplements
 - ◆ Tablets
 - ◆ Lozenges
 - ◆ Vitamin-fluoride preparations
 - ◆ Liquids and drops
- Fluoridated salt (not available in the U.S.)
- Any other source of fluoride that is swallowed (e.g., many foods naturally have fluoride or are processed with fluoridated water)

Topical fluorides applied to the enamel surfaces of teeth to prevent decay cause an exchange of chemical compounds, remineralizing the tooth surface and making it less likely to decay. Topical fluorides are not intended to be swallowed.

Examples of topical fluoride are:

- Toothpaste
- Mouth rinse
- Fluoride gel, which is typically placed in a tray that is held in the mouth for several minutes
- Fluoride varnishes, a gel which is painted on the teeth

Advise the pregnant women that prevention, diagnosis, and treatment of tooth decay and gum disease (including dental X-rays and use of local anesthesia) are highly beneficial and can be done any time during pregnancy with no additional harm to her or her baby, as compared to risks associated with not getting care.

Oral Condition Associated with Low Birth Weight

When it occurs during pregnancy, a severe type of periodontal disease called periodontitis has been associated with preterm and/or low birth weight deliveries. Periodontitis is a severe, chronic inflammatory condition of the gingiva (gums) characterized by loss of attachment of the periodontal ligament and bony support of the tooth. Periodontitis is a more severe stage of gingivitis.

Several studies have suggested that untreated periodontal disease in a pregnant woman may lead to an increased risk of delivering a premature and/or low birth weight baby. Other studies have not confirmed this risk. Researchers theorize about the association between premature births and periodontal infection. One hypothesis is that periodontal infection can release bacteria and bacteria-produced toxins into the blood. These toxins may interfere with fetal development. Another theory is that periodontal infection causes an inflammatory reaction in the gums leading to a production of chemical mediators. These inflammatory mediators, produced by the mother's own immune system, may stimulate early cervical dilation and uterine contractions. Further research continues.

Dental Caries and the Risk of Passing of Bacteria from Caretaker to Infants and Toddlers

A growing body of scientific evidence suggests that dental caries (tooth decay) is an infectious and transmissible disease. The primary decay-causing bacterium in a mouth is *Streptococcus mutans*. The caries process usually begins with bacteria in saliva passing from the caretaker to the child after birth.

A mother who has untreated dental caries appears to be the most likely person to pass the bacteria from her saliva to her child's mouth. Dental disease-causing bacteria can also be transmitted to a child from the father, other family members, and other caretakers with similar behaviors.

Here are some ways the mother may lower the chances of passing oral bacteria to her child:

- Avoid sharing the child's eating utensils and food
- Avoid pre-chewing or blowing on the child's food to cool it off
- Avoid licking the child's pacifier before giving it to the child
- Practice daily flossing and at least twice daily brushing with fluoridated toothpaste
- Do not share toothbrushes among family members
- Rinse with a prescribed chlorhexidine rinse
- Use xylitol gum/lozenges 4 to 5 times daily, after eating. To get the most benefit from a product, read the ingredient label; xylitol should be listed as one of the first 3 ingredients, preferably first.
- Have regular dental visits at least once a year, or as often as the dentist recommends

Making Referrals

Make sure you refer a pregnant woman to a dentist for an oral health examination if she:

- Has not been to the dentist in the past 6 months
- Shows any signs or symptoms of oral disease or trauma, such as tooth decay, mouth pain, swelling around the jaws, missing/broken/loose teeth, or sore and/or bleeding gums

Every woman who is considering pregnancy should have a dental examination, including a periodontal evaluation. Dental emergencies such as pain and infection should be treated immediately.

Dental plaque and poor brushing/flossing are the major causes of gingivitis during pregnancy, not increased hormone levels.

- **Dental caries (tooth decay):** The dentist should treat decayed teeth and introduce a preventive plan to reduce bacterial counts. The use of chlorhexidine rinses, xylitol chewing gum, and topical fluoride application during pregnancy may be useful in reducing the levels of decay-causing bacteria in the mother's mouth.
- **Gingivitis (gum disease):** If you suspect the pregnant woman has gum disease, which may include periodontal infection, refer her to a dentist immediately. Pregnant women should be made aware of the risks of periodontal disease and the problems it can cause them and their babies.

Clients enrolled in Medi-Cal programs may not realize they have dental benefits. Please refer to the following list of dental referrals to help clients find a dentist:

- Denti-Cal Program: 1-800-322-6384 for beneficiary services
www.denti-cal.ca.gov/WSI/Bene.jsp?fname=ProvReferral
- Children's Health and Disability Prevention (CHDP) Program
www.dhcs.ca.gov/services/chdp/Pages/countyoffices.aspx
- California Dental Association
www.cda.org/finddentist
- American Academy of Pediatric Dentistry
www.aapd.org/finddentist
- California Society of Pediatric Dentistry
<http://www.cspd.org/search/custom.asp?id=3139>
- California Primary Care Association - Community Clinic and Health Centers
<http://www.californiahealthplus.com/index.cfm/>

[find-my-health-center/](#)

Follow Up

- Some women may have had very little or no dental care during their lives. Make every effort to refer these women to the dentist for a dental check-up and teeth cleaning right away.
- During follow-up visits, make sure to ask about the last visit to the dentist and document the findings. If the mother has not seen a dentist since your last recommendation, make the referral again.
- Note any changes that the client might report about her oral health and make appropriate referrals.
- Provide the patient with handouts provided in this guide on how to take care of her mouth at home before, during, and after pregnancy.
- Dental caries (tooth decay) is a transmissible infectious disease. Mother, father, and other family members can transmit the bacteria that cause dental caries to their children. Remind mothers that appropriate brushing and flossing to remove and control decay-causing bacteria from their mouths will benefit both them and their babies. In addition, remind mothers not to share their children's food and utensils.
- Encourage mothers to take their child for their first dental visit by age 1 as recommended by the American Academy of Pediatrics, the American Academy of Pediatric Dentistry, and the American Dental Association. However, be aware that not all dentists are comfortable seeing such young children. Mothers may need to ask their babies' pediatricians for an appropriate referral.

Some studies have suggested that untreated periodontal infection in a pregnant woman may lead to an increased risk of delivering a preterm and/or low-birth weight baby

To help a mother enroll her child into a public insurance program or find a dental provider that accepts this insurance, call to do a warm transfer:

- 1-800-322-6384 for information about Medi-Cal dental insurance (Denti-Cal), or look on the Medi-Cal website under "Find a Dentist" at: www.denti-cal.ca.gov/WSI/Bene.jsp?fname=ProvReferral

Resources

For Clients: The following brochures are highly recommended and are available in English and Spanish by the National Institute of Dental and Craniofacial Research. They are available FREE OF CHARGE at: www.nidcr.nih.gov/ or you can call 1-866-232-4528. Additional publications are available.

- A Healthy Mouth for Your Baby
- The Tooth Decay Process: How to Reverse It and Avoid a Cavity
- Open Wide and Trek Inside
- Seal Out Tooth Decay

For Clients and Professionals: A large variety of oral health materials are available by contacting the National Maternal and Child Oral Health Resource Center at 1-202-784-9771 or by visiting www.mchoralhealth.org. Some may be available free of charge. Some examples of publications include:

- A Healthy Smile for Your Baby: Tips to Keep Your Baby Healthy
- A Healthy Smile for Your Young Child: Tips to Keep Your Child Healthy
- Two Healthy Smiles: Tips to Keep You and Your Baby Healthy
- Taking Care of Your Oral Health When You Are Pregnant
- Taking Care of Your Baby's Oral Health
- Getting Fluoride for Your Child



Prevent Gum Problems When You Are Pregnant

It is common to have gum problems when you are pregnant.

Your gums may swell and bleed. This is called gingivitis or gum disease. When you are pregnant, gum disease can get worse. It is important to brush your teeth often while you are pregnant.



Here's what you should watch out for:

- Your gums may be a very bright, shiny red color
- Your gums may look swollen
- Your gums may bleed easily when you brush or floss

If you have any of these signs, see a dentist right away.

Why worry about gum disease?

You may think that gum disease is not that important. But you should know that:

- Your gum disease can cause serious problems for your baby. You may have a much higher chance of your baby being born too early, too small, or both.
- Your gum disease could get worse. The gums, bone, and tissues around your teeth may pull away from the teeth. If you don't get treated, you could lose your teeth.

Here's what you can do to prevent gum disease:

- Brush your teeth at least twice a day, or more
- Use a soft toothbrush
- Brush your teeth with fluoride toothpaste
- Brush and floss before you go to bed
- Use a fluoride mouth rinse right before you go to bed, so the benefits will last all night long while you sleep
- Floss every day. This will help you clean between your teeth
- Eat healthy foods. Eat foods high in vitamin C and folic acid, such as oranges and cereals with folic acid added.
- Go to the dentist to get your teeth and gums cleaned and checked





Cómo Prevenir Problemas en las Encías Cuando está Embarazada

Es común tener problemas en las encías cuando está embarazada.

Sus encías pueden inflamarse y sangrar. Esto se llama gingivitis o enfermedad de las encías. Cuando está embarazada, la enfermedad de las encías puede empeorar. Es importante que se cepille los dientes frecuentemente cuando está embarazada.

Preste atención a lo siguiente:



Sus encías pueden tomar un color rojo muy intenso y brillante.

Sus encías pueden parecer inflamadas.

Sus encías pueden sangrar fácilmente cuando se cepilla o usa el hilo dental.

Si tiene alguno de estos signos, vea a un dentista de inmediato.

¿Por qué preocuparse sobre la enfermedad de las encías?

Puede creer que la enfermedad de las encías no es tan importante. Pero debería saber que:

La enfermedad de las encías puede causar graves problemas a su bebé. Usted podría tener un riesgo mucho más alto de que su bebé nazca muy pronto, muy pequeño o ambas cosas.

La enfermedad de las encías podría empeorar. Las encías, los huesos y los tejidos que rodean sus dientes podrían separarse de los dientes. Si no recibe tratamiento, podría perder dientes.

Para prevenir la enfermedad de las encías puede hacer lo siguiente:

Cepílese los dientes por lo menos dos veces por día, o más.

Use un cepillo de dientes de cerdas suaves.

Cepílese los dientes con pasta dentífrica con fluoruro.

Cepílese los dientes y use hilo dental antes de acostarse.

Use enjuague bucal con fluoruro justo antes de acostarse, de manera que los beneficios duren toda la noche, mientras duerme.

Use hilo dental todos los días. Esto la ayudará a limpiar entre los dientes.

Coma comidas sanas. Coma alimentos con mucha vitamina C y ácido fólico, como naranjas y cereales con ácido fólico agregado.

Vaya al dentista para que le limpie y examine los dientes.





See a Dentist When You Are Pregnant

It's important to take care of your teeth and gums when you are pregnant.

If you have Medi-Cal, call 1-800-322-6384 for more information about dental insurance.

If your teeth and gums are not healthy, you and your baby can have problems:

- You may have pain and tooth decay
- You may have bleeding gums
- You may lose your teeth
- Your baby may be born too early, too small, or both
- Your baby may get tooth decay later on from the germs in your mouth

For all these reasons, it is important to see a dentist when you are pregnant.

- If you do not have a dentist, ask your health care provider for a referral

You should:

- See a dentist for a check-up
- Get your teeth cleaned
- Get the treatment you need if you have tooth decay or other dental problems

You should see a dentist right away if:

- You have not been to a dentist in the last year
- You have pain in your mouth
- Your gums often bleed
- You have lumps, sores, or anything else that is not normal in or around your mouth

Your dentist may say you need X-rays. It can be safe to have X-rays while you are pregnant. Be sure that you:

- Tell your dentist you are pregnant
- Wear a lead apron over your stomach and a lead collar around your neck while you have X-rays done
- Have X-rays only when needed





Ve a al dentista si está embarazada

Es importante cuidar sus dientes y sus encías mientras está embarazada.

Si tiene Medi-Cal, llame al 1-800-322-6384 para recibir más información sobre seguros dentales.

Si no tiene dientes y encías saludables, tanto usted como su bebé pueden tener problemas:

- Usted puede sentir dolor y tener caries.
- Puede tener encías sangrantes.
- Puede perder sus dientes.
- Su bebé puede nacer prematuramente, ser muy pequeño o ambas cosas.
- Luego del nacimiento, su bebé puede llegar a tener caries de las bacterias de su boca.

Por todas estas razones es importante que visite al dentista si está embarazada:

- Si no tiene un dentista, pídale a su médico una referencia para un dentista.

Usted debería:

- Ver al dentista para una revisión dental.
- Hacerse una limpieza dental.
- Hacer el tratamiento que necesite en caso de tener caries u otros problemas dentales.

Usted debería ver al dentista inmediatamente si:

- No ha visto al dentista en el último año.
- Tiene dolor en la boca.
- Sus encías sangran con frecuencia.
- Tiene bultos o úlceras o cualquier otra cosa que puede no ser normal en su boca o alrededor de ella.

Es posible que su dentista le diga que necesita radiografías. Puede ser seguro sacarse radiografías si está embarazada. Asegúrese de:

- Decirle a su dentista que está embarazada.
- Usar un delantal de plomo sobre el vientre y un cuello de plomo mientras le hacen la radiografía.
- Sacar las radiografías solamente cuando sea necesario.





Keep Your Teeth and Mouth Healthy! Protect Your Baby, Too.



You can protect your teeth.

It is important to:

- Brush with fluoride toothpaste at least twice every day using a soft toothbrush
- Floss your teeth every day

See a dentist right away if you have:

- A toothache
- Sore or bleeding gums
- A broken tooth
- Pain or swelling inside your mouth
- Any other dental problem

Get your cavities filled before your baby is born.

- Germs in your mouth cause tooth decay
- You can pass tooth decay germs in your mouth to your baby
- Your baby can get cavities from the germs in your mouth that you have passed to them

Here's how you can prevent your baby from getting cavities:

- Take care of your own teeth
- Never share your baby's spoon or fork
- Don't taste your baby's food or blow on it to cool it, before giving it to your baby
- Clean your baby's pacifier with water, not by licking it
- Clean your baby's teeth every day with a tiny dab or smear of fluoridated toothpaste
- Take your baby to see the dentist by age one



Puede proteger sus dientes.

Es importante que:

- Se cepille los dientes con un cepillo de cerdas suaves y con pasta dentífrica con fluoruro por lo menos dos veces todos los días
- Use hilo dental todos los días

Vea a un dentista de inmediato si tiene:

- Dolor de muelas
- Encías inflamadas o sangrantes
- Un diente roto
- Dolor o inflamación en la boca
- Cualquier otro problema dental

Arréglese las caries antes de que nazca el bebé:

- Los gérmenes pueden causar caries
- Puede contagiar los gérmenes de su boca que causan caries a su bebé
- Su bebé puede tener caries debido a los gérmenes que usted le transmita

Para evitar que su bebé tenga caries:

- Cuídese sus propios dientes
- Nunca comparta con su bebé una cuchara o tenedor
- No pruebe la comida de su bebé ni la sople para enfriarla antes de dársela
- Limpie el chupón de su bebé con agua, no chupándolo
- Lávele los dientes a su bebé todos los días con una pequeña cantidad de pasta dentífrica con fluoruro
- Lleve a su bebé a ver al dentista cuando cumpla 1 año

Goals

Help your client:

- Understand that dental caries (tooth decay) is a transmissible infectious disease and learn how to reduce the caretaker-to-child transmission of decay-causing bacteria
- Understand and identify tooth decay and other oral problems common in infancy and early childhood, as well as common dental emergencies
- Understand that tooth decay impacts children's functioning, including eating, sleeping, speaking, learning, and growth
- Learn how to prevent dental disease in their child, and even though primary teeth are temporary, tooth decay can occur which can cause problems with their permanent teeth.
- Understand the importance of starting infants off with good oral care to help protect their teeth for decades to come
- Establish a regular source of oral health care (a "dental home") for their child by age 1

Background

Dental caries (tooth decay) is the most common chronic condition affecting children in the U.S. In California, a 2005 study found that 54% of kindergartners had experienced tooth decay and 28% of kindergartners had active untreated tooth decay.

Primary (baby) teeth begin to develop prenatally at 5 to 6 weeks of pregnancy. The first primary teeth usually start to erupt by the time the baby is 6 months old. By age 2 or 3 years, a child has the complete set of 20 primary teeth.

By age 6 or 7 years, the 4 permanent first molar teeth will erupt. These are the first permanent (adult) teeth to erupt and they erupt right behind the last primary teeth.

Many children who are eligible for dental insurance are not enrolled. All children who have Medi-Cal insurance also have dental coverage under Denti-Cal but parents or caregivers may not know it. Refer parents to a Denti-Cal provider and assure follow-up.

Parents and caregivers should pay special attention to these teeth because they should last a lifetime!

Early Childhood Caries

Tooth decay in children aged 5 years or less is also known as Early Childhood Caries (ECC), sometimes referred to as Baby Bottle Tooth Decay. This type of tooth decay is caused mainly by inappropriate feeding practices in the presence of *Streptococcus mutans*, the primary bacteria involved in the development of dental caries. ECC primarily affects the 4 upper front baby teeth, but may involve other teeth as the decay spreads. The overall prevalence of ECC is believed to be 5% among children below the age of 5 years in the U.S. However, in minority populations, such as among Native Americans, the rate of ECC can be as high as 70%.

A pregnant woman should be informed of common oral health conditions that may affect her baby as well as ways to prevent and/or treat these conditions.

To prevent ECC tell your client:

- Starting at birth, wipe baby's gums clean with a soft washcloth and water after every feeding
- The last thing to touch baby's gums or teeth before bedtime should be a toothbrush or water
- Do not put baby to sleep with a bottle containing anything other than water
- Do not bottle feed with sugar-containing substances such as juice and soda. When juices are offered, they should be from a cup
- Teach baby to drink from a cup by age 1; do not bottle feed baby after 12 months.

- If the baby likes to carry around a training (sippy) cup, make sure it only contains water. In this case, teach baby to drink from a regular cup instead of a sippy cup
- Do not use pacifiers dipped in honey, syrups, or other sugars
- Do not give baby honey at all before age 1

Important Information

Bacterial Transmission to Children

Dental caries (tooth decay), including ECC, is an infectious and transmissible disease. Dental caries results when bacteria in the mouth metabolize certain foods and sugars to produce acids that destroy (demineralize) tooth surfaces and underlying tooth structure resulting in a cavity. The primary bacterium causing tooth decay is *Streptococcus mutans*. The caries process usually begins with the passing of bacteria to the child from the caretaker's mouth, usually the mother. A mother who has untreated dental caries appears to be more likely to pass the bacteria to her child. Decay-causing bacteria can also be passed to a child from the father, other family members, and other caretakers.

How does the transmission occur?

Some likely ways of passing bacteria in the caregiver's saliva to the child's mouth are:

- Caregiver and child share eating utensils and food
- Caregiver pre-chews or blows on the child's food to cool it off
- Caregiver shares the same toothbrush with the child
- Caregiver "cleans" the child's pacifier by licking it

How to reduce caretaker-child transmission:

- The caretaker should have any active tooth decay treated by a dentist as soon as possible
- A dentist or physician may prescribe antimicrobial (germ killing) rinses like chlorhexidine during the

Note about breastfeeding: Although breastfeeding babies have much lower rates of ECC, breastfeeding does not completely protect babies from caries. Some breastfed babies, who feed at will for an extended period of time, may develop a pattern of caries similar to that found in ECC.

prenatal and postnatal periods, and make other efforts to decrease the levels of *Streptococcus mutans* in the mother's mouth

- Xylitol chewing gum may be recommended, 4-5 times a day, after eating. Xylitol can kill *Streptococcus mutans* and other decay-causing bacteria and does not cause tooth decay.
- The caregiver should not share utensils, food, or toothbrush with the child, nor lick the pacifier

Why early prevention and treatment for the child?

- If tooth decay goes untreated during the first years of life, the child is more likely to have cavities in both the primary and permanent teeth
- Attention to a child's oral health will prevent pain and the complications associated with tooth decay and cavities

Steps to Take

Ideally, infant oral care begins with prenatal oral health counseling for parents.

How to help parents prevent dental caries from occurring:

1. Educate Parents. Discuss the following 3 topics with clients:

- Examining baby's teeth each week
- Good food and drink choices
- Importance of fluoride for healthy teeth

Examining baby's teeth each week

Parent lays the child's back into the parent's lap with the child's head next to the parent's belly, tilts the child's head back, lifts the child's lip and

looks for early signs of tooth decay (chalky white areas or brown stains near the gum line). This should be done at least once a week.

- Starting at birth, wipe baby's gums clean with a soft washcloth and water after every feeding and before bedtime
- Parents should clean newly erupted teeth (teeth that have pushed through the gums) with a soft child's toothbrush and a tiny dab or smear of fluoride toothpaste
- Each child should have their own small, soft toothbrush
- Children should be given new toothbrushes every 3 months, if possible
- Parents should continue to supervise and brush their children's teeth until about age 6-8 years

Good food and drink choices

The food a baby is given can affect their teeth. To help their child, parents can:

- Choose foods that do not have a lot of sugar in them. High fructose corn syrup is type of liquid sugar commonly found in processed foods and drinks. Sugar combined with bacterial plaque creates acid that destroys teeth.
- Give a child fresh fruits and vegetables instead of candy, cookies, and juice drinks.
- Do not put the baby to sleep with a bottle containing anything other than water
- Avoid sweets between meals. Save sweets for dessert after a meal.

Importance of fluoride for healthy teeth

- As soon as teeth start to erupt (push through the gums) into the mouth, parents should start brushing their children's teeth every day with a soft toothbrush and fluoride toothpaste

Remember: the American Academy of Pediatric Dentistry recommends the child's first dental visit by age 1.

- Limit the amount of toothpaste to a tiny dab or smear to minimize fluoride ingestion
- Parents should also be advised to teach their children to spit out the toothpaste during and after brushing
- Inform parents about the need to use fluoride supplements if the community water is not fluoridated. Parents should contact their dentist or physician for a prescription
- Ask the child's dentist or pediatrician about the need for a topical fluoride application, such as fluoride varnish. Medi-Cal medical providers can apply fluoride varnish up to 3 times a year for children under age 6.
- Mothers and other caregivers should use antimicrobial (germ killing) fluoride mouth rinses

Because a mother can transmit decay-causing bacteria to a child, the control of her own oral health is the key in preventing the transmission of bacteria to the child. Chewing xylitol gum for 5 minutes, 4 to 5 times a day, after eating, will help reduce the level of these bacteria in her mouth.

2. Take the child to a pediatric dentist or general dentist within the first year of life or as soon as the first tooth comes in.

Not all dentists are comfortable seeing very young children, so you may need to help your patients identify dentists trained to see children. The child's pediatrician may be able to do an initial oral health assessment, help the parent with home care advice, and give referrals to oral health professionals.

- This is a good opportunity for early detection and prevention of Early Childhood Caries (ECC)

- Parents will learn about various forms of fluoride, including fluoride supplements if the local water is not fluoridated
- Parents will learn how to take care of a child's teeth and gums
- Parents should be motivated to take care of their child's oral health as well as their own

Dental Emergencies

Injury to teeth is the most common cause of a dental emergency. The incidence of injuries among children increases with age, due to children's increasing activity. The most common injuries are to the upper front teeth and surrounding soft tissues. Some of the most common injuries are fractured crowns (broken or cracked tooth), intrusions (tooth is pushed into the gums), and avulsions (tooth is knocked out of its socket). Soft tissues such as the cheek, tongue, and lips may be cut, lacerated, and bruised.

Dental abscesses usually result from untreated caries (tooth decay), trauma to the tooth, and/or foods/objects wedged between tooth and gums. Symptoms may include pain, swelling, and/or a small pimple on gum tissue.

What to do in case of dental emergencies (for baby teeth – up to age 5 years):

Cut or Bitten Tongue, Lip, or Cheek

- If bruised areas are present, apply ice
- If bleeding is present, apply direct pressure to the area with gauze or cloth
- If swelling is present, apply a cold compress
- If bleeding cannot be controlled immediately, take the child to a dentist or hospital emergency room

If a baby tooth is knocked out:

- Primary teeth should not be replanted (it could cause damage to the permanent tooth bud in formation)

Dental caries is a transmissible infectious disease. The mother and other caretakers can transmit the bacteria that cause tooth decay (caries) to the baby.

- Take the child to a dentist immediately

Bleeding after primary (baby) tooth falls out

- Pack a clean gauze or cloth over the bleeding area. Have the child bite on the gauze with pressure for 15 minutes. Repeat this 1 to 3 times.
- If bleeding persists, take the child to a dentist

Dental abscess

- Take the child to the dentist immediately. Infection from a badly decayed tooth may travel to the brain and, in rare cases, cause death.

Follow Up

- Remind the mother about the importance of maintaining her own oral health as well as her child's oral health
- Remind the mother about the concept of mother-to-child transmission of decay-causing bacteria. Ask her if she has any additional questions
- Ask if the mother and her baby have visited the dentist. If not, make appropriate referrals for both. The child's first visit to the dentist should be by age 1 year, or as soon as the first tooth erupts (pushes through the gum)
- Remind the mother to clean her baby's teeth, especially before putting the baby to bed. Also, remind the mother to examine her child's teeth at least once a week.
- Ask the mother about the baby's feeding habits to prevent Early Childhood Caries. Remind the mother that around 6 months of age, the baby should begin to drink from a cup.

The younger the child when tooth decay (caries) begins, the greater the risk of future decay in both the primary (baby) and permanent teeth.

Making Referrals

Remember: Many children who are eligible for dental insurance don't have it! Other children who are currently enrolled in Medi-Cal may not know they already have dental coverage and will need a referral to a dental office or clinic that accepts this insurance.

To help a mother enroll her child into a public insurance program or find a dental provider that accepts this insurance, call to do a warm transfer. Call to make an appointment for the mom or child and hand the phone to the mother once you talk with a customer service representative to make an appointment.

Denti-Cal (Medi-Cal) Program: 1-800-322-6384 (beneficiary services), if the client is already enrolled in Medi-Cal. If the client is not already enrolled, refer to your local county social services agency for eligibility determination.

For more resources, refer to the local Child Health Disability Prevention Program (CHDP) at: <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/OralHealthProgram/OralHealthProgram.aspx>

Your local dental society - listings are in the phone book or online

Also refer to the CDPH Oral Health Program web page at: <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/OralHealthProgram/OralHealthProgram.aspx>

Resources

For additional publications, other patient educational materials (many of them are available FREE OF CHARGE), directories, and resource guides, contact the:

National Oral Health Information Clearinghouse

nidcrinfo@mail.nih.gov

1-866-232-4528

<http://www.nidcr.nih.gov/EducationalResources>

One of its free publications is: A Healthy Mouth for Your Baby brochure. This easy-to-read brochure is for parents with infants or toddlers. It highlights the importance of using fluoride to protect teeth, cleaning your baby's teeth, and preventing baby bottle tooth decay. It is available in English and Spanish and should be ordered online.

National Maternal and Child Oral Health Resource Center

Georgetown University

2115 Wisconsin Avenue, N.W., Suite 601

Washington, DC 20007-2292

OHRInfo@georgetown.edu

1-202-784-9771

1-202-784-9777 (fax)

<http://mchoralhealth.org/toolbox/professionals.php>

An informative book available to download is:

Bright Futures in Practice: Oral Health—Pocket Guide –

This resource is designed to help health professionals implement specific oral health guidelines during pregnancy, postpartum, infancy, early childhood, middle childhood, and adolescence. It addresses risk assessment for dental caries, periodontal disease, malocclusion, and injury. A PDF file version can be found at: www.brightfutures.org/oralhealth/about.html.

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Protect Your Baby from Tooth Decay



Even babies can get tooth decay. You can protect your baby!

You may not know that:

- Your baby can get cavities from the germs in your mouth!
- You or other caregivers can spread these germs to your baby with your/their saliva

These tips can help:

- Get a dental check-up and the treatment you need
- Make sure your own teeth and mouth are healthy
- Never share your baby's spoon or fork
- Don't chew your baby's food or blow on it to cool it, and then give to your baby
- Clean your baby's pacifier with water, not by licking it

When your baby is born – 1 year

- Clean your baby's gums and any teeth every day. Most babies get their first teeth around 6 months of age.
- Use a moist, soft, child's toothbrush or a clean, soft washcloth and water
- Clean your baby's gums and teeth once or twice a day, especially before bedtime
- The last thing to touch the baby's gums or teeth before bedtime should be a toothbrush or water
- Don't put your baby to bed with a bottle. If your baby falls asleep at the bottle, take it out of the baby's mouth.

6 months – 1 year

- Let your baby drink with a cup when your baby is 6 months old
- Some babies like to carry around a bottle or training cup. Make sure it has only water in it.
- Don't let your baby use a bottle after 1 year. Use a regular cup, not a sippy cup.
- As soon as your baby's first tooth comes in, check every week for early signs of tooth decay. Look for chalky white areas or brown stains near your baby's gums. If you see any, take your baby to the dentist right away.

Take your baby to the dentist after your baby gets his first tooth. Make sure your baby sees the dentist by age 1.



Protect Your Baby from Tooth Decay

1 – 2 years

- Stop bottle-feeding
- Some babies like to carry a training cup around. Make sure it has only water in it.
- Don't give your baby sweet snacks between meals
- Clean your child's gums and teeth with a washcloth or soft toothbrush and a very small dab of fluoride toothpaste
- Check every week for early signs of tooth decay. Look for chalky white areas or brown stains near your baby's gums. If you see any, take your child to the dentist right away.
- Take your child to the dentist for an exam. Ask about fluoride and sealant treatments.

2 – 3 years

- Check every week for early signs of tooth decay. Look for chalky white areas or brown stains near your baby's gums. If you see any, take your child to the dentist right away.
- Brush your child's teeth, or watch your child brush, 2 or 3 times a day. Be sure your child brushes before bedtime.
- Use a tiny dab of fluoride toothpaste with every brushing
- Teach your child to spit out the toothpaste after brushing
- Stay away from sugary drinks like juice or soda
- Don't give your child too many snacks like cookies and candy. Sweet foods help cause tooth decay. Instead, give whole grain foods, nuts, fruits, and vegetables for a healthier diet.
- Take your child to the dentist for an exam. Ask about fluoride and sealant treatments.



When you take care of your baby's teeth early on, you will:

- Protect your baby from pain
- Lower the chances your child will have cavities now or when he or she is older
- Help your child have healthy teeth for a lifetime

Proteja a su bebé de las caries

Aun los bebés pueden llegar a tener caries. ¡Usted puede proteger a su bebé!

¿Sabía que...?:

- ¡Su bebé puede contraer caries de las bacterias de su boca!
- Usted u otros cuidadores pueden transmitir los gérmenes al bebé a través de la saliva.

Estas sugerencias pueden ayudarla:

- Hágase un chequeo dental y realice el tratamiento que necesite.
- Asegúrese de mantener una boca y dientes sanos.
- Nunca comparta la cuchara o el tenedor con su bebé.
- No muerda la comida de su bebé ni la sople para enfriarla antes de dársela.
- Limpie el chupón de su bebé con agua y no chupándolo.
- Limpie todos los días las encías y cualquier diente que tenga su bebé. A la mayoría de los bebés les salen sus primeros dientes alrededor de los 6 meses de edad.
- Use un cepillo de dientes para niños de cerdas suaves y húmedo o un paño limpio y agua.
- Limpie las encías y los dientes de su bebé una o dos veces por día, en especial antes de que se vaya a dormir.
- Lo último que tiene que estar en contacto con las encías y los dientes de su bebé antes de que se vaya a dormir tiene que el cepillo de dientes o agua.
- No ponga a dormir a su bebé con el biberón. Si su hijo se duerme tomando el biberón, retíreselo de la boca.

Nacimiento a 1 año

6 meses a 1 año

- Cuando su bebé tenga 6 meses de edad, permítale beber de una taza.
- A algunos bebés les gusta llevar a todos lados su biberón o taza entrenadora. Asegúrese de que esta contenga solamente agua.
- No permita que su bebé use el biberón después del año de edad. Use una taza normal, no una tasa para bebés.
- Tan pronto como le salga el primer diente a su bebé, revíselo cada semana para detectar los primeros signos de caries. Busque áreas de color blanco o café cerca de las encías de su bebé. Si llegara a ver alguna, lleve a su bebé al dentista inmediatamente.

Lleve a su bebé al dentista cuando le salga su primer diente. Asegúrese de que su bebé vea al dentista antes del año de edad.



Proteja a Su Bebé de las Caries

1 a 2 años

- Deje de usar el biberón para alimentar a su bebé.
- A algunos bebés les gusta llevar a todos lados una taza entrenadora. Asegúrese de que ésta contenga solamente agua.
- No le dé a su bebé bocadillos dulces entre comidas.
- Lave las encías y los dientes de su bebé con un paño o un cepillo de dientes de cerdas suaves y una pequeña cantidad de pasta de dientes con fluoruro.
- Revise los dientes de su bebé cada semana para detectar los primeros signos de caries. Busque áreas de color blanco o café cerca de las encías de su bebé. Si llegara a ver alguna, lleve a su hijo al dentista inmediatamente.
- Lleve a su hijo al dentista para una revisión dental. Pregunte acerca de los tratamientos con fluoruro y selladores dentales.

2 a 3 años

- Revise los dientes de su hijo cada semana para detectar los primeros signos de caries. Busque áreas de color blanco o café cerca de las encías de su hijo. Si llegara a ver alguna, lleve a su hijo al dentista inmediatamente.
- Cepille los dientes de su hijo, u observe como lo hace, 2 o 3 veces por día. Asegúrese de que su hijo se cepille los dientes antes de irse a dormir.
- Use muy poquita pasta de dientes con fluoruro en cada cepillado.
- Enséñele a su hijo a escupir la pasta de dientes luego de cepillarse.
- Evite bebidas con azúcar como jugos o refrescos.
- No le dé a su hijo demasiados bocadillos como galletas o dulces. Los alimentos dulces ayudan a causar caries. Elija alimentos más saludables como cereales integrales, nueces, frutas y verduras.
- Lleve a su hijo al dentista para una revisión dental. Pregunte acerca de los tratamientos con fluoruro y selladores dentales.

Al cuidar los dientes de su bebé desde tan temprana edad, usted:

- Protegerá a su bebé del dolor.
- Reducirá las probabilidades de que su hijo tenga caries cuando sea mayor.
- Ayudará a que su hijo tenga dientes saludables para toda la vida.



Goal

Help your client:

- Understand the importance of prenatal exercises (including Kegels)
- Know how to exercise and lift safely

Background

As the body changes, exercise can give a pregnant woman a sense of well-being, relaxation, and comfort. But certain precautions need to be taken during this time.

As pregnancy progresses and the baby weighs more, safe lifting techniques will become more important in preventing back strain or injury.

Some clients should not exercise during pregnancy.

Any client with the following risk conditions should not exercise during pregnancy. Risk conditions:

- Hypertension (high blood pressure)
- Leaking fluids from the vagina
- Preterm labor during a prior or current pregnancy
- Incompetent or weakened cervix
- Opening of the uterus that has been sewn closed to prevent a miscarriage or premature birth
- Persistent vaginal bleeding
- Slow growth of unborn baby (intrauterine growth restriction)

Steps to Take

For all clients without the risk conditions outlined above:

- Review with each client how to do Kegel exercises and other recommended pelvic exercises. See the handout *Exercises To Do When You Are Pregnant*.
- Encourage clients who have been exercising before pregnancy to keep exercising moderately. Exercise of low to moderate intensity is recommended up to 30 minutes per day. Exercise can be activities such as walking, dancing, or swimming. Review the handout *Stay Active When You Are Pregnant* with the client.
- Clients who have not exercised much should limit a new exercise program to 10 to 20 minutes per day.
- For more advanced exercise, discuss the handout, *Keep Safe When You Exercise*.
- Practice safe lifting techniques with clients.
- Back should be straight, knees bent, feet apart, 1 foot slightly ahead of the other.
- Brace the pelvic floor muscles and abdominal muscles (tense stomach area and bottom).
- Keep objects/children that are being lifted close to the body.
- Use leg muscles to do the work, rather than the back or abdomen.

For high-risk clients:

Refer to a medical practitioner to discuss exercise.

Follow Up

Review safe lifting techniques (see above) with clients, especially during the third trimester.

Clients who have toddlers, do housekeeping, or have jobs that require lifting are of special concern. Review safe lifting techniques at every visit for clients who lift often.

Resources

Pamphlets

American College of Gynecologists and Obstetricians

409 12th Street NW, Washington, DC 20024-2188

Pamphlet Distribution Center: 1-800-762-2264.

<http://www.acog.org/Patients>

ACOG Frequently Asked Questions FAQ119, "Exercise During Pregnancy"

ACOG Frequently Asked Questions FAQ115, "Easing Back Pain During Pregnancy"

ACOG Frequently Asked Questions FAQ045, "Exercise and Fitness"

March of Dimes: Exercise During Pregnancy

www.marchofdimes.com/pregnancy/physicalactivity_exercise.html



Exercises To Do When You Are Pregnant

These exercises are good for pregnant women to do:

1. Kegel Exercises

Before the 4th month:

- Lie on your back. Put a pillow under your head and neck.
- Let your arms lie next to your sides
- Bend your knees. Put feet about 12 inches apart. Keep your soles flat on the floor.
- Squeeze tight the muscles around your vagina and anus. Hold these muscles tight for about 5–10 seconds. You can find these muscles when you pee (urinate). Stop the flow for a second. Those are the muscles you want to tighten and relax.
- Slowly let your muscles relax
- Do Kegels up to 10-20 times in a row, at least 3 times each day

After the 4th month:

- Stand or sit to do Kegels
- Do not lie on your back. Your growing uterus can put too much weight on the large blood vessels in your back. You and your baby may not get enough oxygen if you lay on your back.
- Do Kegels up to 10-20 times in a row, at least 3 times each day

2. Pelvic Tilt

Before the 4th month:

- Lie on your back on the floor
- Press the small of your back against the floor while you let out your breath
- Relax your spine while you take in a deep breath
- Repeat this 5 times, twice a day, when possible



After the 4th month:

- Stand against a wall
- Press your back next to the wall while you let out your breath
- Then relax your spine while you take a deep breath
- Repeat this 5 times, twice a day, when possible
- Do not lie on your back. Your growing uterus can put too much weight on the large blood vessels in your back.

3. Angry Cat

Do this to take the weight of your uterus off your spine.

- Get on your hands and knees. Make your back flat.
- Keep your head and neck straight
- Arch up your back like an angry cat. Pull in your tummy muscles.
- Hold for 3 seconds
- Then relax. Make your back flat again.
- Do this 5 or 6 times each day. You can also do it when you are in labor.



Ejercicios para hacer durante el embarazo

Estos ejercicios son buenos para las mujeres embarazadas.

1. Ejercicios Kegel

Antes del cuarto mes:

- Acuéstese boca arriba. Coloque una almohada debajo de su cabeza y cuello.
- Deje los brazos a sus costados.
- Doble las rodillas. Separe los pies unas 12 pulgadas. Mantenga las plantas de los pies planas en el piso.
- Apriete los músculos alrededor de su vagina y ano. Manténgalos apretados por 5 a 10 segundos. Estos son los músculos que usa cuando orina (hace pipí). Detenga el flujo por un segundo. Estos son los músculos que necesita tensionar y relajar.
- Lentamente deje que se relajen los músculos.
- Haga hasta 10 a 20 Kegels seguidos, por lo menos 3 veces al día.

Después del 4to mes:

- Haga Kegels de pie o sentada.
- No se acueste boca arriba. Debido a que su útero está aumentando de tamaño, puede aplicar demasiado peso sobre los vasos sanguíneos grandes de la espalda. Puede ser que usted y su bebé no reciban suficiente oxígeno si se acuesta boca arriba.
- Haga hasta 10 a 20 Kegels seguidos, por lo menos 3 veces al día.

2. Inclinación de la Pelvis

Antes del 4to mes:

- Acuéstese boca arriba en el piso.
- Presione la parte inferior de su espalda contra el piso mientras exhala.
- Relaje su columna mientras inhala profundamente.



- Repítalo 5 veces, dos veces al día cuando sea posible.

Después del 4to mes:

- Póngase de pie contra una pared.
- Presione su espalda contra la pared mientras exhala.
- Luego relaje su columna mientras inhala profundamente.
- Repítalo 5 veces, dos veces al día cuando sea posible.
- No se acueste boca arriba. Debido a que su útero está aumentando de tamaño, puede aplicar demasiado peso sobre los vasos sanguíneos grandes de la espalda.

3. Gato Enojado

Haga este ejercicio para reducir el peso de su útero en la columna.

- Póngase a en cuatro patas. Haga que su espalda quede plana.
- Mantenga rectos su cabeza y cuello.
- Arquee su espalda como un gato enojado. Tensione los músculos de su vientre.
- Manténgalos tensionados por 3 segundos.
- Luego relájese. Vuelva a poner su espalda en posición plana.
- Haga este ejercicio 5 a 6 veces al día. También puede hacerlo durante el trabajo de parto.



Stay Active When You Are Pregnant

Here are good things to do when you are pregnant:

- Walk
- Swim (The water should not be too hot or too cold)
- Bicycle (You may want to use a stationary bike to protect you from falls that can happen as your uterus gets bigger)
- Do Kegel exercises (See the handout *Exercises To Do When You Are Pregnant*)
- Go to exercise classes for pregnant women
- Try to relax. You can sit in a chair or lay on your side. Breathe in through your nose. Breathe slowly out through your mouth.

If you were used to being active before you were pregnant, you may be able to:

- Jog up to 2 miles per day
- Swim
- Do exercises of low to moderate intensity for prenatal or postpartum women
- Lift weights (Do not hold your breath while you lift the weights)
- Ski cross-country below 10,000 feet
- Hike

When you are pregnant, you should NOT:

- Do exercises that might harm the abdomen
- Do exercises that involve jerky, bouncy motions
- Jog more than 2 miles per day
- Play contact sports like football or karate
- Ride horseback

It can also be dangerous to:

- Water ski, dive, surf, or scuba dive
- Ski downhill
- Bicycle when the ground is wet
- Skate



Always talk with your doctor before you start an exercise program. It is a good idea to try to exercise at least 30 minutes every day.



Manténgase Activa Durante el Embarazo

Lo que debe hacer y no debe hacer:

Las siguientes son buenas actividades para realizar cuando está embarazada:

- Camine
- Nade (el agua no debe estar demasiado caliente o demasiado fría)
- Ande en bicicleta (quizás quiera usar una bicicleta fija para protegerla de caídas que pueden ocurrir a medida que su útero aumenta de tamaño)
- Realice ejercicios de Kegel (Vea el folleto *Ejercicios para hacer durante el embarazo*)
- Acuda a clases de ejercicio para mujeres embarazadas
- Intente relajarse. Puede sentarse en una silla o acostarse de costado. Inhale por la nariz. Exhale lentamente por la boca.

Si estaba acostumbrada a ser activa antes del embarazo, es posible que pueda:

- Correr hasta dos millas por día
- Nadar
- Hacer ejercicios de intensidad baja a media para mujeres embarazadas o después del embarazo
- Levantar pesas (no sostenga la respiración cuando levante pesas)
- Realizar esquí de fondo a menos de 10,000 pies
- Realizar excursiones

Cuando está embarazada NO debe:

- Realizar ejercicios que pueden lastimar el abdomen
- Realizar ejercicios de movimiento con saltos y rebotes
- Correr más de dos millas por día
- Hacer deportes de contacto, como por ejemplo fútbol americano o karate
- Andar a caballo

También puede ser peligroso:

- Realizar esquí acuático, clavados, surfear o bucear.
- Realizar esquí de pista.
- Andar en bicicleta cuando el suelo está mojado.
- Patinar



Hable siempre con su médico antes de iniciar un programa de ejercicios. Es una buena idea intentar realizar por lo menos 30 minutos de ejercicio por día.



Keep Safe When You Exercise

Call your health care provider right away if you:

- Feel pain when you exercise
- Feel dizzy
- Are short of breath
- Think you might faint

There are other warning signs to watch for.

- Bleed or leak fluid from your vagina
- Have a rapid heartbeat when you rest
- Have a hard time walking
- Have pain or swelling in your calf
- Have contractions
- Have chest pains
- Have a headache

Follow these safety tips:

- Don't do anything that could hurt your abdomen. Stay away from karate and other contact sports.
- Avoid becoming overheated. Don't exercise in hot weather. Wear light clothing.
- Don't lie on your back after you are 4 months pregnant
- Stay away from activities that could lead to falls
- Don't do full sit-ups or leg lifts with both legs
- Bend your knees when you touch your toes
- Don't stand still for long periods of time

Get the food and water you need when you exercise:

- Drink plenty of water. You will need at least 8 glasses of water a day when you are pregnant.
- Drink extra water when you exercise
- Eat plenty of healthy food. Eat a healthy snack after you exercise.

After you give birth:

- Talk with your doctor about when to start to exercising again
- Go back to your exercise program slowly, as you feel you can
- Start out easy in the first few days after your baby is born
- Exercise longer and a little harder day by day



When you exercise, remember:

- You should be able to talk normally while exercising. If you are not able to have a normal conversation, you are causing your heart to work too hard.
- When you get tired, stop.
- Do not jerk, bounce, or jump.



Manténgase Segura Cuando Realiza Ejercicios

PASOS A SEGUIR

Llame a su proveedor de atención de la salud de inmediato, si:

- Siente dolor al realizar ejercicios físicos
- Se siente mareada
- Le falta el aire
- Siente que va a desmayarse

Hay otras señales de advertencia para tener en cuenta.

- Sangra o pierde líquido de la vagina
- Tiene latidos acelerados del corazón cuando descansa
- Tiene problemas para caminar
- Tiene dolor o inflamación en su pantorrilla
- Tiene contracciones
- Tiene dolor de pecho
- Tiene dolor de cabeza

Siga los siguientes consejos de seguridad:

- No haga nada que pueda lesionar su abdomen. Evite el karate y otros deportes de contacto.
- Evite recalentarse. No realice ejercicios físicos cuando hace mucho calor. Use ropa liviana.
- No se acueste boca arriba después del cuarto mes del embarazo
- Evite las actividades que podrían resultar en caídas
- No haga ejercicios abdominales ni de elevaciones de piernas con ambas piernas a la vez
- Doble las rodillas cuando se toca los dedos del pie
- No esté de pie sin moverse por largos períodos de tiempo

Obtenga la comida y agua que necesita cuando realiza ejercicios:

- Tome agua en abundancia. Tendrá que tomar por lo menos ocho vasos de agua por día cuando está embarazada.
- Tome agua adicional cuando realice ejercicios
- Coma comida saludable en abundancia. Coma un bocado saludable después de realizar ejercicios.

Después del parto:

- Hable con su médico sobre cuándo puede volver a hacer ejercicios físicos
- Vuelva lentamente a su programa de ejercicios, a medida que se sienta cómoda
- Empiece de a poco en los primeros días después del nacimiento de su bebé
- Empiece a hacer ejercicios más intensos por más tiempo todos los días



Cuando realice ejercicios físicos, recuerde:

- Debe poder hablar normalmente cuando mientras realiza los ejercicios. Si no puede llevar una conversación normal, está haciendo trabajar demasiado fuerte a su corazón.
- Cuando se cansa, pare.
- No realice movimientos entrecortados, rebotes o saltos.

Goal

Help your client:

- Identify risks associated with the use of tobacco
- Stop smoking or consider reducing smoking
- Seek treatment if she smokes

Background

Approximately 10-12% of women in the U.S. smoke cigarettes during pregnancy. Yet smoking during pregnancy is a major contributor for the following problems.

Health risks can be lessened as soon as a woman stops smoking. Stopping before the 4th month has the greatest benefits.

Complications during pregnancy:

- Serious problems with the placenta, such as placenta previa or placenta abruption
- Vaginal bleeding
- Miscarriage
- Preterm birth
- Stillbirth
- The risks from smoking increase the more a woman smokes and the longer she smokes. Pregnant women aged 35 and older who smoke are at higher risk for pregnancy complications. A decrease in smoking may lower the risk of harm to the unborn baby.

Complications for the infant and/or child in later years:

- Low birth weight and/or poor growth (small for gestational age (SGA))
- Sudden Infant Death Syndrome (SIDS)
- Birth defects and physical malformations such as cleft lip or cleft palate
- Learning disorders and behavioral problems

No amount of smoking is safe for pregnant women. Quitting or cutting down is a high priority.

Stages of Quitting

Smokers who quit smoking typically go through the following 6 stages of quitting. It is common to try to quit several times before being successful. Use the Stages of Quitting to assess the client's readiness to quit or cut down on using tobacco.

1. **No Interest:** not considering quitting or motivated to quit.
2. **Somewhat Interested:** uncomfortable with smoking but not seriously considering quitting.
3. **Preparation:** intends to quit in the near future; has made small changes in smoking behaviors.
4. **Action:** makes an effort to quit; has made a firm decision to quit; needs support techniques to cope with urges to smoke.
5. **Maintenance:** able to overcome the temptation to smoke; developing a nonsmoking habit, but still vulnerable to the urge to smoke.
6. **Relapse:** prompted to smoke by stress; disappointed and less confident that quitting is possible.

Note: Some pregnant clients want an early birth or small baby due to fear of labor and delivery. They may use this as a reason to keep smoking. Babies born preterm under these conditions are more likely to have severe and lasting disabilities and health problems (see *Preterm Labor Guidelines* for more information on risks for preterm babies).

Stopping before the 4th month has the greatest benefits, but any decrease is beneficial to the health of the pregnant woman and her unborn baby. "Light" or "mild" cigarettes are not a safer choice during pregnancy.

The baby will be healthier if the client does not smoke while breastfeeding. The chemicals in cigarette smoke are passed from the breast milk to the baby.

Smokeless tobacco (chewing or snuff) and water pipe smoking (hookahs, shisha) can also cause complications during pregnancy and increase health risks to the infant/child in later years.

Steps to Take

For clients who do not smoke: (using the Four As - see side panel)

Praise her healthy lifestyle and ask if she knows the dangers of smoking for her and her baby. Encourage her not to begin while she is pregnant—or ever!

For clients who do smoke:

State, “I am glad you told me about your use of tobacco. Its important information.”

ASK her about her tobacco use. Explain your medical concern, “I am concerned because I know that using tobacco during pregnancy can cause a child to be born too early or too small, to have learning problems or physical problems.”

ADVISE your client to stop smoking or to seek smoking cessation treatment, “I know that the best thing you can do for your child is to cut down or stop smoking.”

Let the client give you her reaction. Help her identify her readiness to quit or cut down.

Emphasize the positive:

- Stopping now will give her a better chance for a healthy baby.
- Her concern for her baby will help her be a good mother.
- She will feel better when she is not smoking.

ASSIST her by giving practical steps to quit or cut down, and give support during the process.

Give and review the handout *You Can Quit Smoking*. Point out the resources on the handout for help quitting.

Four As for encouraging women to quit smoking:

- **Ask:** about tobacco use at every contact with clients (smoking or contact with secondhand smoke).
- **Advise:** all tobacco users to consider quitting.
- **Assist:** according to client readiness/stage of change.
- **Arrange:** offer to arrange for follow-up/referral. Follow up at the next visit.

Keep the medical providers you work with informed of your discussion.

ARRANGE for her to seek additional assistance. If necessary, refer her to a smoking cessation program.

Consider referring her to another CPSP practitioner such as the psychosocial expert for more counseling and support. See *Substance Use/Abuse Guidelines* in the “Psychosocial” section.

If necessary, see resources on the next page for more information.

For clients not ready to quit or cut down: (using the Four As - see side panel)

If a client continues to smoke, even though she is aware of the possible risks for her and her baby, she can be considered to have a smoking addiction.

In-depth counseling is usually not in the scope of a CPHW. This can be done by a trained individual such as a psychosocial professional, or a smoking cessation program, or a trained CPHW.

However, it is still possible to help a client with her addiction to tobacco by following these steps:

State, “I am glad you told me about your use of tobacco. It is important information.”

ASK about her current tobacco use. Explain your medical concern, “I am concerned because I know that tobacco use during pregnancy can cause a child to be born too early or too small, have learning problems, or physical problems”

ADVISE your client to stop smoking or seek smoking cessation treatment, “I know that the best thing you can do for your child is to stop smoking.”

Let the client give you her reaction. **ASSIST** your client by helping her identify her readiness to quit or cut down. Provide steps to quit or cut down.

ARRANGE additional assistance as appropriate. Refer her to a smoking cessation program (See *Prenatal Substance Use/Abuse* resources in the “Psychosocial” section).

Keep the medical provider you work with informed of your discussion.

If the client wants to think about quitting or cutting back, review the handout *You Can Quit Smoking*.

Teens

Teens often smoke with friends and may need extra support to cut down or quit smoking. Appeal to their interest in their self-image as you explain the drawbacks of smoking:

- Odors in hair and clothes
- Fingers and teeth turn yellow or brown
- Bad breath and taste when kissing
- Dry skin with premature wrinkling
- Burns on clothing, upholstery, and carpets

You can also help a teen calculate the amount of money she spends each week or month on cigarettes and what other things she could buy with that money (music media, concert or movie tickets, maternity outfits, baby clothes, etc.).

Additional tips to help women quit smoking:

You can help women move through the stages of quitting with the following help:

- Review with her the health risks for her and her baby. The sooner she quits the more helpful it will be for the baby.
- Remind her that her family needs a healthy mother.
- Increase her awareness of the problems with smoking and benefits of not smoking.
- Give her quit tips.
- Support her when she decides to quit.
- Remind her about how to reduce stress and urges to smoke.
- Remind her to reward herself.
- Praise her for her accomplishment
- If she relapses, remind her that this is a small set back and that she can quit.
- Give her some materials on quitting that she can read.
- Refer her to a smoking cessation program in her community (see “Resources”).

Follow Up

At each visit, ask any client who uses tobacco how she is doing in limiting her use. Support any decrease in use.

If the client is using often and has set up an appointment in a smoking cessation program:

- Schedule extra appointments to support her efforts to quit or cut down her tobacco use.
- If the client tells you that sometimes she feels awful while she is cutting back, remind her that this is the effect of tobacco leaving her body, and that it takes time for the body to heal itself. Remind her that exercise, eating right, and getting plenty of sleep will help.

If the client is smoking often and has NOT set up an appointment in a smoking cessation program:

- Find out why the client has not done so.

- Brainstorm with her on how she can overcome any obstacles to going.
- Again, follow the guidelines above, “Steps to Take – For clients not ready to quit or cut down”.

Discuss the client’s tobacco use with other staff members, so all providers can support and encourage the client to quit and provide needed interventions. All staff should be aware of goals set by the client to give her support and encouragement.

Resources

The Tobacco Education Clearinghouse of California (TECC)

TECC provides a variety of low cost educational materials on tobacco use, smoking cessation, and secondhand smoke materials. Numerous materials are designed specifically for African-American, American-Indian, Asian/Pacific Islander, and Hispanic/Latina pregnant women.

To order materials:

www.TobaccoFreeCatalog.org

1-800-258-9090, ext. 103

1-831-438-4822, ext. 103 or ext. 230

1-831-438-1442 (fax)

tccorder2@tecc.org

ETR Associates/TECC

4 Carbonero Way, Scotts Valley, CA 95066

California Smokers’ Help Line

A free telephone service, sponsored by the California Department of Public Health and by First 5 California, for people who are ready to quit using tobacco. It offers telephone counseling, educational materials, quit kits, and referral services.

1-800-NoButts (direct line counseling service)

www.californiasmokershelpline.org

www.NoButts.org

For help to quit smoking call:

English: 1-800-NO-BUTTS or 1-800-662-8887

Spanish: 1-800-456-6386

Mandarin and Cantonese: 1-800-838-8917

Vietnamese: 1-800-778-8440

Korean: 1-800-556-5564

Deaf/Hearing Impaired: 1-800-933-4TDD or
1-800-933-4833

Chew/Smokeless Tobacco: 1-800-844-CHEW or
1-800-844-2439

For Teens - A smoking cessation: nobutts.ucsd.edu

SmokeFree.Gov

A website designed to help your client stop smoking today. It offers quit guides and phone and instant messaging counseling to help quit smoking. It also offers a mobile phone app for smart phones to help with smoking cessation. It also offers information and quit guides to pregnant women.

www.smokefree.gov

1-800-QUITNOW 1-800-784-8669 /

TTY 1-800-332-8615

American Cancer Society

1-800-227-2345

www.cancer.org

American Lung Association

1-800-LUNG-USA or 1-800-586-4872

National Headquarters 1-212-315-8700

Lung HelpLine 1-800-548-8252

www.lungusa.org

American Academy of Family Physicians

1-800-944-0000 / 1-800-274-2237 or 1-913-906-6000

www.aafp.org

Centers for Disease Control and Prevention

Smoking and Tobacco Use

1-800-CDC-INFO or 1-800-232-4636

www.cdc.gov/tobacco

Goal

Help your client:

- Identify where she may be exposed to secondhand smoke
- Take steps so she and her family can avoid secondhand smoke
- Talk to family members/friends if they expose her to secondhand smoke

Background

Secondhand smoke is the smoke inhaled from a burning cigarette or exhaled by a smoker. Pregnant women and babies should not be exposed to secondhand smoke. There is no safe level of exposure to tobacco smoke.

Secondhand smoke is a serious health hazard causing close to 50,000 deaths per year. Tobacco smoke contains over 4,000 chemicals and harmful substances; 250 of them are known to be toxic or cause cancer.

Studies have found that exposure to secondhand smoke in women is associated with uterine cancer, cervical cancer, heart disease, asthma, respiratory illnesses, and breast cancer.

When a pregnant woman breathes secondhand smoke, less oxygen will reach the unborn baby. Without enough oxygen, her baby is likely to weigh less.

Secondhand smoke increases a baby's risk of dying from Sudden Infant Death Syndrome (SIDS).

Babies and children suffer many ill effects from breathing secondhand smoke, including pneumonia, bronchitis, ear infections, asthma, and slowed lung growth.

Pregnant women and babies should not be exposed to secondhand smoke. There is no safe level of exposure to tobacco smoke.

Steps to Take

For all clients:

Discuss the dangers of secondhand smoke.

Look for secondhand smoke exposure: Clients may be exposed to smoke from cigarettes, pipes, or cigars at home, at work, in a car, in public places, or in other situations. All exposure should be avoided if possible. Encourage her to avoid all smoke, even at occasional visits to friends or other places.

Use the Four A's Model

Assist a client in reducing her exposure to secondhand smoke:

- **Ask** about her frequency of smoke exposure, and where and when she is around smoke.
- **Advise** her to avoid all smoke and discuss the negative health effects caused by secondhand smoke.
- **Assist** her in finding ways to avoid secondhand smoke. Suggest direct communication with smokers, or indirect (such as posting signs in the home or bringing home pamphlets). She might like to invite a supportive family member to her appointment to help find ways to avoid smoke.
- **Arrange** to follow up on her plan to reduce her exposure to smoke. Congratulate her on plans she makes.

If appropriate, give the client the handout *Keep Your Baby Safe and Healthy* which mentions avoiding secondhand smoke.

Follow Up

At the next visit, ask about her success in avoiding secondhand smoke. Track progress in her chart and follow up at each appointment with support, suggestions, and resources.

Resources

The Tobacco Education Clearinghouse of California (TECC)

TECC provides a variety of low cost educational materials on tobacco use, smoking cessation, and secondhand smoke materials. There are many materials for African-American, American-Indian, Asian/Pacific Islander, and Hispanic/Latina pregnant women.

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4 Carbonero Way

Scotts Valley, CA 95066

California Smokers' Help Line

A free telephone service for people who are ready to quit using tobacco is available, offering telephone counseling, materials, quit kits, and referral services. They also offer information on secondhand smoke. This information is sponsored by the California Department of Public Health.

1-800-NoButts or or 1-800-662-8887 is their direct line counseling service.

www.californiasmokershelpline.org

www.NoButts.org



You Can Quit Smoking

Tobacco can harm your unborn baby.

- Your baby could be born too early or too small
- Your baby could have problems later on

You can quit smoking. Talk to your health care provider about what can help.

Here are some ideas to help you quit:

- Write down the date you will quit
- Keep a diary of when and why you smoke
- Have a list of other things to do besides smoking. You could:
 - ◆ Take a walk
 - ◆ Take deep breaths
 - ◆ Eat fresh, healthy snacks

It can also help to:

- Write down a list of reasons why you want to quit. Tape them up where you will see them often.
- Focus on 1 day at a time
- Ask a family member or friend to quit with you
- Think how you will use the money you will save

Remember, the sooner you quit the healthier your baby will be.

Ready for more information?

- Call 1-800-NOBUTTS or 1-800-662-8887
www.NoButts.org
- Call 1-800-QUITNOW or 1-800-784-8669
www.smokefree.gov
- Call this number for a class near you:

Reasons I want to quit:

- So my baby will be healthy
- Because it is so expensive
- So my home will smell better
- So I won't have to go out to buy cigarettes when I have a baby
- _____
- _____
- _____



Usted puede dejar de fumar

El tabaco puede hacerle daño a su bebé antes de nacer:

- Su bebé podría nacer demasiado temprano o demasiado pequeño.
- Su bebé podría tener problemas más adelante

Usted puede dejar de fumar. Hable con su proveedor de atención de la salud sobre qué la puede ayudar.

Estas son algunas ideas para ayudarla a dejar de fumar:

- Escriba la fecha en que dejará de fumar.
- Haga un diario de cuándo y por qué fuma.
- Haga una lista de otras cosas que puede hacer en lugar de fumar. Podría:
 - ◆ Ir a caminar.
 - ◆ Respirar profundo.
 - ◆ Comer bocadillos frescos y saludables.

También puede ayudarla:

- Escribir una lista de razones por las que quiere dejar de fumar. Péguela en un lugar donde la verá con frecuencia.
- Concéntrese en superar 1 día a la vez.
- Pídale a un familiar o amigo que deje de fumar junto con usted.
- Piense en cómo usará el dinero que ahorrará.

Recuerde que cuanto antes deje de fumar, más saludable será su bebé.

¿Está lista para obtener más información?

- Llame al 1-800-NOBUTTS o al 1-800-662-8887 www.NoButts.org
- Llame al 1-800-QUITNOW o al 1-800-784-8669 www.smokefree.gov
- Llame a este número de teléfono para una clase cercana a usted: _____

Razones por las que quiero dejar de fumar:

- Para que mi bebé sea saludable.
- Porque es tan costoso.
- Para que mi casa huela mejor.
- Para que no tenga que ir a comprar cigarros cuando tenga al bebé
- _____
- _____
- _____

Goal

Help your client:

- Identify risks with use of alcohol, over-the-counter (OTC) drugs, and street drugs
- Stop or reduce any substance use
- Seek treatment

Background

Drinking alcohol or using drugs can cause tragic consequences for the unborn baby.

Alcohol and drugs can travel through the mother's blood (across the placenta) and enter the baby's blood. This exposure can cause babies to have physical, mental, and/or behavioral problems. Although not every baby will have obvious problems, no one can predict which child will be affected.

The good news is that many women who have been using drugs or alcohol on a long-term basis may want to quit during pregnancy.

Harm to the unborn baby can occur at any time during pregnancy. It is never too late to stop drinking or doing drugs when a woman is pregnant. The sooner she stops the better it will be for her and the baby.

Steps to Take

For all clients:

- Ask all clients about their use of drugs and alcohol
- Briefly discuss the effects of alcohol or drug use during pregnancy. See "The Risks" section in the side panel.
- Explain that all types of drugs may be harmful (over-the-counter (OTC), prescription, and street)
- Encourage her to tell all of her health and dental care providers that she is pregnant. With this information they will be able to provide medicines and medical treatments that will not harm the baby.

Pregnant woman should avoid all types of alcohol and drugs. There is no safe level of drug or alcohol use for pregnant women. Many over-the-counter and prescription drugs can also harm unborn babies. Alcohol use is the leading preventable cause of birth defects.

The Risks

During pregnancy, drugs and alcohol can travel through the mother's blood (across the placenta) to the unborn baby and cause the following problems:

- Miscarriages or physical abnormalities
- Slow growth and premature birth
- Increased risk for medical complications, preterm labor, and death of the baby
- Increased risk for abnormal facial features
- Increased risk of death for babies before their first birthday (SIDS), low birth weight, central nervous system damage, withdrawal effects, physical malformations, and developmental disorders that show up when they are older

For occasional users:

- State, "I am glad you told me about your use of _____. It is important information."
- Explain your medical concern, "I am concerned because I know that _____ use during pregnancy can cause a child to be born too early or too small or to have lifelong learning or physical problems"
- Advise her to stop her alcohol/drug use and/or seek treatment, "I know that the best thing you can do for your child is to stop using _____."
- Help her identify her readiness to quit or cut down
- Emphasize the positive:
 - ◆ Stopping now will give a better chance for a healthy baby

- ◆ Her concern for her baby will help her be a good mother
- ◆ She will feel better when not using drugs or alcohol
- Provide practical steps to quit or cut down and give support during the process. Give and review the handout *You Can Quit Using Drugs or Alcohol*.
- Keep the medical providers you work with informed of your discussion
- As appropriate, refer her to a substance use treatment program. See referrals box below.
- Refer her to another CPSP practitioner such as the psychosocial expert for more counseling and support. See *Mental Health* "Resources" in the "Psychosocial" section for more guidance.
- Advise her to stop her alcohol/drug use and/or seek treatment, "I know that the best thing you can do for your child is to stop using _____."
- Help her identify her readiness to quit or cut down
- As appropriate, refer her to a substance use treatment program. See referrals box below.
- Keep the medical providers you work with informed of your discussion.
- Refer her to another CPSP practitioner such as the psychosocial expert for more counseling and support. See *Mental Health* "Resources" in the "Psychosocial" section for more guidance.

For clients who can't stop:

If a client continues to use substances even though she is aware of the possible risks for her and her baby, she can be considered to have an addiction. This addiction can interfere with her physical, psychological, or social well-being. Addiction, or chemical dependency, is an illness.

In-depth counseling is usually not in the scope of the CPHW. Additional training is recommended for staff working with pregnant women who use drugs or alcohol.

However, it is still possible to help a client with her addiction by following these steps:

- State, "I am glad you told me about your use of _____. It is important information."
- Explain your medical concern, "I am concerned because I know that _____ use during pregnancy can cause a child to be born too early or too small or to have lifelong learning or physical problems".
- At each visit, ask any client who uses drugs or alcohol how she is doing in limiting her use. Support any decrease in use.
- If the client is using often and has set up an appointment in a treatment program:
 - ◆ Schedule extra appointments to support her efforts to quit or cut down her substance use.
 - ◆ If the client tells you that sometimes she feels awful while she is cutting back, remind her that this is the effect of the drugs/alcohol leaving her body, and that it takes time for the body to heal itself. Remind her that exercise, eating right, and getting plenty of rest will help.
- If the client is using often and has NOT set up an appointment in a treatment program:
 - ◆ Find out why the client has not done so. Brainstorm with her how she can overcome any obstacles to going.
 - ◆ Follow the guidelines above, "Steps to Take – For clients who can't stop".

Follow Up

- Discuss the client's occasional drug or alcohol use with other staff members in a case conference, so all providers can support and encourage the client to quit and provide needed interventions. All staff should be aware of goals set by the client to give her support and encouragement.

A woman who is not ready to quit at first may be ready later. Recognize her situation and continue to support her struggles, no matter how small her efforts.

Referral Phone Numbers:

Alcoholics Anonymous:

Phone: _____

Narcotics Anonymous:

Phone: _____

Local health department substance abuse services:

Resources**California Department of Health Care Services**

www.dhcs.ca.gov

The California Department of Health Care Services (DHCS) oversees prevention, treatment, and recovery services for alcohol and drug abuse. The Department will refer you to your local county for all services. To be connected with your local county, please call:

1-800-879-2772 or

1-916-327-3728

<http://www.dhcs.ca.gov/individuals/Pages/MHPContaktList.aspx>

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You Can Quit Using Drugs or Alcohol

Drugs and alcohol can hurt your unborn baby.

There are things you can do to quit or to cut down your use of drugs or alcohol.

For a day or 2, write down each time you use alcohol or drugs. Ask yourself what caused you to do so. Maybe you were worried or scared. Maybe you were with certain friends.

Get help if you:

- Feel sad or depressed
- Are worried about money
- Face violence or other problems

Some ideas to help you quit or cut back:

- Decide what date you will quit
- Make a list of healthy things you like to do
 - ◆ Tape it where you can see it often
 - ◆ Look at this list if you get the urge to use drugs or alcohol
- Ask a friend or family member to quit with you
- Join a self-help group to get the support you need
- Identify 2 or 3 friends or family members you can call for support if you feel like using drugs or alcohol

Remember, you only need to get through 1 day at a time.

There are drug and alcohol treatment agencies in your area.

1. Ask your health care provider for a referral.

Name: _____

Phone: _____

2. Call 1-800-879-2772.
3. Visit <http://www.dhcs.ca.gov/individuals/Pages/MentalHealthPrograms-Ind.aspx>

Healthy things I like to do:



Puede Dejar de Usar Drogas o Alcohol

Las drogas y el alcohol pueden hacerle daño a su bebé antes de nacer.

Hay cosas que puede hacer para dejar de usar drogas o alcohol, o para reducir su uso de drogas o alcohol.

Por uno o dos días, anote cada vez que usa alcohol o drogas. Pregúntese por qué los empezó a usar. Quizás estaba preocupada o tenía miedo. Quizás estaba con ciertos amigos.

Obtenga ayuda si:

- Se siente triste o deprimida
- Está preocupada por el dinero
- Enfrenta violencia u otros problemas

Algunas ideas para ayudarla a reducir su uso o dejar de usar drogas o alcohol:

- Decida en qué fecha dejará de usar drogas o alcohol
- Haga una lista de las cosas saludables que le gusta hacer
 - ◆ Péguela en un lugar donde la verá con frecuencia
 - ◆ Mire la lista si tiene ansias de usar drogas o alcohol
- Pídale a un familiar o amigo que deje de usar drogas o alcohol junto con usted
- Únase a un grupo de autoayuda para obtener el respaldo que necesita
- Identifique a dos ó tres amigos o familiares a quienes puede llamar para obtener respaldo si tiene necesidad de usar drogas o alcohol

Recuerde que solo tiene que superar un día a la vez.

Hay agencias de tratamiento de drogas y alcohol en su zona.

1. Pídale a su proveedor de atención de la salud que le dé una remisión

Nombre: _____

N° de teléfono: _____

2. Llame al 1-800-879-2772.
3. Visite <http://www.dhcs.ca.gov/individuals/Pages/MentalHealthPrograms-Ind.aspx>

Cosas saludables que me gusta hacer:

Goal

Help your client:

- Discuss her plans for having more children in the future
- Describe any contraceptive methods she would consider using

Background

Talking about family planning allows women to choose when they want to become pregnant and how many children they may have. Women who are unsure if they want more children tend to be less successful using birth control. They have more unplanned pregnancies.

The best time to discuss family planning is in the client's third trimester. A woman who chooses her birth control method before delivery will be better prepared to use her method soon after delivery. To ensure the best outcome for the next pregnancy, wait at least 18 to 60 months before becoming pregnant again. Having enough time between children helps parents cope with the demands of childrearing and with finances. It allows parents to provide physical, emotional, and intellectual nurturing for each child.

Some clients may have become pregnant through donor insemination, perhaps because their partner is also a woman. Such clients may not need birth control education, but may want to discuss plans for future children. When talking to clients, use a nonjudgmental and non-assuming interview style. Ask open-ended questions to find out the most appropriate way to provide family planning.

Steps to Take

For all clients:

- Explain the reasons you are talking about family planning:
 - ◆ So the client can be ready to begin using her method after delivery
 - ◆ So she doesn't get pregnant immediately after having this baby unless she wants to.
- Help clarify her plans for having more children in the future:
 - ◆ Ask the client what her plans are for having children in the future, *When would you like to have another baby?*
 - ◆ Ask her what methods she has used. Ask her to describe her experiences with these methods.
 - ◆ Ask what method she is thinking about using after the delivery of her baby
- Help the client determine which method(s) she might like to select:
 - ◆ Determine if the client wants a permanent birth control method (sterilization) or a temporary one
 - Consider ordering this booklet: "What Is Right for You? Choosing a Birth Control Method" (see "Resources") to review with the client
 - ◆ If she wants a permanent birth control method (sterilization), discuss:
 - Sterilization
 - If she does not want more children but she doesn't want sterilization, she may want a long-acting method (such as an implant or IUD). An IUD can be inserted within the first 10 minutes after the placenta is delivered or after the first week postpartum.

◆ For clients who want temporary birth control methods, discuss the following:

- Frequency of needing protection (daily, weekly, or just occasionally). Barrier methods (condoms, diaphragms, caps, sponge, and foam) may be the best choice for occasional protection. Cervical caps have much higher failure rates among women who have delivered a baby (compared to those who have not). The cervical cap should not be recommended for postpartum use without informing the client of the decreased effectiveness.
- Some methods require a woman to touch her genitals for insertion (female condoms, diaphragm, cap, sponge, spermicide-foam, film, gel, cream); not everyone is comfortable doing that
- Methods that require use during sex may not be acceptable to some clients (condoms and spermicide)
- Condoms provide the best protection against STIs if she's at risk. Other barrier methods also provide some protection against STIs (such as spermicide and diaphragms).
- If she's interested in abstinence, or in methods that require periods of abstinence (such as Fertility Awareness Method or Natural Family Planning), recommend a barrier method as a back-up in case she changes her mind
- If avoidance of unintended pregnancy is of high importance, she may want a method that has a high effectiveness rate (implant, shot, IUD, pill, patch, or ring)

■ Review each method the client is interested in

■ Explain emergency contraception (EC pills)

- ◆ Available at pharmacies to men and women 17 or older
- ◆ Available free to clients after delivery through Family PACT (see "Resources")
- ◆ Call 1-888-668-2528 for information and where to get EC pills

For clients who are breastfeeding:

■ If a client plans to breastfeed, review the effect breastfeeding has on a woman's fertility:

- ◆ For women who breastfeed exclusively (the infant drinks only breast milk, no other food, formula, or beverages), ovulation will generally not happen for the first 6 months postpartum. However, since ovulation occurs before menstruation, you cannot assume that she will not get pregnant, even if she does not have a period. See the *Breastfeeding Guidelines* in the "Nutrition" section for information on breastfeeding and family planning.

■ Birth control methods that are recommended for breastfeeding women include:

- ◆ Barrier methods (condom, diaphragm, sponge, spermicides)
- ◆ LAM (Lactational Amenorrhea Method). See Contraceptive Technology in the "Resources" section for more information. LAM is a method with guidelines, and relies on the contraceptive effects of breastfeeding.
- ◆ IUDs
- ◆ Progestin-only hormonal methods. The progestin-only hormonal methods safe for breastfeeding women include the mini pill, implant, and the shot.
 - Combined pills (progestin and estrogen) may reduce the mother's milk supply and are not recommended

- ◆ Tubal ligation for women/vasectomy for men. Refer them to an office that provides sterilization. See *Family PACT* under the “Resources” section.
- ◆ Fertility awareness

Follow Up

- At the postpartum visit, ask if she is still satisfied with her choice of a birth control method.
- Give her information about how to obtain the chosen method if she does not have it yet.
- If she has not used the method before, review how to use it and give her written information that she can take with her.

Resources

Irvington Publishers, New York.

Book: *Contraceptive Technology*, Hatcher, R.A. et al. Latest edition available in hardcover, soft cover, and CD-ROM. 1-800-218-1535

Newsletter: Contraceptive Technology Update

AHC Media
352 Piedmont Rd.
Building 6, Suite 400
Atlanta, GA 30305
1-800-688-2421
www.ahcmedia.com

Referral to family planning clinics - Family PACT

A statewide referral information number will refer low-income women to a clinic near her that provides low-cost, sliding-fee family planning services. The clinics accept Medi-Cal and offer FamilyPACT. 1-800-942-1054

Emergency Contraception – referral and information

1-888-668-2528

Sterilization Pamphlet - “Permanent Birth Control for Men and Women”

Available for free download

Female Sterilization - English and Spanish

www.dhcs.ca.gov/Documents/89884_EngFemale.pdf

www.dhcs.ca.gov/Documents/113414_SpFem_L2.pdf

Male Sterilization - English and Spanish

www.dhcs.ca.gov/Documents/113414_EngMale_L3.pdf

www.dhcs.ca.gov/Documents/113414_SpMale_L4.pdf

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There are safety issues for babies in the car and at home. Immunizations are important to keep a baby healthy. There are 3 topics discussed here:

- Car safety
- Safety at home
- Immunizations

Car Safety - Infant Car Seats

Goal

Help your client:

- Understand how to safely use the infant car seat

Background

Car accidents are the number 1 preventable cause of death and permanent injury in children. As of January 1, 2012, in California, children under the age of 8 must be secured in a car seat or booster seat in the back seat. Children under the age of 8 who are 4 feet, 9 inches or taller may be secured by a safety belt in the back seat. Infants must ride in a rear facing infant car seat until they are 2 or have reached the height and weight recommended by the car seat manufacturer. While it may be tempting for a client to carry an infant in their arms or even breastfeed when traveling in a car, this is the most dangerous way for a baby to travel.

Steps to Take

For all clients:

Ask if she has used an infant car seat before and if she can tell you how to use one.

Demonstrate how to put an infant car seat into a car. Then, have her demonstrate how to put an infant car seat into her car. Use a baby (or doll) to show her how to put an infant into the car seat (snug

straps, blankets outside the straps, rolled blankets to secure head if needed, etc.). Be sure she understands the basic concepts and can demonstrate how to correctly secure an infant into the car seat.

Infants must ride in a rear facing infant car seat in the back seat until they are 2 years old or have reached the height and weight recommended by the car seat manufacturer. When they have reached this size, they may sit in a forward facing child safety seat in the back seat. All children whose weight or height is above the forward facing limit for their car seat should use a Belt-Positioning Booster Seat until the vehicle seat belt fits properly, typically when they have reached 4 feet, 9 inches in height and are between 8 and 12 years of age.

Review the handout *Keep your Baby Safe and Healthy*.

Follow Up

When a client comes in for her postpartum visit:

- Ask her if she has been using her car safety seat, and to describe how it is fastened in the car
- Ask her to tell or show you how she is securing her baby in the car seat
- Make sure she has car seats for her other children, if needed

Resources

Safety Belt Safe

1-800-745-SAFE

www.carseat.org

Safety at home

Goal

Help your client:

- Identify a pediatric care provider for her baby before she delivers
- Understand danger signs of illness in the newborn and what to do if these occur
- Understand how to keep her baby safe at home

Background

Many women have infant care beliefs and practices learned from their families. For example, some parents may want to swaddle their infant, keep the infant inside, or want the infant to cry loudly to exercise the lungs. Support any practices that are not harmful.

Steps to Take

For all clients:

Review the handout *Keep Your Baby Safe and Healthy*. If you need more information about any topic, see “More Information” on the next page.

Discuss the handout *When Your Newborn Baby is Ill* at the third trimester and postpartum visits. Help her to identify a medical provider for her baby. Make sure she knows the danger signs of illness and who to call on weekdays, weekends, and evenings.

Follow Up

When she comes in for her postpartum visit, discuss:

- If she has her crib set up safely
- If she has placed the Poison Control number next to her phone
- How she is protecting the baby from falls

- Where she should take her infant if he or she becomes seriously ill in the evenings or weekends, as well as on the weekdays
- If needed, give her another copy of the handouts, *When your Newborn Baby is Ill* and *Keep your Baby Safe and Healthy*.

Resources

SafeKidsUSA

301 Pennsylvania Avenue N.W., Suite 1000
Washington, DC 20004
1-202-662-0600
1-202-393-2072 (fax)
www.safekids.org

First 5 California

2389 Gateway Oaks Drive, Suite 260
Sacramento, CA 95833
1-916-263-1050
1-916-263-1360 (fax)
<http://www.ccfca.gov/parents/health-center.aspx?id=7&sub=33>

Center for Injury Prevention Policy & Practice

(Educational handouts in English, Spanish, and Vietnamese)
6475 Alvarado Road, Suite 105
San Diego, CA 92120
1-619-594-3691
www.cippp.org/sheets/safetysheet.htm

U.S. Consumer Product Safety Commission

Washington DC
General Information: 1-301-504-7923
Consumer Hotline: 1-800-638-2772
www.cpsc.gov

Immunizations for your Baby

Pregnant women also need immunizations to protect themselves and their babies. See page 42.

Goal

Help your client:

- Understand the importance of immunizations

Background

Immunizations protect children from diseases that could result in severe illness, hospitalization, or even death.

Before leaving the hospital, each newborn should be given an immunization card or record with all immunizations given. This card or record should be brought to every medical visit and kept in a safe place at home.

Emphasize that the card or record will be required before the child can enter daycare or school.

Steps to Take

For all clients:

- Discuss the handout *Your Baby Needs to be Immunized* with your client during the third trimester and postpartum visit
- Show her an example of an immunization card and explain that her child must have this card or other Immunization record with up-to-date immunizations to start daycare or school
- Ask if there are barriers for her, such as transportation or cost, in having her child immunized. Discuss any barriers the client raises, including those beliefs such as fear of autism, severe reactions to immunization substances, it's not "natural", etc.
- Refer her to a clinic where the baby can get immunizations, if necessary

Follow Up

At the postpartum visit:

- Ask the client if she has the immunization card or other immunization record
- Remind her to bring it to each visit to the doctor
- Emphasize that the card or other immunization record will be required before the child can enter daycare or school

Resources

County Health Department immunization

Low-cost or no-cost immunization clinics and for up-to-date information on immunizations

Phone: _____

Get Free Materials from your Local Health Department

The California Department of Public Health, Immunization Branch has several resources available to support your educational messages around immunizations during pregnancy. They are free to download and many can be ordered FREE from your local health department. Visit EZIZ.org for additional flu and pertussis (whooping cough) prevention materials.

More Information

Safe Sleep for Your Baby

The American Academy of Pediatrics (AAP) released the policy statement, "SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment," and an accompanying technical report on October 18, 2001.

The expanded 2011 AAP recommendations for infant safe sleep are summarized below:

- Always place infants on their backs to sleep for every sleep.

- Use a firm sleep surface for infants. A firm crib mattress covered by a fitted sheet is the recommended sleeping surface.
- Room-sharing without bed-sharing is recommended. The infant's crib, portable crib, play yard, or bassinet should be placed in the parents' bedroom close to the parents' bed.
- Keep soft objects and loose bedding out of the crib to reduce the risk of Sudden Infant Death Syndrome (SIDS), suffocation, entrapment, and strangulation. Bumper pads are not recommended to be used in cribs.
- Avoid smoke exposure during pregnancy and after birth.
- Avoid alcohol and illicit drug use during pregnancy and after birth.
- Breastfeeding is recommended and is associated with a reduced risk of SIDS.
- Consider offering a pacifier that is not attached to a string at nap time and bedtime. For breastfed infants, delay pacifier introduction until breastfeeding has been firmly established, usually by 3 to 4 weeks of age.
- Avoid overheating, overbundling and avoid covering the infant's face and head. Use sleep clothing or infant sleep sacks that are designed to keep the infant warm rather than blankets.
- Infants should be immunized in accordance with recommendations of the AAP and the Centers for Disease Control and Prevention. Infants should be seen for regular well-child checks in accordance with AAP recommendations.
- Avoid commercial devices marketed to reduce the risk of sleep related infant deaths.
- Do not use home cardiorespiratory monitors as a strategy to reduce the risk of SIDS.
- Supervised, awake tummy time is recommended to facilitate development and to minimize development of positional plagiocephaly (Flat Head Syndrome).

Resources

The National Institute of Child Health and Human Development Safe to Sleep Campaign website: <http://www.nichd.nih.gov/sts/pages/default.aspx>

Secondhand Smoke

Secondhand smoke is the smoke inhaled from a burning cigarette or exhaled by a smoker. Pregnant women and babies should not be exposed to secondhand smoke. There is no safe level of exposure to tobacco smoke. Secondhand smoke can result in asthma, pneumonia, ear infections, and Sudden Infant Death Syndrome (SIDS). See the Secondhand Tobacco Smoke guidelines for more background information.

Crib Safety - Effective June, 2011

The sale of drop-side rail cribs has been banned because they are dangerous to the baby. It is illegal to sell or donate drop-side rail cribs. Tell your client not to buy drop-side rail cribs at yard sales or garage sales.

Some drop-side rail cribs have been fitted with a device used to secure the drop-sides on cribs, called an immobilizer. Not all immobilizers have been tested for safety. Help your client determine the safety of her baby's crib by contacting the cribs' manufacturer or the U.S. Consumer Product Safety Commission (CPSC), located in the "Resources" section.

Smoke Detectors

Smoke detectors should be in the kitchen and in the hallway near the bedrooms. They should be tested once a year to be sure they work.



Keep Your New Baby Safe and Healthy



The sale of drop-side rail cribs has been banned because they are dangerous to the baby. It is illegal to sell or donate drop-side rail cribs. Do not buy drop-side rail cribs at yard or garage sales. Call the U.S. Consumer Product Safety Commission (CPSC) to make sure your old crib is safe. CPSC Consumer Hotline: 1-800-638-2772

Keep your baby safe in the crib:

- Place your baby on his or her back when you lay him or her down to sleep.
- Make sure your baby's crib is safe:
 - ◆ The bars on the crib should be no wider than 2 and 3/8 inches apart
 - ◆ The mattress should be the same size as the crib
 - ◆ The mattress should be firm and tight fitting
 - ◆ Do not use:
 - Plastic bags to protect the mattress
 - Loose fitting sheets or blankets
 - Soft toys, pillows, or crib bumpers in the crib
 - A crib with missing, broken, or loose parts
 - A drop-side crib
 - ◆ Do not place cords, such as from a baby monitor or mini-blinds, near the crib

Keep your baby safe while sleeping:

The 2011 American Academy of Pediatrics (AAP) warn parents not to sleep with their babies.

If you must share a bed with your baby:

- Remove all soft bedding and soft objects from around your baby
- Make sure your baby does not sleep with multiple persons, anyone who is not a parent, including other children
- Do not smoke, drink, or use drugs that make it hard for you to wake up while your baby is sleeping in your bed

Keep your baby safe from falls:

- Do not leave your baby on a high surface. Your baby could roll over, jerk, or wiggle off the edge of a bed, couch, or changing table. If your baby falls, check for injuries.
- Call your doctor if the baby seems dazed, confused, or irritable after a fall
- If your baby acts normal after a fall, keep a watchful eye on your baby for 24 hours
- Call your doctor if anything makes you feel uncomfortable about your baby's fall



Keep Your New Baby Safe and Healthy

Keep your baby safe from poisons:

Call the Poison Control Center right away if your baby breathed in, swallowed, or touched a poison.

- Remove any clothing that touched the poison
- Rinse skin touched by poison with running water
- If your baby inhaled poison, go to a place with fresh air
- If your baby drank poison, do not try to make your baby throw up
- Do not give your baby home remedies
- The Poison Control Center will tell you what to do

Remember to place the Poison Control number next to your phone.

Call Poison Control at 1-800-222-1222.

If you forget the number, just call 911.

Keep your baby safe from burns:

- Do not microwave a bottle of formula or breast milk
 - ◆ It may have hot spots that could burn your baby's mouth

- After warming a bottle of formula or breast milk, test a few drops on your wrist. It should feel like the temperature of the room. It should not feel hot.
- Test bath water with your wrist
- Make sure your smoke detectors work

Keep your baby safe from choking:

- Do not let the baby have small objects, such as a button, coin, or part of a toy
- Keep the baby away from plastic bags and balloons
- Avoid foods that are:
 - ◆ The size of your baby's throat, like grapes or hot dogs
 - ◆ Hard (hard candy, raw vegetables, cheese chunks, raisins, beans, peas, popcorn, corn chips, or potato chips)
 - ◆ Soft (like gummy bears or gummy candy, caramels, or marshmallows)

Take a class on Infant CPR (Cardio-Pulmonary Resuscitation).

Classes in your community:

Keep your baby safe in the car:

- Put your baby in a safety seat every time they ride in the car, even on their first ride home from the hospital.
- Follow the manufacturer's instructions when you put the seat in the car. Place it in the center of the back seat of the vehicle, facing backwards.

Programs that lend or rent infant car seats:

Keep Your Baby Healthy:

- Keep your baby away from those who are smoking
- Take your baby in for shots
- Breastfeed your baby if possible

Have you found a good doctor for your baby? If not, ask your health care provider for help.



Mantenga a su bebé seguro en la cuna



Está prohibida la venta de cunas con barandales móviles porque son peligrosas para el bebé. Es ilegal vender o donar una cuna con barandales móviles. No compre cuna con barandales móviles en ferias o ventas de garaje. Llame a la Comisión de Seguridad de Productos del Consumidor de los EE. UU. (CPSC, por sus siglas en inglés) para verificar que su cuna vieja sea segura. Línea de ayuda al consumidor de CPSC: 1-800-638-2772

Mantenga a su bebé seguro en la cuna:

- Coloque a su bebé boca arriba cuando lo acuesta a dormir.
- Verifique que la cuna de su bebé sea segura:
 - ◆ Las barras de la cuna no deben tener más de 2 y 3/8 de pulgadas de separación.
 - ◆ El colchón debe ser del mismo tamaño que la cuna.
 - ◆ El colchón debe ser firme y caber justo en la cuna.
 - ◆ No use:
 - Bolsas de plástico para proteger el colchón.
 - Sábanas o cobijas sueltas.
 - Juguetes suaves, almohadas o chichoneras en la cuna.
 - Una cuna con partes rotas, sueltas o faltantes.
 - Una cuna con barandales móviles.
 - ◆ No coloque cables, como por ejemplo del monitor del bebé o de las persianas, cerca de la cuna.

Mantenga a su bebé seguro cuando duerme:

La 2011 Academia Norteamericana de Pediatría (AAP, por sus siglas en inglés) advierten a los padres que no deben dormir con sus bebés.

Si tiene que compartir una cama con su bebé:

- Quite toda la ropa de cama blanda y objetos blandos alrededor de su bebé.
- Asegúrese que su bebé no duerma con otras personas, cualquiera que no sean sus padres, incluyendo otros niños.
- No fume, no tome ni use drogas que le hagan difícil despertarse mientras su bebé está dormido en su cama.

Proteja a su bebé de las caídas:

- No deje a su bebé en una superficie elevada. Su bebé podría darse vuelta, sobresaltarse o menear hasta caerse de la orilla de una cama, sillón o cambiador. Si su bebé se cae, revíselo para ver si está lesionado.
- Llame a su médico si el bebé parece estar aturdido, confundido o irritable después de una caída.
- Si su bebé actúa normalmente después de una caída, obsérvelo de cerca durante las próximas 24 horas.
- Llame a su médico si algo la hace sentir inquieto después de la caída de su bebé



PASOS A SEGUIR

Proteja a su bebé de los venenos:

Llame al Centro para el Control de Envenenamiento de inmediato si su bebé inhaló, tragó o tocó un veneno.

- Quítele toda la ropa que tocó el veneno.
- Enjuague la piel que tocó el veneno con agua corriente.
- Si su bebé inhaló un veneno, vaya a un lugar con aire fresco.
- Si su bebé tomó veneno, no intente hacer que vomite.
- No le dé remedios caseros a su bebé.
- El Centro para el Control de Envenenamiento le dirá qué hacer.

Ponga el número de teléfono del Centro para el Control de Envenenamiento al lado de su teléfono.

Llame al Centro para el Control de Envenenamiento al 1-800-222-1222.

Si se olvida el número de teléfono, marque el 911.

Proteja a su bebé de las quemaduras:

- No caliente un biberón de fórmula o leche materna en el microondas
 - ◆ Puede tener puntos calientes que podrían quemarle la boca a su bebé

Mantenga a su Bebé Seguro y Saludable

- Después de calentar un biberón de fórmula o leche materna, pruebe unas pocas gotas en su muñeca. Debería sentir ser la misma temperatura que la sala en la que está. No debe estar caliente.
- Pruebe el agua de la tina con su muñeca.
- Verifique que funcionan sus detectores de humo.

Proteja a su bebé de los ahogos:

- No deje que el bebé tenga objetos pequeños, como por ejemplo un botón, moneda o parte de un juguete.
- Mantenga al bebé alejado de bolsas de plástico y globos.
- Evite alimentos que son:
 - ◆ Del mismo tamaño que la garganta de su bebé, como por ejemplo uvas o salchichas.
 - ◆ Duras (dulces duros, verduras crudas, cubos de queso, pasas de uva, frijoles, chícharos, palomitas de maíz, chips de maíz (totopos), o papas fritas).
 - ◆ Blandas (como por ejemplo ositos de goma o dulces de goma, dulces de caramelo o malvaviscos).

Tome una clase de Resucitación Cardiopulmonar (CPR) infantil.

Clases en su comunidad:

Mantenga a su bebé seguro en el carro:

- Coloque a su bebé en un asiento de seguridad cada vez que viaje en el carro, incluso en el primer viaje a su casa desde el hospital.
- Siga las instrucciones del fabricante para colocar el asiento en el carro. Colóquelo en el centro del asiento de atrás del vehículo, mirando hacia atrás.

Programas que prestan o alquilan asientos de seguridad para bebés:

Mantenga a su bebé saludable:

- Mantenga a su bebé alejado de personas que están fumando.
- Lleve a su bebé a darse las vacunas.
- Dele pecho a su bebé de ser posible.

¿Ya tiene buen doctor para su bebé? Si no, pídale ayuda a su proveedor de atención de la salud.



When Your Newborn Baby is Ill

What to watch for:

If your baby is less than 3 months old, here's what to watch for when your baby seems ill.

Call your health care provider right away if:

- Your baby's temperature is 100.4°F or more. Take your baby's temperature by the rectum. Ask how to use a thermometer if you do not know how.
- Your baby skips 2 feedings in a row
- Your baby throws up with force, so that the vomit shoots out
- Your baby throws up more than just "spitting up" after he or she eats

Call right away when your baby has diarrhea:

- If your baby's stools (poop) are not normal
- If your baby has loose or watery stools
- If your baby's stools have a very bad odor
- If there is blood or mucus in the stools or urine

Call right away if:

- Your baby does not wet at least 4 to 6 diapers every 24 hours
- Your baby cries more than normal and you cannot comfort or stop your baby
- Your baby does not seem as alert as normal or sleeps more than usual
- Your baby seems weak or floppy
- Your baby does not cry as loudly as you are used to

Call right away if:

- Your baby's skin or eyes are yellow
- Your baby has a purple rash that does not lighten when you press it



Call 911:

- If your baby has trouble getting air in and out
- If your baby's skin is turning blue
- If your baby is choking

Write your address and phone number near the phone. That way you or your baby's caregiver can read it to the 911 operator.



Cuando su Bebé Recién Nacido se Enferma

A qué debe estar atenta:

Si su bebé tiene menos de tres meses de edad, las siguientes son cosas a tener en cuenta cuando su bebé parece estar enfermo.

Llame a su proveedor de atención de la salud de inmediato si:

- La temperatura de su bebé es de 100.4° F o más. Mídale la temperatura en el recto. Pregunte cómo usar un termómetro si no sabe hacerlo.
- Su bebé saltea dos horarios de comida seguidos
- Su bebé vomita con fuerza, de manera que el vómito sale proyectado
- Su bebé vomita más que la regurgitación normal después de comer

Llame de inmediato cuando su bebé tiene diarrea:

- Si las heces ("caca") de su bebé no son normales
- Si su bebé tiene heces blandas o líquidas
- Si las heces de su bebé tienen un olor muy feo
- Si hay sangre o mucosidad en las heces u orina

Llame de inmediato si:

- Su bebé no moja por lo menos cuatro a seis pañales cada 24 horas
- Su bebé llora más que lo normal y no lo puede consolar o detener el llanto
- Su bebé no parece estar tan alerta como lo está normalmente o duerme más que lo normal
- Su bebé parece estar débil o flojo
- Su bebé no llora tan fuerte como está acostumbrado

Llame de inmediato si:

- La piel u ojos de su bebé están amarillos
- Su bebé tiene un sarpullido violeta que no se aclara cuando lo toca



Llame al 911:

- Si a su bebé le cuesta inhalar y exhalar aire
- Si la piel de su bebé se empieza a poner azul
- Si su bebé se está ahogando

Escriba su dirección y número de teléfono cerca del teléfono. De esa manera usted o el cuidador del bebé pueden leerlos al operador de 911.

Goals

Help your client:

- Understand the difference between identical and fraternal twins
- Understand the health risks associated with multiple births
- Reduce the risks associated with multiple births
- Make realistic plans for postpartum care of her babies
- Develop a support system

Background

The birth of twins, triplets, or more is called a multiple birth. Multiple births are much more common today than in the past for 2 main reasons. First, more women over 30 are getting pregnant and women over 34 years of age have a higher chance of having multiples. Second, more women are becoming pregnant with the help of infertility treatments.

Identical twins or fraternal twins? Twins can be either identical or fraternal. The difference is the number of fertilized eggs. For identical twins, there is 1 fertilized egg. This single fertilized egg splits into 2 identical fertilized eggs early in the pregnancy. Two identical babies develop, sharing the same sex, blood type, and eye and hair color. Identical twins usually have their own amniotic sac and may or may not share a placenta.

If there is more than 1 fertilized egg, the twins will be fraternal. In this case, each egg is fertilized by a different sperm. Because each baby is created by a different egg and a different sperm, these babies may not look alike. They can be different sexes or the same sex. Each baby will have its own amniotic sac and its own placenta.

When there are more than 2 babies, these babies can be identical, fraternal, or a combination of both. When there are more than 2 babies (triplets, quadruplets, etc.) the babies are referred to as multiples (and sometimes, “supertwins”).

Women carrying multiples are at higher risk for:

Low Birth Weight Babies: Babies born at a low birth weight may develop mental and physical difficulties. A baby born weighing 5 pounds, 8 ounces or less is considered low birth weight.

Preeclampsia/Toxemia: Another terms for this is gestational hypertension. Twin pregnancies are twice as likely as single pregnancies to have preeclampsia.

Preterm Birth: The biggest risk associated with multiple pregnancies is that the babies will be born early, before 37 weeks. This is called preterm or premature labor. Nearly half of all twins are born prematurely. With 3 or more babies, there is an even higher risk of premature birth.

Shared Placenta: Each baby can either have a separate placenta or share a placenta with 1 or more others. When multiples share a placenta, 1 baby may get too much blood flow and the other may get too little. They are at risk for a condition known as twin-to-twin-transfusion syndrome (TTTS). Only about 10% of identical twins who share a placenta will develop TTTS.

Steps to Take

For all clients expecting multiples:

- Find out how twins and multiples are handled in your practice. If the client will be referred for high-risk care, explain the process to her.
- Give and review the handout *If Your Labor Starts Too Early*
- Give and review the handout *Getting Ready for Multiples*
 - ◆ For more information on topics you may discuss with your client, see the “Additional Information” at the end of this guideline. You may not have time to discuss all these details with every client, but you can use this “Additional Information” to broaden your knowledge, and to enrich your discussions with your clients.

- Give and review the handout *Baby Products, Discounts, and Coupons*
- Provide referrals - Give all clients these 2 referrals, which are listed on the handout *Getting Ready for Multiples*
 1. The National Organization of Mothers of Twins Clubs (NOMOTC): www.nomotc.org. Click on “find a local club” and enter your client’s zip code to find a twins club in her area. These clubs are not only for parents of twins, but are also for parents of multiples.
 2. MOST = Mothers of Supertwins. An international support group for parents of multiples. 1-631-859-1110
www.mostonline.org

For clients with twin-to-twin-transfusion syndrome (TTTS):

- Twin-to-Twin Transfusion Syndrome Foundation
This group provides information, helps the woman to identify questions she should ask her doctor, and offers possible financial support for women with children who have twin-to-twin transfusion syndrome. 1-800-815-9211
<http://www.tttsfoundation.org/index.php>
mary@tttsfoundation.org

Follow Up

- Ask your client if she understands the symptoms of preterm labor. Remind her to watch and call: to watch for any symptoms and to call her health care provider immediately, day or night, if there are symptoms.
- A client may deliver multiples vaginally or by caesarean. Find out how your practice handles this and discuss with the client.
- Refer the client to the provider to discuss issues beyond your expertise. Help her prepare her questions and explain her concerns.

- Review her preparations to take care of multiple babies and help her connect with referrals. Keep in mind that, due to exhaustion, the client may need you to contact the referrals from the list below that are appropriate for her. If possible, call the resource/referral for the client.
- Encourage your client to develop a support system and help her to think of ways she can comfortably ask for and accept help from relatives and friends (Review the suggestions in the *Getting Ready for Multiples* handout).

Resources

Twin-to-Twin Transfusion Syndrome Foundation

This group provides information, questions the client should ask her doctor, and possible financial support for women who have twin-to-twin transfusion syndrome. 1-800-815-9211

<http://www.tttsfoundation.org/index.php>
mary@tttsfoundation.org

Center for Loss in Multiple Birth (CLIMB)

For women who lose 1 or more multiples
1-907-222-5321

www.climb-support.org

Local Resources:

- Financial assistance, food supplements, and churches
- Sources of used clothing and equipment, such as secondhand stores and flea markets
- La Leche League
- Nursing Mother’s Council
- Parental stress relief organizations
- Car seat programs
- Taxi vouchers

Information on TTTS:

Twin-to-twin transfusion syndrome (a brief video):

www.nlm.nih.gov/medlineplus/ency/anatomyvideos/000132.htm

Source: National Library of Medicine
www.climb-support.org

Additional Information

Issues you can discuss with your client that may help her prepare for multiples.

Nutrition

If a woman can eat right and gain the recommended weight, she can help reduce the risk of low birth weight babies and preterm labor.

Eating right is important because it will help the client keep her energy, give her babies a strong start, and help prevent anemia. Eating right means eating a balanced diet and taking prenatal vitamins. A client expecting multiples should have regular visits with a dietician.

To find the recommended weight gain for women carrying twins, see the “Nutrition” section.

Women carrying more than 2 babies should discuss their recommended weight gain with their medical provider.

Exercise and Rest

Regular non-stressful exercise is important. However, as the babies grow the client may need to reduce her activity level and rest more.

When resting, a client may want to rest part of the time on her left side. This allows blood to flow more freely, with less pressure from her expanding uterus.

Clients who have physically demanding jobs or are experiencing preterm labor may have to rest more or stop work early. Help the client make plans for a leave of absence from work. Also help the client plan for finding help with her children, housework, etc., especially if she is on bed rest.

Helping a Family Prepare for the Arrival of Multiples

The arrival of multiples has a major impact on the family. Everyone in the household can expect to sleep less due to the demands of 24-hour baby care. Preparing ahead for the babies will help everyone to manage

well during the first few weeks. What can a client do to prepare herself and her family? Some ideas are listed below. As time permits, you may want to integrate this information into your discussion with your client.

Support

The client will need to ask friends and family for extra help. She will need to find people to help with daily chores, care for the babies and older siblings, and to give her time to sleep and take care of herself.

The client can ask a friend or relative to come over and take care of the babies during the evening while the parents get a few hours of unbroken sleep.

She can also get support from a local mothers of twins (and multiples) club. Connect her with local club(s) using the handout *Getting Ready for Multiples*.

Identifying the babies

At first it may be difficult to tell the babies apart, even if they do not look very similar. Sleepy parents may temporarily mix them up and even feed 1 of the babies twice. If the babies look very similar, it is helpful to mark the toe of 1 with nail polish. Another idea is to dress the babies in different colors and/or different styles of clothing.

Clothing

Secondhand children’s clothing stores are an inexpensive place to get clothes.

How parents dress multiples influences whether others relate to the babies as a group or as individuals. Newborn multiples are not greatly affected by the public notice they receive when dressed differently. However, when multiples are dressed alike all the time, they can become so used to the “star effect” that they may feel lost without their co-multiple(s).

Siblings

It is wise to prepare older siblings by explaining that the new babies will be identical or fraternal, and allow them to participate in the preparations. They

may want to help arrange the babies' clothes and furniture. The babies will more easily win the hearts of their older siblings if they come home from the hospital with a small gift for each sister or brother. Sometimes it is helpful for the older siblings to have their own "multiples" as dolls or bears. Then they can safely express their mixed emotions about the real babies. Parents can remind visitors to pay attention to the older children by taping a note to the front door that says, "Please talk to the big kids first."

Transportation

Each baby will need its own car seat in order to leave the hospital. The family will eventually need a stroller with a seat for each baby. Having the car seats and strollers will help the family get out for appointments and to shop for food, etc., and will help prevent the risk of isolation.

Special Needs and Loss

If any of the babies have a special need there will be additional stress on the entire family. The family will have to learn to meet this baby's special needs, and will need extra support from friends, family, etc. If 1 of the babies dies, the parents will have the task of mourning while caring for the other babies (see *Perinatal Loss* in the "Psychosocial" section).

Supplies

Babies can share a crib when they are small. This gives them the comfort of snuggling together in their fetal position. They can also share baby supplies (lotions, diapers, etc). The client may want to ask a friend for help shopping for supplies, as multiples use up supplies very quickly.

At first they won't need many toys. As they grow, they can easily share some toys. They will also each need their own toys, even if the toys are the same, like pull toys or stuffed animals.

Bonding

When there are 2 or more babies, parents may first bond with the whole group, and then connect with each baby in special ways. If 1 of the babies has to stay in the hospital, the parents will need to make a special effort to stay connected with all the babies.

Breastfeeding

The benefits of human milk to multiples and their mothers are the same as for all mothers and babies - maybe even more so, since multiples may be born early. Breast milk gives the best nutrition and immunity and is especially beneficial for premature infants. A registered dietitian should work with the mother in adjusting her diet because it can take a while to comfortably adapt to breastfeeding. The mother will be deciding what positions work best for her to breastfeed her babies. Some mothers like to feed 2 babies at the same time, while others prefer individual feedings.

Some mothers may choose to feed their babies formula as well as breast milk on occasion. If any of the babies are hospitalized, the mother will need to pump breast milk for their feedings. With lots of encouragement, it is possible to breast and bottle feed multiples. See the *Breastfeeding Guidelines* in the "Nutrition" section.

Bottle feeding

If a client chooses to bottle feed, the mother will need to learn how to feed the babies together without propping up their bottles. She will want to rotate them from feeding to feeding so each baby has time in her arms.

Sleep

It may help for the adults in the household to take turns sleeping through the night. The client may want to ask a friend or relative to care for the babies during the evening while the parents catch a few hours of unbroken sleep. Once the babies are on the same schedule for feeding and sleeping, it will be easier to find time to rest.



Getting Ready for Multiples

Having more than 1 baby is an exciting time. You can give your babies the best possible start by taking good care of yourself now.

Take care of yourself:

- Eat healthy foods
- Drink at least 8 to 10 glasses of water a day
- Get some exercise. Ask your health care provider about how much you can do.
- Stay away from heavy work and long commutes

It is important to rest and relax:

- Rest if you are tired. Try resting on your left side.
- Take naps
- Lower your stress. Talk to a friend or a counselor.

Find people who can help:

You will need help while you are pregnant and after your babies are born. There will be too much work to do alone. You will need helpers. These may be friends, relatives, or neighbors. Find out who can help you:

- Shop
- Cook
- Do laundry
- Clean the house
- Help with your children
 - ◆ Care for your older children
 - ◆ Bathe the babies
 - ◆ Change diapers
 - ◆ Care for the babies while you sleep



Who are the people you might be able to ask for help?

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____



Getting Ready for Multiples

Learn about twins and multiples:

- Ask parents with multiples for helpful tips
- Ask at the library for books on twins and multiples
- Join a Mothers Club for mothers of twins or supertwins (multiples)
 - ◆ National Mothers of Twins Clubs:
www.nomotc.org
 - ◆ MOST (Mothers of Supertwins):
www.mostonline.org
1-631-859-1110

Prepare to breastfeed:

- Breast milk is the best food for your babies. Your body can make enough milk once you start breastfeeding.
- You can provide complete nutrition for 2 or more babies
- Ask to see a lactation consultant

Help your older children get ready for the babies:

- Let them help you get baby clothes together and the crib(s) ready
- Let them know how they can help when the babies arrive

Gather baby clothes and equipment:

- Clothes
- Diapers
- Crib(s) - they can share a crib at first
- Stroller(s) - when the babies are small, you can use a single stroller for 1 baby and a baby pack for the other. Later on, you may need a twin stroller.
- Car Seats - each baby needs a car seat when they leave the hospital and every time they ride in a car
- A rocking chair can relax you and the babies. Baby swings can also be a big help.

Find ways to save money:

- Visit, or ask a friend to visit, local secondhand stores for children
 - ◆ Ask the store to call you if they find a twin/multiple stroller
- Ask your health care provider for the handout *Baby Products, Discounts, and Coupons*. It has a list of companies who help families with multiples.

Cuando tiene más de un bebé, es un momento de excitación. Puede darles a sus bebés el mejor inicio posible si empieza a cuidarse bien ahora.

Cuídese:

- Coma alimentos saludables
- Beba por lo menos 8 a 10 vasos de agua por día
- Haga algo de ejercicio físico. Pregúntele a su proveedor de atención de la salud qué cantidad de ejercicio puede hacer.
- Evite el trabajo pesado y los viajes largos

Es importante descansar y relajarse:

- Descanse si está cansada. Intente descansar acostada sobre el lado izquierdo.
- Duerma la siesta
- Reduzca su estrés. Hable con un amigo o con un consejero.

Encuentre a personas que la puedan ayudar:

Necesitará ayuda durante el embarazo y después de que nazcan los bebés. Habrá demasiado trabajo para hacerlo sola. Necesitará ayudantes. Pueden ser amigos, familiares o vecinos. Averigüe quién la puede ayudar a:

- Hacer las compras
- Cocinar
- Lavar la ropa
- Limpiar la casa
- Ayudar con los niños
 - ◆ Cuidar a sus hijos más grandes
 - ◆ Bañar a los bebés
 - ◆ Cambiar pañales
 - ◆ Cuidar a los bebés cuando duerme



¿Quiénes son las personas a las que podría llegar a pedir ayuda?

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____



Cómo Prepararse para Más de un Bebé

PASOS A SEGUIR

Aprenda sobre los mellizos y más:

- Pídales a padres con mellizos que le den consejos útiles
- Pida libros sobre mellizos y más en la biblioteca
- Únase a un Club de Madres para mamás de mellizos y supermellizos (más de dos bebés)
 - ◆ Clubes Nacionales de Madres de Mellizos: www.nomotc.org
 - ◆ MOST (Madres de Supermellizos): www.mostonline.org
1-631-859-1110

Prepárese para dar pecho:

- La leche materna es la mejor comida para sus bebés. Una vez que le empiece a dar pecho a los bebés, su cuerpo podrá producir suficiente leche.
- Puede proporcionar toda la nutrición para dos o más bebés
- Pida ver a una asesora de lactancia

Ayude a sus hijos mayores a prepararse para los bebés:

- Deje que la ayuden a preparar la ropa y la(s) cuna(s)
- Dígales cómo pueden ayudar una vez que lleguen los bebés

Reúna toda la ropa para los bebés y los equipos necesarios:

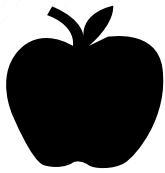
- Ropa
- Pañales
- Cuna(s). Pueden compartir una cuna al principio.
- Cochecito(s), cuando los bebés son pequeños, puede usar un cochecito simple para un bebé y llevar al otro en una mochila para bebés. Más adelante, es posible que necesite un cochecito doble.
- Asientos de seguridad. Cada bebé necesita un asiento de seguridad cuando se van del hospital y cada vez que anden en carro.
- Una silla hamaca puede ayudar a relajarla y relajar a los bebés. Las hamacas para bebés también pueden ser una gran ayuda

Encuentre maneras de ahorrar dinero:

- Visite tiendas locales de objetos de segunda mano para niños, o pídale a un amigo que las visite
 - ◆ Pida que la tienda la llame si encuentran un cochecito para dos o más bebés
- Pídale a su proveedor de atención de la salud que le dé un folleto llamado Productos de bebé, descuentos y cupones (*Baby Products, Discounts, and Coupons*). Tiene una lista de empresas que ayudan a familias con mellizos o más.

STEPS TO TAKE

NUTRITION



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These Steps to Take Guidelines are to be used with your office protocols which are your facilities' procedures for providers (Health Education, Nutrition, Psychosocial) services, and related case coordination.

(Client Handouts are indicated in bold)

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Good nutrition is vital before, during and after pregnancy to help ensure the optimal health of both the mother and her infant. Pregnant women need more calories, protein, iron, folic acid, and other vitamins and minerals than before pregnancy. After the first trimester, normal-weight women need an average of only 300 additional calories a day while pregnant. Excess calories during pregnancy puts the mother at risk for excess weight gain that may lead to maternal and infant negative outcomes. Actual additional calorie needs depend on a woman's pre-pregnant weight, height, age and activity level. Breastfeeding women also need increased nutrients and calories based on their breastfeeding status. Refer to ChooseMyPlate.gov-Health and Nutrition Information for Pregnancy and Breastfeeding Women (www.choosemyplate.gov/pregnancy-breastfeeding.html) to guide women to make healthy eating choices, track their food intake and weight gain, and set healthy eating goals. Use the handout *MyPlate for Moms* to guide women to make healthy choices and get the nutrients and calories they need.

A healthy weight and good nutrition prior to conception plays an important role in fetal development and birth outcomes. Lower rates of spinal column defects in newborns have been found when mothers took supplements of multivitamins prior to or around the period of conception. It is now recommended that all women of childbearing age eat folate rich foods and a vitamin supplement containing 400 micrograms (mcg) of folic acid.

Inadequate food access and intake, extremes in weight status, eating disorders, severely restricted diets, chronic medical conditions, and tobacco, alcohol, or other substance use are some of the factors that may impair a woman's health and nutritional status and the health of her baby.



CPSP Nutrition Services

Ongoing nutrition services are an important aspect of a woman's prenatal and postpartum care. See the CPSP Provider Handbook for a description of nutrition assessment requirements, clarification of basic versus specialized care, description of required nutrition assessment skills, nutrition risk conditions warranting involvement of skilled nutrition professionals, billing information for nutrition services, and making client referrals.

Good nutrition during pregnancy also helps prepare women for breastfeeding. Gaining the appropriate amount of weight is important to meet the energy needs of breastfeeding. Consuming adequate nutrients maintains the woman's nutrient stores. Postpartum is the time to replace needed nutrients, normalize weight and continue a foundation of good nutrition to foster the health of the entire family.

The Role of the Registered Dietitian

Certain medical conditions, social factors, and dietary practices can affect a woman's need for calories, nutrients, and diet composition. Women with special needs or complex conditions may benefit from a consultation with a registered dietitian (RD). The RD can provide additional assessment and medical nutrition therapy to control or alleviate complex conditions such as diabetes and hyperemesis gravidarum. Specialized nutrition services are recommended for, but not limited to, the following conditions:

Anthropometric

Underweight: Prepregnancy weight <90% desirable body weight

Very overweight: Prepregnancy weight >135% desirable body weight

1st Trimester: Excessive weight loss

2nd or 3rd Trimester: Excessive or inadequate weight gain

Biochemical

- Anemia: Hemoglobin (Hgb) <10.5-11.0 g/dL
Hematocrit (Hct) <33 vol% Mean Corpuscular Volume (MCV): <83 cu mi or >95 cu mi (folate deficiency)
- 1st trimester 85 -97.8 μm^3 , 2nd trimester 85.8 - 99.4 μm^3 , 3rd trimester 82.4 - 100.4 μm^3 (higher levels can indicate B12 or folate deficiency)
- Glucose Intolerance: (results of 75 gram, 2-hour Oral Glucose Tolerance Test (OGTT) having any value above cut off: Fasting: ≥ 92 mg/dL 1 hr ≥ 180 mg/dL 2 hr ≥ 153 mg/dL (Note: ACOG still prefers a 2 step screening for GDM. The International Association of Diabetes and Pregnancy Study Group (IADPSG) recommends the one step method. ACOG is leaving the choice of test method up to the individual physician practice group or clinic.)
- Hypovolemia: (2nd or 3rd Trimester): Hgb >13.9 g/L Hct >41.9 vol%

Clinical (Physical/Medical/Obstetrical)

Previous or current obstetric history/complications or risks:

- Alcohol, Drug and Tobacco use
 - ◆ Any alcohol before pregnancy or during prepregnancy
 - ◆ Any cigarettes during pregnancy, or more than 10 cigarettes/day before pregnancy
 - ◆ Use of narcotics, cocaine, hallucinogens (LSD, etc.), marijuana, amphetamines, and/or other street drugs
 - ◆ Chronic use of over-the-counter (OTC) medications, such as laxatives, antacids, herbal remedies known or suspected to cause toxic side effects or affect nutritional status
- Use of prescription drugs known to affect client's nutritional status
- Anesthesia/surgery/recent trauma
- Bariatric surgery
- Cancer
- Cardiopulmonary disease:
- Functional heart disease
- Organic disease (tuberculosis)
- Asthma requiring treatment
- Current pregnancy risks
- Adolescence: 15 years or less at time of conception
Less than 3 years since onset of menses
- High parity: 5 or more previous deliveries at greater than 20 weeks gestation
- Hyperemesis Gravidarum (severe nausea and vomiting unresponsive to routine management causing dehydration, metabolic disturbance and weight loss)
- Short interpregnancy: Less than two years between delivery (or interval: termination of pregnancy) and conception
 - ◆ Multiple gestation
- Breastfeeding: Breastfeeding while pregnant, breast/nipple anomalies
- Developmentally disabled
- Gastrointestinal disease including celiac disease, irritable bowel syndrome, and inflammatory bowel disease
- Gestational diabetes, diabetes and pre-diabetes
- HIV/AIDS
- Infection, severe (such as Tuberculosis)
- Intrauterine Growth Retardation (poor fetal growth)
- Mental retardation
- Neurological disease/epilepsy
- Other chronic disease, such as renal, liver and thyroid disease

- Physical signs of malnutrition
- Polycystic ovary syndrome
- Preeclampsia (pregnancy induced hypertension) including pre-hypertension
- Prescription drugs: Use of tranquilizers, sedatives, stimulants
- Previous poor birth outcomes:
- Low birth weight infant (<5.5 lbs)
- Small-for-gestational-age (SGA) infant
- High birth weight infant (>9 lbs)
- Congenital anomaly
- Hemorrhage (antepartum)
- Psychosocial problems: Severe emotional distress or anxiety affecting appetite or eating
- Sickle Cell Anemia

Dietary

- Diet inadequate in two or more food groups with no improvement on second visit
- Disordered eating (current or history of anorexia nervosa, bulimia, compulsive eating)
- Homelessness/no cooking facilities
- No food in the house on more than two occasions
- Other unusual or restrictive dietary practices that CPSP practitioner is unfamiliar with (i.e., vegan food habits)
- Pica: Eating of nonfood substances (starch, clay, ice, coffee grounds, etc.)
- Special or therapeutic diet (current)
- Toxic use of vitamins and minerals, such as:
Vitamin A >8,000 IU/day
Vitamin D >400 IU/day
Vitamin C >2,000 mg/day
Vitamin B-6 >100 mg daily
Iodine >11 mg daily
- Vegan diet
- Vitamin/mineral supplements: Excessive use of nutrient supplements

- Additional conditions for referral to a nutritionist:
Any nutritional problem with which staff does not feel comfortable in counseling

The local Perinatal Services Coordinator can help identify registered dietitians in your community and set up a referral system. The Women, Infants, and Children Program (WIC) does not provide medical nutrition therapy.

Nutrition Guidelines

The following nutrition guidelines were designed to help the CPSP practitioner complete the nutrition assessment and provide information on common nutrition related concerns. Complex or high-risk conditions requiring specialized nutrition care by the registered dietitian or medical provider are not included.

Nutrition Assessment

All nutrition services begin with an assessment of anthropometric, biochemical, clinical, and dietary data to identify key nutrition issues affecting the woman and her pregnancy. This information is used to develop an individual nutrition plan to help access, select, prepare, and eat healthy and safe foods during her pregnancy and maintain healthy eating habits throughout her life.

Assessment Guidelines

Complete an initial nutrition assessment and individualized care plan on every client within four weeks of entry into care. If the client declines the assessment, document this in her chart. Offer the assessment at future visits. Some clients may need to be offered the assessments several times.

Offer nutrition reassessments at least once every trimester and at the postpartum visit. High-risk clients may need more interventions and may be seen more frequently. Offering healthy eating information throughout her pregnancy and postpartum will reinforce the woman's nutrition goals.

Resources

MyPlate Daily Food Plans for Pregnancy & Breastfeeding Health and Nutrition Information for Pregnant and Breastfeeding Women

www.choosemyplate.gov/pregnancy-breastfeeding.html

Pregnancy Eating for Two

<http://womenshealth.gov/pregnancy/you-are-pregnant/staying-healthy-safe.html>

California MyPlate Resources

California MyPlate for Teens (English and Spanish)
California MyPlate for Moms (English and Spanish)
California MyPlate for Gestational Diabetes (English and Spanish)

<https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Topics/Nutrition-MyPlate.aspx>

U.S. Department of Agriculture and U.S. Department of Health and Human Services

U.S. Department of Health and Human Services and U.S. Department of Agriculture. *2015 – 2020 Dietary Guidelines for Americans*. 8th Edition. December 2015.

Available at:

<http://health.gov/dietaryguidelines/2015/guidelines/>

Institute of Medicine (IOM). *Nutrition During Pregnancy and Lactation: An Implementation Guide*, 1992, National Academy Press, Washington, D.C.
www.nap.edu/openbook.php?record_id=1984

Order a hard copy from:

www.nap.edu/catalog.php?record_id=1984

California Nutrition and Physical Activity Guidelines for Adolescents

These guidelines were developed to assist health professionals in improving the nutrition and physical activity practices of adolescents.

www.cdph.ca.gov/HealthInfo/healthyliving/nutrition/Pages/TeenGuidelines.aspx

California Department of Public Health, Maternal Child Adolescent Health; Weight gain grids.

- There are weight gain grids for women with an underweight, normal, overweight or obese prepregnant weight and for normal, overweight and obese women carrying twins. There are no weight gain grids for underweight women carrying twins. For these women, or women in any weight category carrying more than twins, consult with their physician to determine an appropriate weight gain.

All women need to gain weight during pregnancy to support the growth, development, and health of their babies and the changes in their bodies. Weight gain during pregnancy is called “gestational weight gain”. Weight gain recommendations have changed over the years and the guidelines included here present the most recent research on healthy gestational weight gain.

There is no single amount of weight gain that is right for all women. Recommended weight gain depends on a woman’s pre-pregnancy height and weight. An underweight woman needs to gain more than an overweight or obese woman. Women starting pregnancy obese need to gain the least amount of weight. The rate of weight gain is also important. Monitoring weight at each visit and plotting on a weight gain grid is the expected CPSP standard of care.

Providing women with personalized weight gain goals and education is important for a healthy birth outcome and the long-term health of a woman and her baby. Studies indicate that the majority of women are not receiving consistent or appropriate advice about weight gain and that most women gain beyond weight gain recommendations. CPSP offers an important opportunity for personalized weight gain education and counseling during pregnancy and postpartum. A healthy weight postpartum is vital for the woman’s health and the healthy outcomes of future pregnancies.

Risks of Unhealthy Preconception Weight

Today nearly half of California women enter pregnancy overweight or obese, with African-American and Hispanic woman experiencing the highest rates (Maternal and Infant Health Assessment (MIHA), 2009). Women entering pregnancy overweight or obese are at higher risk for gestational diabetes, pregnancy-related high blood pressure, premature delivery, cesarean section,

and postpartum weight retention. Infants born to overweight or obese women have higher rates of delivery complications and increased risk of birth defects, high birth weight, and obesity later in life. It is not advised to encourage overweight or obese women to restrict their dietary intake to lose weight. It is important that all women eat adequate nutrients and calories to support a healthy pregnancy.

Women entering pregnancy under a healthy weight are at higher risk for premature delivery, low birth weight, and a baby that faces higher risks of chronic diseases in later life such as high blood pressure, type 2 diabetes, and heart disease. Underweight women are more at risk of inadequate weight gain, which increases possible pregnancy complications and risks.

Risks of Low Gestational Weight Gain

Women who gain less than the recommended amount of weight during pregnancy are more likely to have low birth weight infants and poor pregnancy outcomes. Babies born small may be at greater risk for high blood pressure, type 2 diabetes and heart disease later in life. Women who are young, smoke, or begin pregnancy underweight are especially at risk for not gaining enough weight during pregnancy.

Risks of High Gestational Weight Gain

Women with high weight gain are more likely to deliver high birth weight infants increasing the risk of labor and delivery complications and increased cesarean sections. High weight gain may increase the risk of gestational diabetes, hypertension, preeclampsia, and permanent increases in weight leading to overweight and obesity. Helping women avoid high weight gain is important, especially for nulliparous women as they tend to experience the highest weight gain. Weight restriction outside of the weight gain recommendations or weight loss during pregnancy should be discussed between the health care provider and the woman.

Weight Gain Guidelines

These guidelines are based on of the Institute of Medicine’s (IOM) 2009 Weight Gain During Pregnancy: Re-examining the Guidelines report.

These guidelines encourage women to gain weight according to their pre-pregnancy Body Mass Index (BMI) category. BMI is a number calculated using a person’s weight and height (kg/m² or 703 x weight (lbs) / ht² (inches)) and provides a reliable indicator of body fatness for most people.

The Center for Disease Control and Prevention offers BMI assessment tools at: www.cdc.gov/healthyweight/assessing/bmi/index.html

Women who smoke, adolescents, African Americans and women of short stature are encouraged to gain within their BMI weight gain category without any modifications to their gestational weight gain recommendation. Weight gain is recommended for obese women and weight loss or weight restriction is not recommended as a general rule. The current IOM guidelines strongly encourage health care providers to offer all pregnant women counseling on healthy eating and physical activity to help women gain within their recommended weight range and return to a healthy postpartum weight.

Recommended Total Gestational Weight Gain

Pre-pregnancy weight is divided into four BMI categories. There is a recommended total weight gain range and a weekly weight gain rate for each BMI weight category. A woman’s BMI category is determined by her pre-pregnancy weight and height using Table 1 or a BMI calculator (www.cdc.gov/healthyweight/assessing/bmi/index.html). Healthy birth outcomes are possible over a wide weight gain range. The four BMI categories and recommended weight gain range for each category are listed in Table 2.

Table 1: WEIGHT CATEGORIES FOR WOMEN ACCORDING TO HEIGHT AND PREPREGNANT WEIGHT (LB.)*

Height (ft. in.)	Underweight (lbs)	Normal Weight (lbs)	Overweight (lbs)	Obese (lbs)
	BMI <18.5	BMI 18.5-24.9	BMI 25-29.9	BMI ≥30
4'7"	< 80	80-107	108-128	> 128
4'8"	< 83	83-111	112-133	> 133
4'9"	< 86	86-115	116-138	> 138
4'10"	< 89	89-119	120-143	> 143
4'11"	< 92	92-123	124-148	> 148
5'0"	< 95	95-127	128-153	> 153
5'1"	< 98	98-132	133-158	> 158
5'2"	< 101	101-136	137-163	> 163
5'3"	< 105	105-140	141-169	> 169
5'4"	< 108	108-145	146-174	> 174
5'5"	< 111	111-149	150-179	> 179
5'6"	< 115	115-154	155-185	> 185
5'7"	< 118	118-159	160-191	> 191
5'8"	< 122	122-164	165-196	> 196
5'9"	< 125	125-168	169-202	> 202
5'10"	< 129	129-173	174-208	> 208
5'11"	< 133	133-178	179-214	> 214
6'	< 137	137-183	184-220	> 220
6'1"	< 140	140-189	190-227	> 227
6'2"	< 143	143-194	195-233	> 233
6'3"	< 148	149-199	200-239	> 239
6'4"	< 152	152-204	205-246	> 246

To calculate BMI go to www.nhlbisupport.com/bmi/
 BMI=Weight (kg)/Height² (m²)

* Institute of Medicine. Weight Gain During Pregnancy: Reexamining the Guidelines. National Academies Press: Washington, DC. 2009

Example

A woman who is five feet, two inches tall and weighed 145 pounds at the time of her last menstrual cycle will have a BMI of 27 (according to Table 1). She would be in the overweight category.

Table 2: RECOMMENDATIONS FOR TOTAL AND RATE OF WEIGHT GAIN DURING PREGNANCY BASED ON PRE-PREGNANCY BMI¹

Pre-pregnancy BMI Category	BMI	Total Weight Gain Range (lbs)	Rates of Second and Third Trimester Weight Gain*
Underweight	<18.5	28-40	1-1.3
Normal Weight	18.5-24.9	25-35	0.8-1.0
Overweight	25.0-29.9	15-25	0.5-0.7
Obese	≥30.0	11-20	0.4-0.6

* Calculations assume a 0.5-2.0 kg (1.1-4.4 lbs) weight gain the first trimester (based on Siega-Riz et al., 1994; Abrams et al., 1995; Carmichael et al., 1997)

¹ Institute of Medicine. *Nutrition During Pregnancy, Part 1, Weight Gain*. National Academy Press: Washington, DC. 1990.

Example

The overweight woman in the previous example should gain a total of 15 to 25 pounds and 0.5 to 0.7 pounds per week after the first trimester.

Some women may gain more or less than the recommended amount. Gains outside the recommended range may be appropriate and it is important for each woman to have a discussion with her provider about her personalized weight gain goals and progress. There are no new recommendations specific for adolescents or severely obese women (BMI 40 or greater). It is important for severely obese women and adolescents to discuss personalized weight gain recommendations for pregnancy with their health care providers.

Twins

The 2009 IOM report provides guidelines for women pregnant with twins. The guidelines do not give specific recommendations for underweight women with twins or for other multiple births.

<u>BMI Category</u>	<u>Pounds</u>
Normal weight	37-54
Overweight	31-50
Obese	25-42

Importance of Assessing and Monitoring Gestational Weight Gain

Starting pregnancy at a healthy weight (normal BMI) is best to ensure a healthy outcome for both mother and baby. All women need to know how much total weight gain is recommended for their BMI category and stay informed about their weight gain progress. Plotting women's weight on a grid at each prenatal visit is important for monitoring weight gain progress. The weight gain grid allows the woman to clearly see her weight gain progress and helps her learn about the importance of healthy eating and physical activity.

It is important for the health care provider to assess several factors to determine whether gains outside the recommended range are appropriate:

- The quality of the woman's diet
- Any changes in physical activity patterns
- The pattern and total gain during previous pregnancies and pregnancy outcomes
- The age of the woman (very young mothers may gain more for their own growth and older multiparous women may gain less weight)
- Any pre-existing or new clinical conditions

Because weight gain is of vital interest to almost all women, assessing weight gain is an effective way to begin nutrition assessment and education. Assessing weight gain helps identify women in need of referral for in-depth nutrition assessment, education and other resources. A referral to a registered dietitian is recommended for women who enter pregnancy obese and/or are gaining outside of the guidelines.

How to Determine Gestational Weight Gain Goals and Assess Weight Gain

To determine recommended prenatal weight gain and track weight gain progress at each visit, you must know the woman's height, weight, pre-pregnant weight, and number of weeks gestation. Chart the woman's weight gain at each visit so she can track her progress.

Follow the step-by-step directions below:

1. Determine the Woman's BMI Weight Category by Assessing Her Height and Pre-Pregnant Weight:

- **Weight:** To obtain an accurate weight, place the scale on firm flooring (tile or wood, not carpet). Have the woman remove shoes and heavy clothing (coats, jackets, sweatshirts, etc.). Make sure the woman stands with both feet in the center of the scale. Record the woman's weight to the nearest decimal fraction (e.g., 155.5 pounds).
- **Height:** Measure the woman without shoes. Have the woman place her heels, buttocks and shoulder blades (three points of contact) against the wall or surface, stand up straight and look forward, with her head erect and not touching the wall or surface.
- **Pre-pregnant weight:** Ask the woman her weight at the time of her last menstrual cycle or refer to her medical record for a recorded pre-pregnant weight closest to the woman's last menstrual period. Some women do not know their pre-pregnant weight.
- **BMI:** Determine the woman's BMI weight category using Table 1 located on the page 13 or use an online BMI calculator such as www.nhlbisupport.com/bmi.

- **If pre-pregnant weight is unknown and the woman is less than 16 weeks gestation:** Calculate her BMI category by using the earliest first trimester weight available. Plot her weight on the grid that is appropriate for her BMI. Using her current week gestation, plot her current weight as normal weight gain.

2. Find the Recommended Range and Second/Third Trimester Rate of Weight Gain on Table 1:

- Each prepregnant weight category, underweight, normal weight, overweight and obese have specific weight gain recommendations

3. Use the Weight Gain Grid Correctly:

- Use the weight gain grid to see if the woman is gaining weight within the recommended range
- There are weight gain grids for each of the four weight categories: underweight, normal weight, overweight and obese
- New weight gain grids are available for twin births in three weight categories: normal weight, overweight and obese. No grid is available for underweight women with twins. Find weight gain grids in "Nutrition Tools" in the Appendix.
- Choose the weight gain grid that matches the woman's weight category. Find weight gain grids in "Nutrition Tools" in the Appendix.

Features of the Weight Gain Grids

<https://www.cdph.ca.gov/Programs/PSB/Pages/MCAH.aspx>

- The vertical zero line starts at conception
- The horizontal zero line represents the woman's pre-pregnant weight
- Each horizontal line above the zero represents one pound more than the pre-pregnancy weight
- Each line below the zero line is one pound less than the woman's pre-pregnant weight

- Each vertical line represents one more week into the pregnancy; there is a bold vertical line for each trimester
- The two lines on the weight gain grid represent the range of weight gain considered healthy for each BMI category. For this example, the recommended range for weight gain for a woman with normal pre-pregnant weight is 25-35 pounds.

4. Plot the Weight Gain Grid:

- Fill in the information on the correct weight gain grid
- If the woman is less than 16 weeks gestation, weigh and measure the woman and calculate her BMI category by using the earliest first trimester weight
- Weigh and measure the woman with shoes off and light outer clothes only. Many women appreciate privacy and sensitivity when they are weighed and measured. Take time to be accurate and caring.
- Compare the woman's weight at each visit with her pre-pregnancy weight. This number equals the number of pounds she has gained or lost.
- Determine the number of weeks gestation on the date she is first weighed
- Place a dot on the grid where the line representing the number of pounds gained or lost crosses the line representing the weeks of gestation
- Check to see whether the total weight gain at this visit falls within the woman's target weight gain range and if she is gaining the correct amount of weight per week
- Show the woman where her weight falls on the grid. Discuss her weight gain progress. Ask how she feels about her weight gain so far and make sure she knows her recommended GWG range.

5. Plotting Weight When Pre-pregnant Weight Gain is Unknown:

- Plot weight gain at each prenatal visit and assess weight gain progress. Always subtract the pre-pregnant weight from the current day's weight measurement.
- Look at the woman's medical record for a pre-pregnant weight near the time of her last menstrual period
- If her weight is unknown and the woman is less than 16 weeks gestation, weigh and measure the woman and use that weight as a pre-pregnant weight. If the woman is past 16 weeks and her weight is unknown, refer to the health care provider for a preferred method to estimate pre-pregnant weight
- If the pre-pregnant weight is unknown, make a note in the medical chart and follow your health care provider's policy and procedures to track weight gain and fetal growth

What the Weight Gain Grid Tells You:

- Weight gain can tell you if the woman is gaining too fast, too slow, or just right. The pattern of weight gain is as important as the total gain.
- The grid is also a screening tool to identify women who need more in-depth nutritional assessment and counseling. Sudden weight gain or loss may signal pregnancy complications.
- When a woman's gain is outside the recommended range, assess factors that may affect her weight gain. See the *Low Weight Gain* and *High Weight Gain* sections in these guidelines.

Some women may not follow the curves of the weight gain grid or may be four or five pounds above or below the recommended line even though they are eating a nutritious diet. Other women may be eating too little or too much. Find out what the woman is eating. Follow the guidelines for *Assessing Dietary Intake*.

Steps to Take

For all women, assess food intake using a 24-Hour Dietary Recall or other approved dietary recall method and compare her diet to *MyPlate for Moms*. Assess if she has the resources to get the healthy foods she needs and if she is on WIC.

- **If her weight gain is within the recommended range**, assess the woman's diet. If her diet is fine, praise her and encourage her to continue eating well. Encourage her to have at least 30 minutes of moderate physical activity each day. Review her food intake at least each trimester and plot her weight gain each visit.
- **If her weight gain is below the recommended range**, review *Low Weight Gain*. Even if the woman is not eating enough of certain foods, look for other factors that may explain the low weight gain or weight loss.
- **If her weight gain is above the recommended range**, review *High Weight Gain*. Do not advise weight loss. Even if the woman is eating too many high calorie foods, look for other factors that may also explain her excess weight gain.

Example: Prenatal Weight Gain Grid

A woman, five feet, four inches, weighed 140 pounds before pregnancy. Her pre-pregnancy BMI of 24 is in the normal weight category. She should strive for an increase of about 1 pound per week for a total gain of 25 to 35 pounds. Her weight should be plotted on the normal weight grid. At 18 weeks gestation she weighs 148 pounds (lbs).

To calculate her gain:

$$148 \text{ lbs} - 140 \text{ lbs} = 8 \text{ lbs}$$

She gained 8 lbs by 18 weeks gestation.

To Plot Her Weight on the Grid:

- Find the vertical line for 18 weeks gestation. Start at zero and count up eight lines (boxes) to indicate a gain of eight pounds by 18 weeks gestation.
- Mark a dot where these two lines meet
- This visit's weight gain falls within the woman's target range because she falls within the two lines on the weight gain grid
- Congratulate the woman for gaining a healthy amount of weight!

Underweight

(Pre-pregnant weight is below normal for height:
BMI of <18.5)

Underweight pregnant women have a greater chance of:

- Preterm birth
- A small, unhealthy baby
- A baby at risk for obesity and chronic diseases later in life

Recommended total weight gain: 28 to 40 pounds

Steps to Take

Assess

- Ask if the woman has pregnancy-related discomforts that affect her appetite
- Assess the intensity, frequency, and duration of her physical activity
- Assess her food intake, meal and snack patterns, and food preparation methods
- Assess how she feels about gaining weight in pregnancy. Is she anxious about weight gain?
- Assess if she has psychosocial issues such as stress/anxiety, body image, depression, or domestic violence that impact her appetite or food intake
- Find out if she is smoking, drinking, or using any substances that affect appetite and weight gain

Advise

- Stress the importance of regular meals and snacks and eating healthy foods when she is hungry. Explain how to follow MyPlate for Moms.
- Recommend a weight gain of at least 4 pounds or more each month (1 to 1.3 pounds per week)
- Explain the importance of gaining 28 to 40 pounds for her health and the health of her baby

- Offer educational materials that illustrate pregnancy weight gain components

Follow Up

- Check weight gain and rate of gain at each prenatal visit. Plot on the Underweight Grid.
- If weight gain is too low, assess the woman's food intake and physical activity patterns and discuss the *Tips to Gain Weight* handout.
- Check to see if the woman is enrolled in WIC and is able to obtain healthy food.

Referral

Refer to a health care provider and registered dietitian for in-depth assessment if:

- Weight loss is more than 4 pounds in the first 12 weeks of pregnancy
- No weight is gained by 16 weeks
- Weight gain is less than 14 pounds at 24 weeks
- Gain of less than 3 pounds in any single month after 14 weeks

Normal Weight

(Pre-pregnant weight is normal for height:
BMI of 18.5-24.9)

Normal weight pregnant women have a greater chance of:

- Giving birth at term (more than 37 weeks) and having a baby with a healthy birth weight
- Delivering vaginally, with fewer complications
- Returning to pre-pregnancy weight postpartum

Recommended total weight gain: 25 to 35 pounds

Steps to Take

Assess

- Assess the woman's food intake, meal and snack patterns, and food preparation methods
- Check to see if she has any pregnancy-related discomforts that affect her food intake

Advise

- Provide advice to relieve discomforts of pregnancy if any are present.
- Explain how to follow *MyPlate for Moms*. Advise eating regular meals and snacks.
- Recommend gaining about 3 to 4 pounds per month after her 16th week (about 1 pound/week)
- Offer educational materials that illustrate pregnancy weight gain components

Follow Up

- Check weight gain and rate of gain at each prenatal visit. Plot on the weight gain grid.
- If weight gain is too low, discuss *Low Weight Gain* and the *Tips to Gain Weight* handouts
- If weight gain is too high, discuss *High Weight Gain* and *Tips to Slow Weight Gain*

Referral

Refer to a health care provider and registered dietitian if:

- Weight loss is more than 5 pounds in the first 12 weeks of pregnancy
- No weight gained by 16 weeks
- Weight gain is less than 12 pounds at 24 weeks
- Gain of more than 6.5 pounds in any month
- Gain of less than 2 pounds in any single month after 14 weeks

Overweight

(Pre-pregnant weight is over normal for height:
BMI of 25.0-29.9)

Overweight women have a greater chance of having:

- A baby who weighs more than 9 pounds
- More problems with delivery and higher risk for cesarean delivery
- Health problems like gestational diabetes and pregnancy-related hypertension
- Postpartum weight retention and obesity-related diseases in the future

Recommended total weight gain: 15 to 25 pounds

Steps to Take

Assess

- Assess the woman's food intake, meal and snack patterns, and food preparation methods
- Assess physical activity and the amount of time the woman is sedentary
- Assess if the woman has psychosocial issues such as stress/anxiety, depression, disordered eating, domestic violence, or alcohol and/or substance abuse that impact her appetite and food intake
- Ask if changes in the woman's lifestyle or routine limit her physical activity
- Assess for other clinical conditions that need addressing by the health care provider

Advise

- Explain how to follow *MyPlate for Moms*. Help the woman understand the recommended number of servings of food groups and portion sizes.
- Discuss regular meals and snacks and listening to her body for eating and stopping cues
- Recommend gaining about 2 to 2.5 pounds per month after the 16th week (about 0.6 lbs per week)

- Explain the importance for both mother and baby of gaining 15 to 25 pounds during pregnancy

Follow Up

- Check weight gain and rate of gain at each prenatal visit. Plot on weight gain grid.
- If weight gain is too low, discuss *Low Weight Gain* and the *Tips to Gain Weight* handouts
- If weight gain is too high, discuss *High Weight Gain* and *Tips to Slow Weight Gain*

Referral

Refer to a health care provider and registered dietitian if:

- Weight loss is more than 5 pounds in the first 12 weeks of pregnancy
- No weight gained by 20 weeks
- Weight gain is less than 8 pounds at 26 weeks
- Gain of less than 2 pounds in a single month after 14 weeks
- Gain of more than 6.5 pounds in any month

Obese

(Pre-pregnant weight is obese for height: BMI of ≥ 30)

Obese women have a greater chance of having:

- A baby who weighs more than 9 pounds
- More problems with delivery
- Higher risk for cesarean delivery and birth defects
- Health problems like gestational diabetes and pregnancy-related hypertension
- Postpartum weight retention and obesity related diseases in the future

Recommended total weight gain: 11 to 20 pounds

Steps to Take

Assess

- Assess the woman's food intake, meal and snack patterns, and food preparation methods
- Assess physical activity and amount of time the woman is sedentary
- Assess if she has psychosocial issues such as stress/anxiety, depression, disordered eating, domestic violence, or alcohol and/or substance abuse that impact her appetite and food intake
- Ask if changes in the woman's lifestyle or routine limit her physical activity
- Assess if other clinical conditions need addressing by the health care provider

Advise

- Help the woman follow *MyPlate for Moms*. Help her understand the recommended number of servings of food groups and portion sizes.
- Discuss regular meals and snacks and listening to her body for eating and stopping cues
- Recommend a total weight gain of 11 to 20 pounds (about 0.5 pounds per week or 2 pounds per month after the 16th week)

- Explain the importance for both the woman and the baby of gaining 11 to 20 pounds

Follow Up

- Check weight gain and rate of gain at each prenatal visit. Plot on weight gain grid.
- If weight gain is too low, discuss *Low Weight Gain* and the *Tips to Gain Weight* handouts
- If weight gain is too high, discuss *High Weight Gain* and *Tips to Slow Weight Gain* handouts

Referral

Women entering pregnancy obese will benefit from a referral to a registered dietitian for and in-depth assessment. They will learn how to gain within recommended weight gain guidelines and to prevent postpartum weight retention and other consequences of obesity.

Refer to a health care provider and registered dietitian if:

- Weight loss is more than 8 pounds in the first 12 weeks of pregnancy
- No weight gained by 20 weeks
- Gain of more than 6.5 pounds in any single month after 14 weeks
- Gain of less than 1 pound in any single month after 14 weeks

Low Weight Gain During Pregnancy

Steps to Take

If the woman's weight gain is too low, use the following questions and interventions to assess and counsel:

Is there an error in measurement or recording?

- Recheck the woman's weight without shoes and plot the weight gain grid
- Was the correct weight gain grid used?

Check the pattern of weight gain. Is her weight in the recommended range for the week of gestation?

- Check the weight gain at previous visits to see if there was excess gain. Weight gain may slow after an initial excess gain.
- Look for a slow, steady gain even if weight gain is low
- Provide suggestions to help the woman gain at the recommended rate
- If gain is low, review her dietary intake and physical activity patterns. Discuss the *Tips to Gain Weight* handout.

Was she very overweight or obese at her pre-pregnant weight?

- Individualize weight gain goal depending on pre-pregnant weight and food intake
- Compare *MyPlate for Moms* with the woman's actual food intake for adequacy in number of servings from each group

Has she had an illness or infection?

- Refer to the health care provider

Does the woman have enough money and resources to get food for herself and her family?

- Review the woman's dietary intake
- Discuss *Tips to Gain Weight*

- Refer to WIC, Food Stamps, and other community food assistance sources

Is nausea, vomiting, or diarrhea a problem?

- See the *Nausea and Vomiting* section and refer to a health care provider as needed

Does the woman have a working stove, oven, or refrigerator at home?

- Offer suggestions on foods that require little preparation: crackers, nuts, breads
- See *Stretching Your Food Dollar*
- Refer to a community agency that can provide a stove or refrigerator, if needed

Does the woman exercise intensely or have a very active work or family life without enough rest?

- Has the woman had lifestyle changes that have increased her physical activity?
- Discuss her exercise habits with a health care provider to ensure safety

Does the woman have habits or issues that may cause low weight gain (e.g., smoking, alcohol or drug use, excessive stress, domestic violence, distorted body image)?

- Refer to health care provider or social worker
- See appropriate "Psychosocial" guidelines as needed

Follow Up

Use the following to reassess the woman's condition:

- Check weight gain and rate of gain at next prenatal visit. Plot on weight gain grid.
- Review individual weight gain goals
- Assess the woman's food intake and compare to *MyPlate for Moms*

Referral

Refer to a health care provider and registered dietitian if weight gain remains below the recommended range.

High Weight Gain During Pregnancy

Steps to Take

If the woman's weight gain is too high, use the following questions and interventions to assess and counsel.

Is there an error in measurement or recording?

- Recheck the woman's weight without shoes. Plot on the weight gain grid.
- Was the correct weight gain grid used?

Was the woman underweight prior to this pregnancy?

- Weight gain should be more rapid if she had a very low weight before pregnancy or if she is young and still growing. Nulliparous women often gain more weight than multiparous women.

What was the woman's weight gain at previous visits?

Check to see if there was a previous weight loss or low gain.

- Look for a pattern of weight gain close to the grid lines. If the total gain is too high, discuss *Tips to Slow Weight Gain*.

Is the pattern of weight gain good and in the recommended range for week of gestation?

- Provide suggestions to help the woman gain at the recommended rate
- Assess her food intake and review *MyPlate for Moms*

Has she recently stopped smoking?

- Provide support and suggest lower calorie foods to eat and other stress reducing activities

Check with health care provider about the possibility of twins or triplets.

- Revise weight gain goals if more than one fetus is found

- If twins or triplets are detected refer to the registered dietitian and health care provider

Has she changed food habits recently or changed activity level due to bed rest or injury?

- Encourage 30 minutes of moderate daily physical activity if permitted
- Check with the health care provider for any activity restrictions

Does the woman have a problem with overeating or food cravings?

- Review and discuss *Tips to Slow Weight Gain*
- Refer to the health care provider and/or registered dietitian for problems with overeating

Does the woman complain of swelling in her hands, feet or ankles?

- Refer to the health care provider for possible edema
- Encourage her to elevate her feet

Follow Up

Use the following to reassess the woman's condition:

- Check weight gain and rate of gain at next prenatal visit. Plot on weight gain grid
- Review individual weight gain goals
- Assess her food intake and review *MyPlate for Moms*

Referral

Refer to a health care provider and registered dietitian if weight gain is more than 6.5 pounds in any month or weight gain remains above the recommended range.

References

Institute of Medicine

Nutrition During Pregnancy, Part 1, Weight Gain
National Academy Press: Washington, DC. 1990.

Weight Gain During Pregnancy: Re-examing the Guidelines, National Academy Press: Washington, DC. 2009.

Influence of Pregnancy Weight on Maternal and Child Health: Workshop Report, National Academy Press: Washington, DC. 2007. (Online version available at: www.nap.edu)



Tips To Gain Weight

It is important to have a healthy weight gain when you are pregnant.

Follow *MyPlate for Moms* to eat all the servings of the healthy food groups you need each day. To gain weight you may need to eat more than you are used to. That's okay, as long as you make healthy food choices!

Check off each tip you are doing already and circle the tip you are willing to try.

Here's what you can do:

- Eat snacks or small meals every two to three hours
- Take snack foods along with you. Try trail mix, nuts, and fruits.
- Drink healthy beverages with calories like milk, fruit juices, and milkshakes
- Keep crackers or other snacks at your bedside
- Eat at night if you wake up and are hungry

Try these easy healthy snacks:

- Put peanut butter on bread
- Make bean dip to eat with chips
- Eat yogurt, custard, pudding, or cheese
- Try healthy cookies and milk. Good cookie choices are: oatmeal, peanut butter, and fruit bars.
- Eat ice cream, frozen yogurt, or ice cream bars
- Eat muffins, bagels, granola, or cereals

More healthy tips:

- Cut back to no more than one cup of coffee or tea with caffeine a day
- Stay away from cigarettes, alcohol, and drugs
- Limit sodas and candy. These foods can fill you up but do not provide needed nutrients



TAKE ACTION

My Healthy Eating Plan to Gain Weight

For my next visit, I will do the following to maintain a healthy weight gain:



Consejos para Aumentar de Peso

Cuando está embarazada, es importante aumentar una cantidad de peso saludable.

Siga *MiPlato para mamás* para comer todas las porciones de los grupos de alimentos saludables que necesita todos los días. Es posible que necesite comer más de cada grupo de alimentos para aumentar de peso. ¡Está bien que coma más, siempre que esté eligiendo alimentos saludables!

Marque cada consejo que ya está haciendo y trace un círculo alrededor de los consejos que está dispuesta a intentar.

Le aconsejamos que haga lo siguiente:

- Coma bocadillos o comidas pequeñas cada dos a tres horas
- Lleve bocadillos consigo. Pruebe frutos secos mezclados (trail mix), nueces y frutas.
- Tome bebidas con calorías, como por ejemplo leche, jugos de fruta, y batidos de leche
- Tenga galletas saladas u otros bocadillos al lado de la cama
- Coma de noche si se despierta con hambre

Pruebe estos bocadillos saludables:

- Agréguele crema de cacahuete al pan
- Haga una salsa de frijoles para comer con totopos
- Coma yogur, natilla, pudín o queso
- Pruebe galletas saludables con leche. Las siguientes galletas son saludables: avena, crema de cacahuete y barras de fruta
- Coma helado, yogur helado o barras de helado
- Coma molletes, bagels, granola o cereales

Más consejos saludables:

- No tome más de 1 taza de café o té con cafeína por día
- Evite los cigarrillos, el alcohol y las drogas
- Limite los refrescos carbonatados y las golosinas. Estas comidas la pueden llenar pero no le dan los nutrientes que necesita.



TOMA ACCIÓN

Mi Plan de Comidas Saludable para Aumentar de Peso

Para mi próxima consulta, haré lo siguiente para alcanzar un aumento de peso saludable:



Tips To Slow Weight Gain

STEPS TO TAKE

Choose foods with fewer calories per bite. Follow *MyPlate for Moms* to eat the healthy food you need from each group. Limit foods that add extra calories and few nutrients to your diet.

Check off each tip you are doing already and circle the tip you are willing to try.

Vegetables and fruits: Aim for at least three cups of colorful vegetables and two cups of fruit each day. Try these tips:

- Eat fresh vegetables and fruits for meals and snacks
- Limit starchy vegetables like potatoes to one or two servings per day
- Eat baked or boiled potatoes instead of french fries
- Limit fruit juice to 1/2 cup each day
- Buy frozen vegetables with no sauces and fruits packed in juices not syrups
- Eat plenty of salad and limit dressings to 1 tablespoon

Milk: Get three servings of milk and milk products each day with fewer calories:

- Nonfat or 1% (skim) milk or low fat soy milk
- Low fat cheese and cottage cheese
- Yogurt with less fat and sugar



Meat and beans: Select 6 to 7 ounces from these low fat choices:

- Fish and water-packed tuna
- Flank or round steak, lean or extra lean ground beef (15% fat). Regular hamburger is 30% fat.
- Any kind of beans, such as pinto, black, or kidney beans made without lard or fat
- Tofu or other vegetarian protein foods
- Extra lean or 97% fat free meats. Eat less bologna, bacon, sausage, and canned meat
- Chicken and turkey without skin
- Broil, barbeque, or bake meats, poultry, and fish to cut fat calories in half

Grains, breads, cereals: Make your 6 to 8 grain servings high fiber and low fat:

- Try whole grain rice, pasta, and noodles. Read the label and look for the words "whole grain".
- Try bran cereal and oatmeal for fiber and fullness
- Watch serving sizes: 1 ounce bread or tortilla, 1/2 cup rice or pasta and 3/4 cup cereal count as one serving. A large bagel counts as four servings. Limit daily servings to seven to eight.
- Try low fat crackers like rice crackers or baked crackers
- Make pastries, cakes, and cookies "once in a while" foods
- Steam or boil rice, noodles, and grains. Frying adds fat.
- Substitute tomato sauce or light sauces on pasta and noodles. Cream and white sauces are high in fat.



Tips To Slow Weight Gain

STEPS TO TAKE

Oils: You need to eat 6 teaspoons of healthy plant oils each day. Limit fats from animals; they are not as healthy for you and they add fat and calories to your food. Try to:

- Use less animal fats like butter, lard, cream and half and half
- Look for the words low fat, lean, extra lean, and fat free on food labels
- Make more food from scratch. Processed food can be high in fat, sugar and sodium.
- Eat less fast food. When you do dine out, choose the lower calorie items.
- Use spray oils when cooking
- Stir fry meats and vegetables to use less oil than deep frying
- Use herbs and spices and small amounts of fat to flavor food



Here are more ideas to try. Check off the ideas that will help you the most:

- Record everything you eat and drink for three days and compare your intake to *MyPlate for Moms*. Writing down what you eat may help you make healthier choices.
- Set two or three daily goals for healthy eating to maintain weight. Write these goals down and share them with someone who can support you.
- Drink plenty of water every day instead of soda or fruit drinks
- Drink decaffeinated coffee drinks with nonfat milk and limit sweeteners and cream
- Eat slowly and chew each bite of food well
- Sit down at a table when you eat. Try to not eat in cars, sitting on the couch, or on the go.
- If you are stressed and upset, talk to someone instead of eating when you are not hungry
- When you eat, simply eat and enjoy your food. Try not to watch T.V., read, or study while eating. Eat with friends and family when you can.
- Eat only when you are hungry. Listen to your body to tell you when you are full.
- Try to stay away from junk foods like sodas, candy, cakes, chips, punch, Kool-Aid®, donuts and popsicles. Pick a healthier choice like calorie-free fruit flavored water, crunchy fruits and vegetables, and air popped popcorn.
- Enjoy sweet foods, chips, and fries as “once in a while” foods



Consejos para reducir el aumento de peso

PASOS A SEGUIR

Escoja alimentos con menos calorías por bocado. Siga *MiPlato para mamás* para comer la comida saludable que necesita de cada grupo de alimentos. Limite los alimentos que agregan calorías adicionales y pocos nutrientes a su dieta.

Marque cada consejo que ya está haciendo y ponga un círculo alrededor de los consejos que está dispuesta a intentar.

Verduras y frutas: Intente comer por lo menos tres tazas de verduras de distintos colores y dos tazas de fruta todos los días. Pruebe estos consejos:

- Coma verduras y frutas frescas en las comidas y bocadillos.
- Limite las verduras con almidón, como las papas, a 1 o 2 porciones por día.
- Coma las papas al horno o hervidas en vez de papas fritas.
- Limite el jugo de fruta a 1/2 taza por día.
- Compre verduras congeladas sin salsa y frutas enlatadas con jugo en lugar de almíbar.
- Coma ensalada en abundancia y limite los aderezos a 1 cucharada.

Leche: Tome 3 porciones de leche y productos de la leche con menos calorías todos los días:

- Leche descremada o con el 1% de grasa (baja en grasa) o leche de soja con bajo contenido de grasa.
- Queso y requesón con bajo contenido de grasa.
- Yogur con menos grasa y azúcar.



Carne y frijoles: Escoja 6 a 7 onzas de las siguientes opciones bajas en grasa:

- Pescado y atún enlatado en agua.
- Bistec arrachera (flank) o redondo, o carne molida magra o extra magra (15% de grasa). La carne molida común tiene el 30% de grasa.
- Cualquier tipo de frijol, como el frijol pinto, frijol negro y frijol rojo, cocinados sin manteca o grasa.
- Tofú u otros alimentos de proteína vegetariana.
- Carnes muy magras o carnes 97% libres de grasa. Coma menos mortadela, tocino, salchicha y carne enlatada.
- Pollo y pavo sin piel.
- Cocine las carnes, aves y pescados asados, a la parrilla o al horno para cortar las calorías por la mitad.

Granos, panes, cereales: Coma 6 a 8 porciones con alto contenido de fibra y bajo contenido de grasa:

- Pruebe arroz, pastas y fideos integrales. Lea la etiqueta y busque las palabras "whole grain" (grano integral).
- Pruebe el cereal de salvado y avena para obtener fibras y sentirse llena.
- Fíjese en el tamaño de las porciones: 1 onza de pan o tortilla, 1/2 taza de arroz o pastas y 3/4 de taza de cereales cuentan como una porción. Un bagel grande cuenta como 4 porciones. Límitese a 7 a 8 porciones por día.
- Pruebe las galletas saladas bajas en grasa, como las galletas de arroz o las galletas horneadas.
- Haga que los pasteles y galletas dulces sean alimentos "ocasionales".
- Cocine el arroz, los fideos y los granos al vapor o hiérvalos. La fritura agrega grasa.
- Use salsas de tomate o salsas con poca grasa para las pastas y fideos. Las salsas a base de crema y las salsas blancas tienen mucha grasa.



Consejos para reducir el aumento de peso

PASOS A SEGUIR

Aceites: Necesita comer 6 cucharaditas de aceites vegetales saludables por día. Limite las grasas animales; no son tan saludables y agregan grasa y calorías a su comida. Intente:


- Usar menos grasas animales, como mantequilla, manteca, crema y mitad leche-mitad crema.
- Busque las palabras “low fat” (bajo en grasa), “lean” (magro), “extra lean” (extra magro) y “fat free” (sin grasa) en las etiquetas de alimentos.
- Prepare más comidas caseras. La comida procesada puede tener un alto contenido de grasa, azúcar y sodio.
- Coma menos comidas rápidas. Cuando salga a comer, escoja las opciones con menos calorías.
- Use aceites en rociador para cocinar.
- Salte las carnes y verduras en aceite para usar menos aceite que al freírlas.
- Use hierbas y especias y pequeñas cantidades de grasa para sazonar la comida.



Estas son más ideas que puede probar. Marque las ideas que la ayudarán más.

- Anote todo lo que coma y beba por 3 días y compare lo que ingiere con MiPlato para mamás. Al anotar lo que está comiendo, podrá tomar decisiones de comida más saludables.
- Fije 2 o 3 metas diarias para comer de forma saludable y mantener su peso. Escriba estas metas y compártalas con alguien que la pueda apoyar.
- Beba agua en abundancia todos los días en lugar de refrescos o bebidas de fruta.
- Beba bebidas de café descafeinadas y con leche sin grasa, y limite los endulzantes y la crema.
- Coma despacio y masque bien cada bocado de comida.
- Siéntese en la mesa para comer. Trate de no comer en carros, sentada en el sofá o de paseo.
- Si está estresada y molesta, hable con alguien en lugar de comer cuando no tiene hambre.
- Cuando coma, simplemente coma y disfrute su comida. Trate de no ver televisión, leer o estudiar mientras come. Coma con amigos y su familia cuando pueda.
- Coma solamente cuando tiene hambre. Preste atención a su cuerpo para saber cuando está satisfecha.
- Trate de evitar la comida chatarra como los refrescos, los dulces, los pasteles, las papitas, el ponche, el Kool-Aid®, las rosquillas y las paletas heladas. Escoja algo más saludable, como agua sin calorías con sabor a fruta, alguna fruta o verdura crujiente, o palomitas de maíz hechas con aire caliente.
- Disfrute de los alimentos dulces, las papitas y las papas fritas como alimentos “ocasionales”.

CPSP Dietary Intake Assessment

 PSP requires that all initial nutrition assessments, trimester reassessments, and postpartum assessments include a dietary intake to compare the woman's food intake to a science-based standard for pregnancy. The United States Department of Agriculture (USDA) has developed nutrition information for pregnant and breastfeeding women: <https://www.choosemyplate.gov/moms-pregnancy-breastfeeding>.

The USDA *ChooseMyPlate (MyPlate) Daily Food Plan for Moms* is an online, personalized, and interactive dietary guideline tool for pregnant, breastfeeding, and formula feeding women (www.choosemyplate.gov/pregnancy-breastfeeding.html). *ChooseMyPlate* replaced *MyPyramid*. Dietary guidelines are available for food intake patterns from 2,000 to 3,000 calories. Specific dietary guidance is not available for obese pregnant and postpartum women, or for women with gestational diabetes or other conditions requiring medical nutrition therapy. If using the online interactive tool is not an option, use the *MyPlate for Moms* handout for both pregnant and breastfeeding women.

There is no one required method or form you must use to assess a woman's diet at her initial, reassessment, or postpartum visit. A complete CPSP nutrition assessment includes:

- A food intake assessment
- A nutrition assessment of dietary strengths, challenges, and practices
- An assessment of weight gain on a grid
- Document findings, intervention, and referrals on the individualized care plan

The *24-Hour Perinatal Dietary Recall* and the *Perinatal Food Group Recall* are dietary intake assessment

forms provided in the "Appendix" under *Nutrition Tools*. Weight gain grids are also available in the "Steps to Take" Appendix.

The dietary assessment and intervention provides an opportunity to:

- Assess strengths and gaps in a woman's typical eating pattern by comparing her intake to *MyPlate for Moms*
- Assess a woman's food insecurity and refer her to needed supplemental food and financial resources
- Assess and address any food safety concerns
- Help a woman develop a healthy eating plan, keeping in mind her food habits, culture, family, weight, health status and lifestyle
- Educate a woman on the healthiest food choices from every food group
- Stress the importance of WIC education and food checks to help the woman achieve a healthy diet. Encourage her to buy and eat the foods WIC offers
- Discuss the importance of safe daily physical activity
- Provide referrals for complex medical/nutrition conditions. "Steps to Take" offers referral criteria under most nutrition guidelines
- Celebrate healthy food and activity habits and changes
- Offer guidance and support for ongoing improvement

How to Assess Food Intake

"Steps to Take" includes two methods to assess the food intake of pregnant, breastfeeding or postpartum women. The first is the *24-Hour Perinatal Dietary Recall* and the second is the *Perinatal Food Group Recall*. No dietary intake method completely reflects a woman's food intake. Both tools provide a basis for educating and encouraging a woman to make healthy eating choices based on *MyPlate for Moms*. Other food intake methods that have been reviewed and approved by state designated staff are allowed.

The 24-Hour Perinatal Dietary Recall

Conducting a *24-Hour Dietary Recall* takes practice. As you learn the steps and complete several recalls you will feel more comfortable and get better results. Experts have found the best results come from using a step-by-step method. For a more complete picture of what the woman ate in the last 24 hours, follow these steps:

Before you begin, always explain what you are going to do.

I am going to ask you to tell me everything you ate and drank during the last 24 hours. I will ask questions to get the most accurate food intake possible. I will compare your food intake with a food guide that includes all the nutrients and energy you need for a healthy pregnancy (or for postpartum and breastfeeding needs). Please be sure you tell me everything you ate or drank, even the small things like butter, salad dressings, cream, and candies, so I can give you the best healthy eating information possible.

Step 1: Make a Quick List

Make a quick list of everything the woman ate or drank during the 24-hour period. Write the food down on the *24-Hour Perinatal Dietary Recall* in the "Food" column. Write down one main food item per line. Do not worry about serving sizes or the time the food was eaten during Step 1.

Key Points:

- Begin in the morning after the woman woke up and write down all the food she ate in a 24-hour time period
- Avoid using words like breakfast, lunch, or dinner. People have different meanings for these words and you also may miss the foods eaten in between meal times.
- Be gentle and kind. Food intake is very personal information and negative comments or gestures may decrease the accuracy of the dietary recall.
- Some people eat in the middle of the night; ask the

woman if she ate anything after she went to sleep

- Record any vitamins, minerals, and other nutrition supplements such as protein powder, fish oils, herbs, etc.

Step 1 Questions:

- Healthy eating is important for you and your baby. Please tell me everything you had to eat or drink yesterday.
- What was the first thing you ate or drank after you woke up yesterday?
- What was the next thing you ate or drank after that?
- What was the last thing you ate in this 24-hour period?

Step 2: Forgotten Food List

Look over the food list with the woman and ask if there is anything else she remembers eating or drinking. Add these foods to the recall.

Key Points:

- Easy to forget foods like butter, half and half, mayonnaise, salad dressings, fats used in cooking, and snacks may contain many calories and few nutrients.
- Check to see that all beverages are recorded, including sodas, coffee, teas, juices, and any type of water-based beverage.

Step 2 Questions:

- Did you have any snacks yesterday?
- What beverage did you drink with this meal?
- Do you use cream or sugar in your drink?
- Did you spread anything on your bread, biscuit, or muffin?
- Did you add butter or margarine to the potato or vegetables you ate?
- Did you add anything to give your food flavor or taste better?
- Did you eat tortillas, pieces of bread, or rolls with your meal?

Step 3: Time and Occasion

It is helpful to ask the woman what time she ate the food to learn more about her food habits and to help her remember other foods she ate. Record times of food eaten in the “Time” column.

Step 3 Questions:

- What time did you eat this meal?
- When did you eat next?
- Was there a special occasion on this day?

Step 4: Detailed Description of Food Eaten

To assess if all the food groups were eaten in the amount needed, you will need to compare the types and amounts of food eaten to MyPlate for Moms. The amounts in MyPlate are described using household measures of cups (fruits, vegetables, and dairy foods), ounces (protein foods and grains) and teaspoons (oils).

It is important to determine the amount eaten of each food group. Use food models and pictures, measuring cups and spoons, dinner plates and bowls to help assess the amount of each food item eaten. Write the amount she ate for each food item in the “How Much” column of the dietary recall.

Step 4 Questions:

- Did you bake, broil, boil or fry the chicken you ate?
- How did you flavor the broccoli you ate?
- How much oil did you use to fry the potatoes?
- How much butter did you add for each pancake?
- Which of these measuring spoons or cups best describes the amount of gravy, salad dressing, sour cream, etc. you ate?

Check for added fat. Cooking methods affect the amount of fat in a woman’s diet. Ask about added cream, butter, sauces, salad dressings, cheese, etc.

Step 4 Questions:

- Did you bake, broil, boil, or fry the chicken you ate?
- Did you leave the skin on or take it off the chicken? Before or after cooking?
- How did you flavor the broccoli you ate?
- How much oil did you use to fry the potatoes?
- How much butter did you add for each pancake?
- Which of these measuring spoons or cups best describes the amount of gravy, salad dressing, sour cream, etc. you ate?

Step 5: Final Review of the 24-Hour Dietary Recall

Ask the woman to look at the complete list of the food items she ate to see if she can remember anything else she ate or drank.

Calculate the Dietary Intake

Once you have recorded all the types and amounts of food eaten in 24 hours, it is time to add up the total number of servings eaten per day in each food group.

You will need to:

- Decide which food group the food or drink fits into
- Review the food groups on the ChooseMyPlate website. You need to decide if the food fits under the grains, vegetables, fruits, dairy, protein, or oils category.
- Decide total amount of each food group eaten

Amounts or servings are counted in cups, ounces or by teaspoons, depending on the food group. The box below describes how food amounts are counted at www.choosemyplate.gov.

Food Amounts for MyPlate for Moms

Food Groups	Amounts or Servings
Vegetables	Vegetables are counted by cups and most pregnant and breastfeeding women need 3 cups a day. 2 cups raw leafy vegetables (like salad) and 1 cup raw or cooked vegetables each count as 1 cup. Total up all the cups of fresh, frozen, and canned vegetables eaten in a day.
Protein	Protein is counted in ounces and most pregnant and breastfeeding women need 6-7 ounces a day. One ounce of meat, 1 egg, ½ ounce of nuts, ¼ cup of cooked beans and peas, ¼ cup tofu, and 1 tablespoon of peanut butter count as 1 ounce of protein. A meat portion the size of a deck of cards is about 3 ounces. Most women eat enough protein rich foods. Vegetarian women can get the protein they need eating legumes, soy products, nuts and seeds. See <i>Vegetarian Eating</i> if the woman does not eat meat, poultry or fish.
Grains	Grains are counted by 1 ounce equivalents and most pregnant and lactating women need at least 6-8 ounces of grains per day. 1 ounce is counted as 1 serving. Common 1 ounce portions: 1 slice of bread, 1 mini bagel, 1 6-inch corn or flour tortilla, ½ cup cooked rice, pasta or hot cereal, 1 cup ready to eat cereal, ½ English muffin, 1 small muffin (2 ½ inches).
Fruits	Fruits are counted by cups and most pregnant and lactating women need 2 cups of fruit each day. 1 cup fresh, unsweetened frozen or canned fruit, ½ - ¾ cup 100% fruit juice and ½ cup of dried fruit count as one cup.
Dairy	Dairy is counted by 1 cup servings and most pregnant and lactating women need 3 cups per day. One cup of dairy equals: 1 cup fluid milk or calcium fortified soy milk, 1 cup yogurt, 1½ ounces of hard cheese, ½ cup shredded cheese, 2 ounces (2 slices) processed cheese, 2 cups cottage cheese and 1½ cups ice cream. Advise to eat pasteurized low and nonfat dairy foods.
Oils	Oils servings are counted in teaspoons and most pregnant and lactating women need 6 teaspoons of oils from plants, nuts and seeds each day. Commonly eaten oils include dressings and plant oils to prepare and cook foods. Use measuring spoons to help women estimate the amount of oil eaten. 1 tablespoon of oil is equal to 3 teaspoons. Solid fats like lard, butter, cream, half and half, do not count as oils, they are counted as empty calories.

Extra fats and sugars—“Empty Calories”

MyPlate for Moms includes limited calories of extra fats and sugars per day. Encourage woman to replace empty calorie food with healthy choices. It is okay for women to have extra fat and sugar once in a while if her weight gain is not high and the foods are allowed in her diet.

Combination or Mixed Dishes

When several foods are used together like casseroles, burritos, spaghetti, lasagna, soups, or stews, you may have to estimate the amount of each food eaten.

Choose *MyPlate Counting Mixed Dishes* can help count the servings sizes in many popular mixed dishes.

See <https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Topics/Nutrition-MyPlate.aspx>. To count the servings and added fat and sugars from individual foods used in mixed dishes, use Food-A-Pedia at: www.choosemyplate.gov/SuperTracker/foodapedia.aspx

Example: Tuna Fish Sandwich

Food Eaten	Food Group	Servings
2 oz. tuna water packed	Protein	2
2 slices whole wheat bread	Grains	2
2 tsp. mayonnaise	Oils	2

Compare the Food Intake to *MyPlate for Moms*

There are two ways to compare a woman's 24-hour dietary intake with *MyPlate for Moms* guidelines. You may compare the woman's food intake to the *MyPlate for Moms* handout or you can enter her height, pre-pregnant weight, due date, activity level, and food intake in the *MyPlate SuperTracker* tool at: www.choosemyplate.gov/SuperTracker/foodtracker.aspx.

Work alongside the woman to develop her individualized food plan and to review the *SuperTracker* results. Note that *MyPlate* will not calculate an eating plan for obese women and should not be used for women with diabetes or other complex health conditions requiring the skills of a registered dietitian.

Steps:

1. Add up the amounts eaten for each food group and record the number under "Total Servings" column on the 24-Hour Perinatal Dietary Recall Intake Form.
2. Compare the number of servings of each food group eaten with the minimum number of recommended servings on *MyPlate for Moms*.
3. Compliment the woman for the strengths of her food choices and intake.
4. Circle or underline all foods eaten that provide extra fat and sugar (e.g., soda, chips, candy, cookies, pastries, and sweet drinks).
5. Review the food groups that are missing or eaten in inadequate amounts. Ask the woman about these food groups. Can she afford these foods? Does she dislike these foods?
6. Ask her what she is willing to do to improve her food intake.
7. Review the handout *What Should I Eat?* and help the woman set healthy eating goals.
8. Document your discussion on the dietary assessment and Individualized Care Plan
9. Record the total number of minutes to complete the entire CPSP nutrition assessment, including plotting of the weight gain grid, a food intake assessment and a nutrition assessment questionnaire. Complete the individualized care plan with the client and schedule a follow up reassessment and intervention.

Web Resources for Food Intake Assessments

These resources are provided to help CPSP practitioners assess dietary intake and provide nutrition counseling and education.

ChooseMyPlate.gov Resources

SuperTracker

Track Food Intake

www.choosemyplate.gov/SuperTracker/foodtracker.aspx

Track Physical Activity

www.choosemyplate.gov/SuperTracker/physicalactivitytracker.aspx

Track Personal Goals

www.choosemyplate.gov/SuperTracker/mytop5goals.aspx

Food-A-Pedia Nutrition information on over 8,000 foods and shows calories from extra sugars and solid fats.

www.choosemyplate.gov/SuperTracker/foodapedia.aspx

Other Resources for Food Intake Assessments

Food Gallery

Oklahoma State University, Department of Nutritional Sciences <http://nutrition.okstate.edu/foodgallery.htm>

This is an excellent resource to help assess dietary intake. The food gallery contains actual pictures of food on 10-inch plates to help people recognize the appearance of various amounts of foods on a plate.

The Perinatal Food Group Recall Method

The *Perinatal Food Group Recall* (found in the Appendix) is an alternative food intake method. This method provides an overview of the woman's daily diet; it does not ask the woman to describe everything she ate in 24 hours. Whatever the dietary assessment method used, it is most important that the woman makes healthy food selections. The *Perinatal Food Group Recall* asks questions about a woman's usual daily intake; it does not ask about her specific intake for one day. Shading on the form's boxes indicates a nutritional concern to address with the client. The "Advise Patient to" column provides brief nutrition guidance for each food group.

Using the Perinatal Food Group Recall Form

- Explain to the woman that you will ask her questions about her usual eating habits in order to determine if she is eating the kinds of and amounts of foods that her body needs for a healthy pregnancy.
- To introduce each food group to the woman you can use *MyPlate for Moms*. Follow the form and explain to the woman what the food group is and how much counts as a serving.

For Example, You Can Say:

The first group is the fruit group. Fruits are counted by cups and most pregnant and lactating women need 2 cups of fruit each day. 1 cup fresh, unsweetened frozen or canned fruit, ½ - ¾ cup 100% fruit juice and ½ cup of dried fruit count as one cup. On a typical day, how many cups of fruit do you eat a day? How many cups of juice do you drink a day? How many cups of dried fruit do you eat a day?

- Determine approximately how many servings of each food group the woman eats on a typical day. It is important she eats at least the minimum number of servings daily to get the nutrients needed. Use the *MyPlate* website, pictures, measuring cups and spoons, food models, etc. to help women identify the number of servings eaten in each food group.

Say:

On a typical day, how many cups of fruit? How many cups of juice? How many cups of dried fruit?

- For most questions, you will indicate the number of food group servings eaten each day by checking the appropriate box such as:
 - Never
 - Fewer than three servings per day, etc. in the appropriate column such as Initial, 2nd Tri(mester), 3rd Tri or Post(partum)

- For questions 6 and 7, you will check either Yes or No
- For question 8, write the total number of cups the woman drinks of each of the types of beverages on a typical day. Sugary drinks are “sometimes foods” and avoiding caffeine is the prudent choice during pregnancy. Twelve ounce cans equal 1½ cups, 16 ounces equals 2 cups and 20 ounce drinks equal 2½ cups.
- For question 9, check “Yes” if the woman eats extra foods from each of the categories. Leave blank if she does not eat these foods. If she does eat these extra foods, ask how much and how often she eats them (e.g., several times a day, once daily, two to three times a week, etc.).
- If the woman’s response falls in a shaded box, such as she never eats vegetables or fewer than three servings on a typical day, give her the advice and check off the box:
 - Aim for three or more servings per day.

	Initial	2 nd Tri	3 rd Tri	Post
Never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fewer than three servings per day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Three or more servings per day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the woman’s response falls in an unshaded box, such as she eats four servings of vegetables on a typical day, tell her that she has made good choices and check off the box.

- Aim for three or more servings per day.
- Check other “advice boxes” as needed. For example if the only vegetables she eats are starchy vegetables like corn, advise her to eat more dark green and orange vegetables.

- For questions 7, 8, and 9, help the woman make healthy substitutions for her usual unhealthy choices if needed such as:
 - ◆ If the patient uses lard in her cooking, ask her which of the healthy plant oils she might try using instead
 - ◆ If the patient eats donuts and chips, ask her which healthy snack foods she might eat instead
- Write the healthy choice on the line provided and check the appropriate “advice boxes” such as:
 - Avoid foods high in fat and sugar and
 - Choose fruits, vegetables, nuts, and seeds as snacks.
- After the last question, review the woman’s strengths and risks with her
- In the Advice section, circle and date one or more items that the woman is willing to improve/change by her next visit. Include these action items in her individualized care plan.
- At the bottom of the form, clearly sign your name, including your job title and the date
- Since the dietary assessment is done at the same time as rest of the woman’s nutrition assessment, the time spent on filling out the form should be included in nutrition assessment minutes. For example, if it took eight minutes to complete the dietary assessment and 27 minutes to fill out the initial nutrition assessment form and plot the weight gain grid, add the numbers together to get 35 minutes. Write 35 minutes on the bottom of the initial nutrition assessment form.
- Patient takes home a copy of *MyPlate for Moms* to reinforce the healthy eating messages

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California MyPlate for Moms

Make half your plate vegetables and fruits, about one quarter grains and one quarter protein. Choose foods that are high in fiber and low in sugar, solid fats and salt (sodium). For most women, these are the average food amounts for one day.



Vegetables

Eat more vegetables.

Use fresh, frozen or low-sodium canned vegetables. Avoid French fries.

Daily Amount

- 3 or more of these choices:
- 2 cups raw leafy vegetables
- 1 cup raw vegetables or juice
- 1 cup cooked vegetables



Protein

Choose healthy protein.

Eat vegetable protein daily. Avoid bacon, hot dogs and bologna.

Daily Amount

- 6-7 of these choices:
- 1 ounce fish, poultry or lean meat
- 1 egg
- ½ ounce nuts
- ¼ cup cooked dry beans, lentils or peas
- ¼ cup tofu
- 1 tablespoon nut butter



Fruits

Add color with fruit.

Make most choices fruit, not juice.

Daily Amount

- 2 of these choices:
- 1 cup fresh fruit
- 1 cup unsweetened frozen or canned fruit
- ½ - ¾ cup juice
- ½ cup dried fruit



Grains

Eat mostly whole grains

like brown rice. Limit bread, noodles and rice that are white.

Daily Amount

- 6 of these choices in the 1st trimester,
- 8 in the 2nd/3rd trimester and while breastfeeding:
- 1 slice whole wheat bread or ½ bagel
- 1 small (6-inch), whole wheat tortilla
- 1 cup cereal
- ½ cup cooked pasta, rice or cereal



Dairy

Enjoy calcium-rich foods.

Choose pasteurized nonfat or lowfat milk, yogurt and cheese.

Daily Amount

- 3 of these choices for women
- or
- 4 of these choices for teens:
- 1 cup milk
- 1 cup soy milk with calcium
- 1 cup of plain yogurt
- 1½ ounces cheese



Choose Healthy Fats & Oils

- Use plant oils like canola, safflower and olive oil for cooking.
- Read food labels to avoid saturated and trans fats (hydrogenated fats).
- Avoid solid fats such as lard and butter.
- Eat cooked fish at two meals each week.
- Limit oils to 6 teaspoons each day.

Choose Healthy Beverages

- Drink water, nonfat or lowfat milk instead of soda, fruit drinks and juice.
- Limit caffeine drinks like coffee and tea. Avoid energy drinks.
- Do not drink alcohol when you are pregnant or may become pregnant.
- Alcohol passes through breast milk. If breastfeeding, talk with your healthcare provider about alcohol use.

California My Nutrition Plan for Moms

These tips can help you to eat well and have a healthy weight during and after your pregnancy. Fill in your weight goals and check off which tips you are willing to try.

Pregnancy: My recommended weight gain in pregnancy is _____ pounds. My current weight gain is _____ pounds.

After Pregnancy: A healthy weight range for me is _____ pounds. My goal is to weigh _____ pounds.

Vegetables

Each day I will:

- Try to eat at least 3 choices of fresh, frozen or low-sodium canned vegetables.
- Flavor vegetables with herbs and spices instead of fat or salt.
- Eat many dark green and orange vegetables.

Protein

Each day I will:

- Try to eat 6-7 choices.
- Grill, broil or bake meat instead of fry.
- Eat beans, nuts, tofu, seeds and nut butter.
- Eat lean meat (15% fat or less).
- Take skin off poultry.
- Eat 12 oz. of fish per week.
- Limit bacon, hot dogs and bologna.

Grains

Each day I will:

- Try to eat 6-8 choices.
- Choose whole grains at least half of the time.
- Eat WIC-approved cereals.

Fruits

Each day I will:

- Try to eat 2 choices.
- Eat a variety of fresh, frozen or canned fruits.
- Choose fresh, frozen and canned fruits without added sugars.
- Limit fruit juice to ½ - ¾ cup juice each day.

Dairy

Each day I will:

- Try to eat 3 choices.
- Choose pasteurized nonfat or lowfat (1%) milk and cheeses.
- Eat plain yogurt. For sweetness, add fruit.
- Choose soy products, with calcium, like tofu.

Fats & Oils

I will:

- Use 6 teaspoons of plant oils like canola, safflower and olive oil daily.
- Bake, broil, steam, or microwave instead of frying.

Extras (Solid Fats, Sugars and Salt)

I will:

- Choose foods low in fat, sugar and salt.
- Read nutrition labels to limit fat, sugar and salt (sodium).
- Choose fruits, vegetables, unsalted nuts and seeds for snacks.

Beverages

I will:

- Drink water, nonfat or lowfat milk instead of sugary drinks.
- Limit caffeine drinks like coffee and tea. Avoid energy drinks.

My Other Ideas

- Make a daily food plan. Go to www.choosemyplate.gov/SuperTracker/createprofile.aspx.

MiPlato para Mamás



Haga que la mitad de su plato contenga vegetales y frutas, alrededor de un cuarto del plato granos y el otro cuarto alimentos con proteína. Elija alimentos ricos en fibras y de bajo contenido de azúcar, grasas sólidas y sal (sodio). Estas cantidades de alimentos son para el consumo diario de una mujer de tamaño promedio. Usted puede necesitar más o menos de las cantidades sugeridas.

Vegetales

Coma más vegetales.

Coma vegetales frescos, congelados o vegetales enlatados bajos en sodio. Evite comer las papas fritas.

Cantidad Diaria

- 3 o más de estas opciones:
- 2 tazas de vegetales de hoja cruda
- 1 taza de vegetales crudos o jugo
- 1 taza de vegetales cocidas



Proteína

Elija proteínas saludables.

Coma proteínas vegetales a diario. Evite el tocino, las salchichas y la mortadela.

Cantidad Diaria

- 6-7 de estas opciones:
- 1 onza de pescado, pollo o carne magra
- 1 huevo
- ½ onza de nueces
- ¼ de taza de frijol, lenteja o chícharo seco cocido
- ¼ de taza de tofu
- 1 cucharada de crema de cacahuete



Granos

Coma mayormente granos integrales

como arroz integral. Limite su consumo de pan, fideos y arroz que no sean integrales.

Cantidad Diaria

- 6 de estas opciones en el 1er trimestre
- 8 en el 2o o 3er trimestre y mientras esté amamantando:
- 1 rebanada de pan integral o ½ bagel
- 1 tortilla pequeña de trigo integral (6-pulgadas)
- 1 taza de cereal
- ½ taza de fideos, arroz o cerea cocidos



Frutas

Agregue color con frutas.

Escoja frutas enteras en lugar de jugos de frutas.

Cantidad Diaria

- 2 de estas opciones:
- 1 taza de fruta fresca
- 1 taza de fruta congelada o enlatada sin azúcar
- ½ - ¾ taza de jugo
- ½ taza de fruta seca



Lácteos

Coma alimentos ricos en calcio.

Elija leche, yogur y queso pasteurizados, descremados o bajos en grasa.

Cantidad Diaria

- 3 de estas opciones para las mujeres
- 4 de estas opciones para los adolescentes:
- 1 taza de leche
- 1 taza de leche de soya enriquecida con calcio
- 1 taza de yogur natural
- 1½ onza de queso



Elija Grasas y Aceites Saludables

- Use aceites vegetales para cocinar como el aceite de alazor (safflower), canola y oliva.
- Lea las etiquetas de los alimentos para evitar consumir grasas saturadas y trans (grasas hidrogenadas).
- Evite las grasas sólidas como la manteca y la mantequilla.
- Coma pescado cocido en dos de sus comidas cada semana.
- Limite su consumo de aceites a 6 cucharaditas por día.

Elija Bebidas Saludables

- Beba agua, leche descremada o baja en grasa en lugar de refrescos, bebidas de frutas y jugo.
- Limite su consumo de bebidas con cafeína como el café o el té. Evite las bebidas energizantes.
- No beba alcohol si está embarazada o pudiera estar embarazada.
- El alcohol pasa al bebé a través de la leche materna. Si está amamantando, hable con su médico acerca del consumo de alcohol.

Mi Plan Nutricional para Mamás

Estas sugerencias pueden ayudarla a comer bien y a mantener un peso saludable durante y después del embarazo. Llene los espacios en blanco con el peso que le gustaría llegar a tener y marque las opciones que está dispuesta a probar.

Embarazo: Me recomendaron subir _____ libras durante mi embarazo. Hasta la fecha, he subido _____ libras.

Después del embarazo: Un peso saludable para mí es _____ libras. Mi meta es pesar _____ libras.

Vegetales

Cada día trataré de:

- Comer al menos 3 porciones de vegetales frescos, congelados o enlatados bajos en sodio.
- Condimentar las verduras en lugar de grasas o sal.
- Comer mucha verdura de color verde oscuro y anaranjado.

Proteína

Cada día trataré de:

- Comer 6 a 7 de porciones.
- Asar u hornear carnes en lugar de freírlas.
- Comer frijoles, nueces, semillas, tofu o crema de cacahuete.
- Comer carne magra (con el 15% de grasa, o menos).
- Quitarle la piel al pollo.
- Comer 12 onzas de pescado por semana.
- Limitar mi consumo de tocino, salchichas y mortadela.

Granos

Cada día trataré de:

- Comer 6 a 8 porciones.
- Elegir granos integrales al menos la mitad del tiempo.
- Comer cereales aprobados por el programa de WIC.

Frutas

Cada día trataré de:

- Comer 2 porciones.
- Comer una variedad de frutas frescas, congeladas o enlatadas.
- Elegir frutas frescas, congeladas y enlatadas sin azúcares añadidos.
- Limitar el consumo de jugos de frutas a ½ - ¾ de taza por día.

Lácteos

Cada día trataré de:

- Comer 3 porciones.
- Elegir leche y quesos pasteurizados descremados o bajos en grasa (1%).
- Comer yogur natural (para endulzarlo, le pondré fruta).
- Elegir productos de soya enriquecidos con calcio, como el tofu.

Grasas y Aceites

- Usaré 6 cucharaditas diarias de aceite vegetal como el aceite de alazor (safflower), canola y oliva.
- Cocinaré los alimentos al horno, asados, al vapor o en el microondas, en lugar de freírlos.

Extras (Grasas Sólidas, Azúcares y Sal)

- Elegiré alimentos bajos en grasas, azúcares y sal.
- Leeré las etiquetas con la información nutricional para poder limitar mi consumo de grasas, azúcares y sal (sodio).
- Para mis bocadillos, elegiré frutas, vegetales, nueces y semillas sin sal.

Bebidas

- Beberé agua, leche descremada o baja en grasa en lugar de bebidas azucaradas.
- Limitaré mi consumo de bebidas con cafeína como el café y el té. Evitaré las bebidas energizantes.

Mis Otras Ideas

- Hacer un plan diario alimenticio. Visite esta página: www.choosemyplate.gov/SuperTracker/createprofile.aspx.
- _____

Background

Fifty to 90 percent of all pregnant women experience nausea and sometimes vomiting in the first trimester. Symptoms of nausea and vomiting usually begin around the eighth week of pregnancy, peak at 10 to 16 weeks, and resolve by the 20th week. Some women may have nausea and vomiting throughout the pregnancy. Nausea and vomiting may be more common in first pregnancies and among younger women. Symptoms often begin in the morning and improve as the day goes on. Some women experience symptoms throughout the day. The cause of symptoms may be due to hormonal changes, stress, and other changes in the body.

Hyperemesis gravidarum occurs in up to 2% of pregnancies and is a serious medical complication of pregnancy that involves uncontrolled, repeated episodes of vomiting. Hyperemesis may cause rapid weight loss and lead to dehydration and other dangerous conditions requiring hospitalization for intravenous fluids, drug therapy, and nutrition. Hyperemesis may be more common among first pregnancies, women of high pre-pregnant weight, or multiple gestations. Medical nutrition therapy is recommended to reduce weight loss and correct nutrition deficiencies.

There is no single effective treatment for nausea and vomiting. The recommendations listed on *Nausea: Tips that Help* must be individualized. Caution the woman to avoid self-prescribed remedies or medications without discussing them with her health care provider.

Steps to Take

Use the questions and interventions to assess and counsel the client:

Is she losing weight or not gaining enough?

- Plot the weight gain grid and check for weight loss or no gain

Immediately refer serious vomiting to the health care provider. The health care provider may refer the client to a registered dietitian for medical nutrition therapy.

Does she eat regular meals? Does she have enough money for food?

- Encourage her to eat small meals high in carbohydrates (e.g. pasta, dry cereal, toast) every two to three hours. Having an empty stomach may make nausea worse.
- Refer to the WIC program and to community resources

What time of day does she have more problems?

- If she feels sick in the morning, encourage an early morning snack before she gets out of bed
- Encourage her to carry snacks and eat frequently, every two to three hours

Which foods sound appealing to her and what foods does she crave?

- Use the nutrition handout *Nausea: Tips that Help* and *Nausea: Choose these Foods* to help the client identify foods she may enjoy
- Drinking cold, clear, and carbonated or sour fluids (e.g. ginger ale, lemonade) in small amounts between meals helps some women

Are there particular foods that upset her stomach?

- Chose alternative protein sources if meat does not appeal to her (e.g. peanut butter, cheese, yogurt, cottage cheese, eggs)
- Limiting intake of highly seasoned, spicy, and high fat foods may help

Is she vomiting?

- Use the nutrition handout *Nausea: What to Do When You Vomit* to help the client identify foods to eat
- Advise her to have cold, starchy, or sour foods on hand before feeling sick

What are her cultural or religious food preferences? Do they affect her food intake?

- Learn about her religious and cultural beliefs
- Support food choices that may help with her nausea

Is she dizzy or has she had fainting episodes?

- Make sure she gets enough liquids and several small meals or snacks daily
- Refer to the health care provider

Is she taking prenatal vitamins or iron pills?

- Delay taking vitamins or iron pills until the evening meal
- If problems persist, try stopping the vitamins and iron pills for a few days
- Discuss with the health care provider

Is she taking any herbal remedies, medications, or using alternative therapies?

- Ginger, special pregnancy suckers, vitamin B6, Sea Bands® and acupressure are advertised to decrease nausea and vomiting in pregnancy. Discuss any remedies used with the health care provider to ensure they are safe and effective.

Has she had an eating disorder in the past or any unusual food habits?

- If she is anxious about gaining weight, refer to the health care provider and registered dietitian

Follow Up

Use the following to reassess the client's condition:

- Evaluate for weight loss and adequacy of daily food intake at each visit
- Ask if she tried any of the recommendations to help with nausea and if they were helpful

Check for vomiting that cannot be stopped, fainting, dizziness, or headaches that persist and refer to the provider if these symptoms are present.

- If she is not taking vitamin and mineral supplements as directed, discuss with the provider
- If problems persist, review suggestions for nausea and vomiting

Referral

Refer to registered dietitian and health care provider if:

- Current weight loss is greater than 5 pounds below reported weight at conception
- Any weight loss of greater than 3 pounds from the last visit
- Symptoms have worsened and vomiting is not controlled
- No weight gain by 16 weeks

Resources

National Guideline Clearinghouse. Nausea and Vomiting of Pregnancy. Department of Health and Human Services. 2009. Retrieved February 2010 at www.guideline.gov/summary/summary.aspx?doc_id=10939&nbr=5719&ss=6&xl=999

References

American College of Obstetricians and Gynecologists (ACOG). *Nausea and Vomiting of Pregnancy*. Washington (DC): American College of Obstetricians and Gynecologists (ACOG); 2004 Apr. 13 p. (ACOG practice bulletin; no. 52).



Many women have nausea or “morning sickness” during the first few months they are pregnant. It is caused by the pregnancy-related hormone changes in your body. Although it is most common in the morning, it can go on all day.

Here Are A Few Ways You Can Help Feel Better

Do not use coffee, cigarettes, or alcohol:

- They can upset your stomach
- They can also harm your baby

You may want to stay away from:

- Stale odors
- Strong cooking odors
- Smoke
- Cleaning fluids or paints
- Perfumes or other smells
- Crowded places
- Places with no fresh air

Stay away from foods that make your nausea worse such as high fat foods, fried foods, and dishes with strong spices.

Listen to what your body wants. Eat foods that:

- Taste good to you
- Keep you from having nausea and vomiting



Get plenty of fresh air:

- Open windows, use fans
- Take brisk walks outdoors

Get up slowly in the morning:

- Put crackers, fruit, or fruit juices near your bed
- Take a few bites before getting up

Drink fluids at least a half hour before or after mealtime:

- Sip small amounts of liquid as often as you can
- Add lemon to water and add water to juices like apple, grape, or mixed juices
- Make broth or noodle soups



Eat snacks or small meals every two or three hours when awake:

- Try snack foods like nuts, cheese, crackers, dried fruits, trail mix, sandwiches, fruit juices, and hard lemon candies
- Eat a little bit every two or three hours even if you are not hungry
- Just before you go to bed, eat a protein, like eggs, cheese, meat, peanut butter, or yogurt

Decide which foods sound good to you. Try some of these snacks:

- Gelatin desserts like Jell-O®
- Fruity foods: popsicles, melons
- Salty pretzels or potato chips, broth
- Dairy foods: ice cream, yogurt
- Soft foods: breads, noodles, mashed potatoes, rice, gelatin desserts like Jell-O®
- Dry foods: crackers, dry cereal
- Yogurt
- Tart foods: lemonade, pickles, sour candies
- Crunchy foods: celery sticks, apple slices, nuts, popcorn
- Liquids: juice, seltzer, sparkling water, ginger ale

Ask your health care provider for other ideas that may help. Discuss the use of any herbal remedies, medications, or alternative therapies with your provider to make sure they are effective and safe for you and your baby.



TAKE ACTION
Tips I Can Try:

Muchas mujeres tienen náuseas o “vómitos de embarazo” durante los primeros meses del embarazo. Son causados por cambios hormonales en el cuerpo relacionados con el embarazo. Aunque son más comunes por la mañana, pueden ocurrir a cualquier hora del día.

Estas son Algunas Cosas que Puede Hacer Para Ayudar a Sentirse Mejor.

No beba café ni alcohol y no fume cigarrillos:

- Le pueden dar malestar estomacal
- También pueden hacerle daño al bebé

Conviene que mantenga su distancia de:

- Los olores a cosas viejas
- Los olores fuertes a comida cocida
- El humo
- Los líquidos de limpieza y las pinturas
- Los perfumes y otros olores
- Los lugares donde hay mucha gente
- Los lugares sin aire fresco

Mantenga su distancia de comidas que le empeoran las náuseas, como las comidas con mucha grasa, las comidas fritas y los platos con condimentos fuertes.

Preste atención a lo que quiere el cuerpo.

Coma comidas que:

- Tengan un sabor que le guste
- No le causen náuseas y vómitos

Tome mucho aire fresco:



- Abra las ventanas, use ventiladores
- Salga y camine a paso rápido

Levántese lentamente por la mañana:

- Ponga galletas de sal, fruta o jugos de fruta cerca de la cama
- Coma algunos bocados antes de levantarse

Beba líquidos al menos media hora antes o después de las comidas:

- Beba pequeños sorbos de líquido lo más a menudo posible
- Beba agua con jugo de limón y añada un poco de agua a los jugos, como los de manzana, uva o mixtos
- Prepare caldos o sopas de fideos

Coma bocadillos o comidas pequeñas cada dos o tres horas cuando esté despierta.

- Pruebe bocadillos como nueces, queso, galletas de sal, frutas desecadas o frutos secos mezclados, sándwiches, jugos de fruta y caramelos duros de limón
- Coma cantidades pequeñas cada dos o tres horas, incluso si no tiene hambre
- Justo antes de acostarse coma un alimento con proteína, como huevos, queso, carne, crema de cacahuete o yogur

Decida qué comidas le suenan bien. Pruebe alguno de estos bocadillos:

- Postres de gelatina como Jell-O®
- Comidas con fruta: paletas heladas, melones
- Pretzels salados o papitas fritas, caldo
- Lácteos: helado, yogur
- Comidas blandas: panes, fideos, puré de papas, arroz, postres de gelatina como Jell-O®
- Comidas secas: galletas de sal, cereal seco
- Yogur
- Comidas ácidas: limonada, pepinos encurtidos, caramelos ácidos
- Comidas crocantes: palitos de apio, rodajas de manzanas, nueces, palomitas de maíz
- Líquidos: jugos, agua mineral, agua con gas, ginger ale

Pídale a su proveedor de atención de la salud que le indique otras cosas que le puedan ayudar. Hable con su proveedor sobre el uso de cualquier tipo de remedios a base de hierbas, medicamentos o terapias alternativas, para verificar que sean eficaces y seguras para usted y su bebé.



TOMA ACCIÓN

Consejos Para Seguir:



Nausea: What to Do When You Vomit

These tips can help:

- Rest
- Get some fresh air
- Take a walk
- Stay away from places with strong odors

Sip on tart juices:

- Try lemonade or cranberry juice with a little water in it
- Plain water may cause more vomiting

Eat candies or fruit with sour or tart flavors:

- Try hard candies, mints, or lemon drops to cover unpleasant tastes in your mouth
- Chew peppermint gum

Eat what you feel like eating at that moment

Try small amounts of sweet or cold foods. You may like:

- Popsicles
- Jell-O®
- Jelly beans
- Pudding
- Fruit
- Custard
- Yogurt
- Ice cream

Try salty foods. They may also help settle your stomach.

Ask your health care provider before you take any medicine or use herbal remedies.

- Do not take any over-the-counter medications, unless your provider says it is safe
- You may need to stop taking prenatal or iron pills for a few days



Call your health care provider if:

- You feel dizzy, weak, or faint
- You have a headache that does not go away
- You vomit five or more times in 24 hours
- You cannot eat any food or hold down any fluid at all



Náuseas: Qué Hacer Cuando Vomita

Estos consejos le pueden ayudar:

- Descanse
- Tome aire fresco
- Camine
- Mantenga su distancia de lugares con olores fuertes

Beba sorbitos de jugos ácidos.

- Pruebe limonada o jugo de arándanos con un poco de agua añadida
- El agua simple podría causarle más vómitos

Coma caramelos o frutas con sabores ácidos o agrios.

- Pruebe caramelos duros, pastillas de menta o caramelos de limón para tapar el sabor desagradable en la boca
- Masque chicle de menta

Coma lo que desee comer en ese momento.

Pruebe comer pequeñas cantidades de alimentos dulces o fríos. Es posible que le gusten los siguientes:

- Paletas heladas
- Jell-O®
- Caramelos de goma (jelly beans)
- Budín
- Fruta
- Natilla
- Yogur
- Helado

Pruebe alimentos salados. También podrían ayudar a calmarle el estómago.

Consulte a su proveedor antes de tomar



cualquier tipo de medicamento o usar remedios a base de hierbas.

- No tome ningún medicamento de venta libre, excepto si su proveedor le dice que lo puede tomar sin peligro
- Tal vez tenga que dejar de tomar pastillas prenatales o de hierro por unos pocos días

Llame a su proveedor de atención de la salud si:

- Se siente mareada, débil o como si se fuera a desmayar
- Tiene un dolor de cabeza que no se le quita
- Vomita cinco veces o más en 24 horas
- No puede conservar nada en el estómago, ni comida ni líquidos



These beverages and foods can help replace what you lose when you vomit. They may help you feel better.

Fluids

- Juices
- Sports drinks
- Caffeine free sodas
- Lemonade
- Noodle soups
- Chicken broth
- Popsicles
- Vegetable juice cocktail
- Soy milk

Snacks

- Pretzels
- Tortilla chips
- Pickles
- Potato chips
- Crackers
- Sunflower seeds
- Peanut butter
- Almonds
- Whole wheat breads
- Bran muffins
- Wheat germ

Fruits and Vegetables

- Avocado
- Banana
- Potato
- Sweet potato
- Winter squash
- Apricots
- Kiwi fruit
- Honeydew melon
- Watermelon
- Cantaloupe
- Spinach



Estas bebidas y alimentos pueden ayudar a poner de vuelta en el cuerpo lo que pierde cuando vomita. Le podrían ayudar a sentirse mejor.

Líquidos

- Jugos
- Bebidas deportivas
- Refrescos sin cafeína
- Limonada
- Sopa de fideos
- Caldo de pollo
- Paletas heladas
- Jugo de verduras mixtas
- Leche de soya

Bocadillos

- Pretzels
- Totopos
- Pepinos encurtidos
- Papitas fritas
- Galletas de sal
- Semillas de girasol
- Crema de cacahuete
- Almendras
- Panes de trigo integral
- Panqués de salvado
- Germen de trigo

Frutas y Verduras

- Aguacate
- Plátano
- Papa
- Camote
- Calabaza de invierno
- Chabacanos
- Kiwi
- Melón dulce (honeydew)
- Sandía
- Melón
- Espinaca

Background

Hearthburn (gastroesophageal reflux) is a burning pain in the mid chest area caused by relaxation of the opening to the stomach. The burning sensation results when food and acid comes back up from the stomach to the esophagus.

Heartburn is a common discomfort affecting 30 to 70% of pregnant women. It is most severe in the last half of pregnancy due to hormonal changes and as the growing uterus places pressure on the stomach. Symptoms are worse after a large meal. Foods that are fatty, spicy, or acidic may cause more heartburn. Alcohol, coffee, chocolate, spearmint, peppermint, and lying down after eating may also cause heartburn.

Steps to Take

Use these questions and interventions to assess and counsel your client. Discuss the nutrition handouts *Heartburn: What You Can Do* and *Heartburn: Should You Use Antacids?*

Is she losing weight or not gaining enough weight?

- Plot the weight gain grid and check for weight loss or inadequate gain
- Encourage eating small, frequent meals to reduce heartburn and maintain weight gain

Was heartburn ever a problem for her before pregnancy?

- If yes, check with health care provider

Does she have a history of bleeding ulcers or other stomach problems?

- If yes, check with health care provider

Refer to the health care provider immediately if burning sensation is continual and becomes a severe pain that runs to the neck, and is worsened when lying down.

Is she physically active every day?

- Encourage walking every day. Walking after meals may help.
- Avoid sitting or lying down right after eating

Does she eat dinner close to bedtime?

- Recommend eating earlier if dinner is within two to three hours of bedtime
- Eating a smaller evening meal may help

Does she fry foods or add oils and fats to her food?

- Suggest broiling, barbecuing, baking, poaching, or boiling instead of frying
- Recommend she use small amounts of oils, butter, margarine, or cream and limit gravies, cream sauces, fries, fatty meats, and other high-fat foods

Does she drink coffee, smoke, or drink any alcohol?

- Advise her to stay away from all of these during the pregnancy
- Refer her to needed resources to stop using tobacco and/or alcohol

Does she take any medicines to treat heartburn?

What does she take and how much?

- Check to make sure the woman is not taking too much antacid, for example no more than eight Tums® daily. Advise her to not take Tums® at the same time she takes her prenatal vitamin.
- Check with the health care provider about other medicines, home remedies, or alternative therapies

Follow Up

Use the following to reassess your client's condition:

- Assess current problems and discuss methods of relief she has chosen and which ones have helped
- If taking antacids daily, check with the health care provider about how much is acceptable for each type
- Discuss her present food and beverage intake to check for possible behaviors and types of foods still causing heartburn
- Discuss which steps she can take to prevent heartburn. See the nutrition handouts *Heartburn: What You Can Do* and *Heartburn: Should You Use Antacids?*

Referral

Refer to the health care provider and registered dietitian if the heartburn continues or worsens, if weight gain is inadequate, or if the woman is taking large amounts of antacids.



Heartburn: What You Can Do

Eat five or six small meals a day instead of two or three large meals.

- Eat food slowly and in small portions
- Eat only small servings (2 to 3 ounces) of lean meat at one time
- Limit your intake of fluids with meals
- Take sips of water, milk, or eat a spoonful of yogurt

Stand or sit up straight after you eat.

- Wait at least two to three hours after you eat before you lie down or go to bed
- Sleep or rest with pillows under your shoulders to prop you up

Being physically active may help heartburn go away.

- Take a relaxing walk
- Sit quietly and breathe deeply
- Try the flying exercise:
 - ◆ Sit cross-legged or tailor fashion
 - ◆ Stretch your arms to the sides
 - ◆ Bring the back of your hands together over your head
 - ◆ Quickly raise and lower your arms
 - ◆ Try doing this 10 times

Wear loose-fitting, comfortable clothing; avoid tight waistbands.

Staying away from these foods might help:

- Greasy, fried, or deep fried foods
- Spicy foods, like chili, pepper, or curry
- Pizza
- Sausage, bacon, and other fatty meats
- Garlic and onions
- Acidic foods, like tomatoes, citrus, salsa
- Coffee (any kind)
- Sodas or teas with caffeine
- Chocolate
- Carbonated beverages



Stay away from alcohol and cigarettes. They can make heartburn worse and they can harm your baby.

Coma cinco o seis comidas pequeñas al día, en lugar de dos o tres comidas grandes.

- Coma lentamente y en pequeñas porciones
- Coma solo porciones pequeñas (2 o 3 onzas) de carne magra por vez
- Limite la cantidad de líquido que bebe con las comidas
- Beba sorbos de agua o leche, o coma una cucharada de yogur

Párese o siéntese derecha después de comer.

- Después de comer, espere al menos 2 o 3 horas antes de recostarse o de acostarse a dormir
- Duerma o descanse con almohadas debajo de los hombros para levantarse el cuerpo

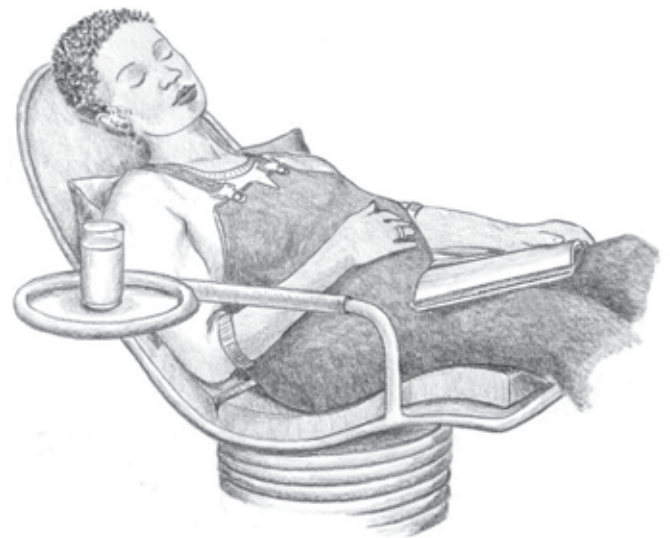
La actividad física podría ayudar a que desaparezca la acidez.

- Salga a caminar tranquila
- Siéntese tranquila y respire profundo
- Pruebe el ejercicio de volar:
 - ◆ Siéntese en el piso con las piernas cruzadas
 - ◆ Estire los brazos a los lados
 - ◆ Junte el dorso de las manos por encima de la cabeza
 - ◆ Suba y baje los brazos rápidamente
 - ◆ Trate de hacerlo diez veces

Use ropa suelta y cómoda; evite las bandas de la cintura apretadas.

No comer las siguientes comidas podría ayudarle:

- Comidas grasosas o fritas
- Comidas picantes, como con chiles, pimienta o curry
- Pizza
- Chorizos, tocino y otras carnes grasosas
- Ajo y cebollas
- Alimentos ácidos, como jitomates, cítricos, salsa
- Café (de cualquier tipo)
- Refrescos o té con cafeína
- Chocolate
- Bebidas carbonatadas



No beba alcohol ni fume cigarrillos. Le pueden empeorar la acidez y pueden hacerle daño al bebé.

Heartburn: Should You Use Antacids?



Check with your health care provider before you use any medicine or herbal remedies.

Check with your health care provider about what you should take.

It may help your heartburn to use antacids. But not all antacids are safe when you are pregnant.

These antacids should be OK to use. But every pregnancy is different.

Ask your health care provider about:

- Tums™
- Maalox™
- Mylanta™
- Riopan™
- Gelusil™

Try the liquid form of the antacid. It may work better.

Some antacids can hurt you or your baby.

- Do not take Alka-Seltzer™ or Fizin™. They have aspirin in them. You should not take aspirin when you are pregnant.
- Do not use baking soda, Soda Mints™, Eno™, or Roloids™. They have too much salt in them.
- If you use antacids too often, you could have problems. Take only as much as your health care provider says is safe.



Consulte a su proveedor de atención de la salud antes de usar cualquier tipo de medicamento o remedios a base de hierbas.

Pregúntele a su proveedor de atención de la salud qué debe tomar.

Tomar antiácidos podría aliviar la acidez. Pero no todos los antiácidos son seguros cuando está embarazada.

Está bien usar estos antiácidos, pero cada embarazo es diferente.

Pregúntele a su proveedor sobre:

- Tums™
- Maalox™
- Mylanta™
- Riopan™
- Gelusil™

Pruebe la forma líquida del antiácido. Puede ser que funcione mejor.

Algunos antiácidos pueden hacerles daño a usted o a su bebé.

- No tome Alka-Seltzer™ ni Fizrin™. Contienen aspirina. No debe tomar aspirina cuando está embarazada.
- No tome bicarbonato de sodio, Soda Mints™, Eno™ ni Roloids™. Contienen demasiada sal.
- Si toma antiácidos demasiado a menudo podría tener problemas. Tome solo la cantidad que su proveedor le diga que está bien.

Background

Bowel movement frequency can vary from three per day to three per week. Constipation involves infrequent bowel movements (fewer than two per week) and hard, difficult to pass stools.

Constipation is a common complaint during pregnancy. One third of pregnant women report feeling constipated during the first and/or third trimester of pregnancy. Constipation may result from hormonal changes that relax the intestines, increased water retention by the body, and pressure placed on the intestines from the growing uterus. Decreased fluid and fiber intake, iron supplementation, limited physical activity, and emotional or physical stress may also contribute to constipation. Women who practice pica (eating clay, dirt, or laundry starch) may develop severe constipation. Constipation may result in backache, fecal impaction, or hemorrhoids.

Recommendations to manage constipation include increasing fluid intake to two to three quarts a day, increasing physical activity, practicing Kegel exercises to increase voluntary pelvic floor muscle contractions, and increasing fiber intake to 25 to 35 grams per day. The goal is a regular, pain-free bowel movement of soft stool. Caution women against the use of castor oil (it may cause uterine contractions) and mineral oil (it can decrease the absorption of fat-soluble vitamins) and other unsafe remedies such as enemas or suppositories. Severe constipation may require medications recommended by the health provider.

Steps to Take

Use these questions and interventions to assess and counsel your client:

How long has it been since her last bowel movement?

- If it has been several days, or if her stool is hard to pass, refer to the health care provider

Does she have any pain in her back? How long has she had it? Does she have bleeding from her rectum?

- If she has any pain or bleeding, refer to the health care provider

Is she taking any laxatives, medicines, stool softeners, or home remedies?

- Consult with the health care provider
- Caution her not to use mineral oil, castor oil, suppositories, or enemas

Is she eating regular meals daily including breakfast?

- Encourage eating meals at regular times, especially breakfast
- Advise her to attempt defecation after meals

Is she eating any nonfood items such as gravel, clay, laundry starch, or dirt?

- Advise her to stop eating harmful nonfood substances
- See *Pica* in this section

What are her cultural or religious food preferences?

- Learn about her cultural beliefs related to normal bowel habits
- Support food choices that may help increase her intake of fluids and fiber

Is she taking prenatal vitamins, iron, and/or calcium pills? Find out how much of each type she takes.

- Consult with the health care provider and/or registered dietitian to make sure she is not taking too much

Is she drinking 2 to 3 quarts of fluids daily? Does she eat high-fiber foods?

- Help her find ways to consume 8 to 10 cups of fluids per day (soups, water, juice mixed with water) and high-fiber foods. Advise against liquids with caffeine: coffee, soda, tea, energy drinks

- Recommend more fiber, as listed on the nutrition handout *Constipation: What You Can Do*

Is she physically active each day?

- Recommend daily walking and Kegel exercises

Follow Up

Use the following to reassess your client's the condition:

- Assess what diet changes the woman has made. Specifically praise her for increasing the fiber and liquids in her diet. Ask her if the constipation has decreased.
- Check what vitamin/mineral tablets she takes. Make sure that she is taking the pills in amounts recommended by her health care provider.
- Make sure she is not using harmful laxatives. Check for intake of nonfood items such as laundry starch, gravel, dirt, or clay. See Pica.

Referral

Refer to the health care provider and registered dietitian if she complains of back pain, has rectal bleeding, has not had a bowel movement for more than several days, or complains of hard, difficult to pass stools.

Resources

U.S. Department of Health and Human Services and U.S. Department of Agriculture

2015 – 2020 Dietary Guidelines for Americans.

8th Edition. December 2015. Available at

<http://health.gov/dietaryguidelines/2015/guidelines/>.

Appendix 13- Fiber Food Sources

(<http://www.cnpp.usda.gov/>)

The National Fiber Council

Fiber food charts, high-fiber menus, free posters and brochures, and comparisons of powder fiber brands for professionals

(www.nationalfiberCouncil.org)

Why It Is Important to Eat Whole Grains - Inside Choose MyPlate

(www.choosemyplate.gov/food-groups/grains.html)



Constipation: What You Can Do

When you are pregnant, you are likely to be constipated from time to time. Here are some ideas to help:

Eat more foods with fiber every day:

- Raw fruits with edible peels instead of juices
- Raw or cooked vegetables with edible peels
- Leafy greens
- Dried fruits: raisins, prunes, figs
- Nuts and seeds
- Whole grain breads, crackers, tortillas with at least 3 grams of fiber

Whole grain cereals with at least 4 grams of fiber.

- Wheat/oat bran
- Brown rice, kashi, quinoa, and other whole grains

Eat regular meals and snacks and chew food very well

Eat breakfast daily

Eating at about the same time each day might help:

- Try several small meals instead of 1-2 large one



Drink plenty of liquids:

- Drink water and other fluids such as: decaf teas, decaf coffee, milk, juice, and soup
- Drink warm/hot liquids before you eat in the morning
- Write down how much liquid you drink. Does it add up to 2 or 3 quarts? If not, drink some more.

Be physically active every day:

- Walk for at least 30 minutes each day
- Do low impact aerobics, swim, and avoid sitting for long periods of time
- Ask your health care provider before you start anything new

Take time for your bowel movements.

Try to have a bowel movement after you eat.

- If you need to go to the bathroom, don't try to hold it. That can make it worse.
- Raise your feet on a stool or box when you have a bowel movement
- Don't strain

Try a natural laxative.

- It can help to eat prunes, figs, or dried apricots. You can also drink juice.

When increasing intake of fiber rich food, make sure you drink plenty of liquid.

Cuando está embarazada, de vez en cuando podría tener estreñimiento. Aquí tiene algunas ideas que le pueden ayudar.

Coma más alimentos con fibra todos los días.

- Fruta fresca con cáscara comestible en lugar de jugo.
- Verdura cruda o cocida con cáscara comestible.
- Verdura de hoja verde.
- Fruta seca: pasitas, ciruelas, higos.
- Nueces y semillas.
- Panes, galletas saladas y tortillas de granos integrales con por lo menos 3 gramos de fibra.

Cereales de grano integral con por lo menos 4 gramos de fibra.

- Salvado de trigo o avena.
- Arroz integral, kashi, quinoa y otros granos integrales.

Coma comidas y bocadillos regularmente y mastique muy bien la comida.

Desayune todos los días.

Tomar las comidas a la misma hora todos los días le puede ayudar:

- Pruebe tomar varias comidas pequeñas en vez de 1 o 2 comidas grandes.



Beba mucho líquido:

- Beba agua y otros líquidos, como el té, café o infusión descafeinados, leche, jugo, caldo o sopa.
- Beba algún líquido caliente o tibio antes de desayunar.
- Escriba cuánto líquido bebe. ¿Suma a 2 o 3 cuartos de galón? Si no, beba más.

Esté físicamente activa todos los días.

- Camine por lo menos 30 minutos todos los días.
- Haga ejercicios aeróbicos de bajo impacto, nade y evite estar sentada por mucho tiempo.
- Consulte a su proveedor de atención de la salud antes de comenzar algo nuevo.

Tome tiempo para los movimientos del intestino.

Trate de mover el intestino después de comer.

- Si necesita ir al baño, no lo espere. Eso puede empeorar la situación.
- Eleve los pies en un banco o una caja cuando mueva el intestino.
- No haga mucho esfuerzo.

Pruebe un laxante natural.

- Comer ciruela, higo o chabacano seco le puede ayudar. También puede beber jugo.

Asegúrese de beber mucho líquido cuando coma más alimentos con mucha fibra.



Constipation: Products You Can and Cannot Use

Always ask your health care provider before you take any medicine or **herbs**.

- Ask what you can take to add fiber or to soften stools. Your health care provider can tell you what is safe.
- Drink a glass of water every time you take added fiber
- Some iron pills have a stool softener that may help. Ask your health care provider.

When you are pregnant, you should NOT use some products.

Some can harm your baby. Others keep you from getting the vitamins you need to keep you and your baby healthy.

Do not use:

- Laxatives
- Castor oil
- Suppositories
- Senna
- Mineral oil
- Some kinds of antacids (Ask your health care provider)
- Enemas

Watch out for:

- Too much calcium or iron can make your constipation worse. Talk to your health care provider about how much you should take.
- Too much hot or iced tea, coffee, or soda drinks can also make it worse. It's a good idea to stay away from caffeine; it robs the body of water.





Consulte siempre a su proveedor de atención de la salud antes de tomar cualquier tipo de medicamento o **hierbas**.

- Pregúntele qué puede tomar para añadir fibra o ablandar las heces. Su proveedor le puede decir qué puede tomar sin peligro.
- Beba un vaso de agua cada vez que tome fibra añadida
- Algunas pastillas de hierro vienen con un ablandador de heces que podría ayudar. Consulte a su proveedor.

Cuando está embarazada NO debe usar ciertos productos.

Algunos pueden hacerle daño al bebé. Otros pueden impedir que obtenga las vitaminas que necesita para que usted y su bebé permanezcan sanos.

No use:

- Laxantes
- Aceite de ricino
- Supositorios
- Sena
- Aceite mineral
- Algunos tipos de antiácidos (consulte a su proveedor)
- Enemas

Preste atención a estas cosas:

- Demasiado calcio o hierro pueden empeorar el estreñimiento. Hable con su proveedor sobre cuánto debe tomar.
- Demasiado té caliente o helado, café o refrescos de cola también pueden empeorarlo. Conviene no consumir cafeína, pues roba agua al cuerpo.

Background

Lactose intolerance (or lactase deficiency) is a lack, or low amount, of an enzyme (lactase) that breaks down the sugar in milk (lactose). When lactose is not digested, it is not absorbed by the body and remains in the intestine where it can cause gas. Intolerance means a lack of ability to digest lactose properly; it is not a food allergy. Clients may confuse lactose intolerance with a milk allergy. True milk allergy is very rare in adults.

The most common form of lactose intolerance develops over time as the body produces less and less lactase. People can become lactase deficient after injury to the small intestine or through digestive diseases like celiac disease, inflammatory bowel disease, and Crohn's disease.

Signs of lactose intolerance include bloating, nausea, cramps, diarrhea, and gas. Symptoms begin within 30 minutes to 2 hours after eating or drinking food containing lactose. The ethnic groups most affected in adulthood are African-Americans, Hispanics, Native Americans, and Asians. The condition is least common among people of northern European descent. No treatment can improve the body's ability to make lactase, but symptoms can be controlled through diet. People vary in the amount of lactose they can handle. Some people can tolerate drinking 1 cup of milk and others may tolerate hard cheese but feel discomfort when drinking milk.

Dairy foods provide calcium, vitamin D and other important nutrients for a healthy pregnancy and long-term health. Most women can successfully incorporate dairy products into their diet using the strategies outlined under "Steps to Take" below. Women need to be informed that lactose intolerance does not mean they must totally avoid milk or dairy products. By gradually eating more foods containing lactose, the total amount of lactose that can be comfortably tolerated increases. Research indicates that up to 2 cups of milk per day can be consumed if taken with meals and spread throughout the day.

If a client reacts to even small amounts of lactose, an over-the-counter lactase enzyme is available in tablet or liquid form. The WIC program offers lactose-free milk that contains the same nutrients found in regular milk and other non-dairy calcium rich foods such as tofu, soy and rice milk, calcium fortified juices, sardines and salmon with soft edible bones, dried beans, and dark green vegetables.

Steps to Take

Use these questions and interventions to assess and counsel your client:

Does she experience gas, bloating, or diarrhea after drinking milk or eating yogurt, cheese, ice cream, or other dairy foods?

- Have her try drinking only 4-ounce portions at one time and warming the milk
- Whole, 2% milk or chocolate milk may be better tolerated than lower fat, unflavored milk
- If she is on WIC, recommend she get low lactose milk or calcium-fortified rice or soy milk, and hard cheeses
- Yogurts with "live, active cultures" and other fermented dairy foods like kefir, buttermilk, and sweet acidophilus milk are more easily tolerated than milk
- Aged cheeses such as cheddar, colby, swiss, and parmesan are lower in lactose
- Refer her to the health care provider to prescribe the lactase enzyme

Can she eat a small portion of these foods without experiencing the problem?

- Start with a small amount of milk (1/4 to 1/2 cup) at meals or as snacks several times a day
- Spread out the amounts of these foods over three meals and two or more snacks daily

Can she eat foods cooked with milk or drink warmed milk?

- Suggest using milk to make soups, puddings, custards, or hot milk drinks

- Warm milk and add a dash of vanilla to improve the taste

What are her cultural or religious food preferences? Do they affect her food intake?

- Learn about her religious and cultural beliefs. Are dairy foods a part of her traditional diet?
- Support her food choices that may help increase calcium in her diet

Does she take calcium pills instead of consuming calcium-rich foods?

- Find out how much calcium the pills contain and how many she takes daily
- Make sure she is not taking oyster shell, dolomite, or bonemeal; they may contain lead
- Check with the health care provider and registered dietitian to be sure she is getting enough vitamin D
- See handouts:
 - ◆ *Do You Have Trouble with Milk Foods?*
 - ◆ *Foods Rich in Calcium*

Does she continue to experience discomfort after eliminating milk products?

- Breads, baked goods, instant potatoes, soups, breakfast drinks, margarine, and some processed breakfast cereals may contain lactose
- Even products labeled “non-dairy” like powdered coffee creamer and whipped toppings may contain lactose
- Help her identify lactose in foods by reading the ingredient list on food labels. Look for the words: milk, lactose, whey, curds, milk by-products, dry milk solids, non-fat dry milk powder.
- Some prescription drugs and over-the-counter medications contain lactose and can affect people with the most severe lactase deficiency
- If the above strategies are unsuccessful, refer to the health care provider and the registered dietitian

Follow Up

Use the following to reassess your client’s condition:

- Find out if the client enrolled in WIC and has tried lactose-free milk and other non-dairy calcium-rich foods such as soy or rice milk, salmon, sardines, tofu, calcium-fortified juices, and dark green vegetables
- Assess current problems. Discuss relief methods the woman has tried and which ones have worked.
- Assess her food intake using a *24-Hour Dietary Recall* to determine her calcium intake from all foods and supplements. (See *MyPlate for Moms, Foods Rich in Calcium* and *Take Prenatal Vitamins and Minerals*)
- Determine whether the calcium intake from all sources (food and supplements) meets the recommended daily level of 1,000 milligrams for pregnancy
- Review ways to reduce lactose intake. Encourage her to try other suggestions.
- Work with the registered dietitian to provide a sample meal plan that contains lower lactose along with calcium and vitamin D rich foods. Use the nondairy food sources list to add extra calcium.

Referral

Refer to a health care provider and/or registered dietitian if symptoms of lactose intolerance persist and the woman is unable to consume three servings of milk or dairy foods each day.

Resources

Academy of Nutrition and Dietetics

<http://www.eatright.org/>

Dairy Council of California

www.dairycouncilofca.org

National Digestive Diseases Information Clearinghouse

Information on lactose intolerance and easy to read client education in English and Spanish

www.digestive.niddk.nih.gov

References

Academy of Nutrition and Dietetics. *Nutrition Care Manual*. <http://www.nutritioncaremanual.org>. Accessed June 2016.

American Dietetic Association. *Manual of Clinical Dietetics*. 6th ed., 2000. Lactose Intolerance. Chapter 13, p. 211-217.

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NIH Publication No. 06-2751. March 2006. Retrieved at www.digestive.niddk.nih.gov

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Do You Have Trouble with Milk Foods?



When you are pregnant, it is important to eat foods with calcium, vitamin D, and protein. Milk foods can be a good way to do this. But some women have a hard time digesting milk foods. This is because milk has lactose, a sugar that many people cannot digest.

You can make it easier to digest milk foods.

You can:

- Eat or drink small servings of milk or yogurt five or six times a day. Have 1/2 cup at a time.
- Have milk with a meal instead of by itself
- Heat your milk before you drink it
- Use milk to make soups or casseroles

Choose foods low in lactose.

- Try yogurt with live active cultures in it. Read the label.
- Eat hard (aged) cheeses. Try jack, cheddar, mozzarella, or parmesan.
- Drink cultured buttermilk. Use it when you bake.

Try these products to help digest milk foods:

- Ask your health care provider about products like Lactaid™ and DairyEase™
- You can take these pills before you eat ice cream, yogurt, and cheese or drink milk
- You can also get liquid drops to add to milk
- You can buy lactose-free milk. WIC offers lactose-free milk and calcium fortified soy milk.

If you still have problems:

- Look for hidden lactose in foods. If the food label lists the words curd, whey, milk by-products, dry milk solids, or non-fat dairy powder, the product contains lactose.
- Ask your health care provider before you take any medicines for diarrhea or gas

Take extra calcium with vitamin D.

- Talk to your health care provider and/or dietitian about what type and how much to take



Cuando está embarazada es importante que coma alimentos con calcio, vitamina D y proteína. Los alimentos lácteos pueden ser una buena manera de hacerlo. Pero algunas mujeres no los digieren bien. Esto se debe a que la leche tiene lactosa, un azúcar que muchas personas no pueden digerir.

Usted puede hacer que le sea más fácil digerirlos.

Puede:

- Comer o beber pequeñas porciones de leche o yogur cinco o seis veces al día. Beba o coma 1/2 taza por vez.
- Beba leche con las comidas, en lugar de beberla sola
- Caliente la leche antes de beberla
- Use leche para hacer sopas o platos al horno

Escoja alimentos con poca lactosa.

- Pruebe yogur con cultivos activos vivos. Lea la etiqueta.
- Coma quesos duros (maduros). Pruebe jack, cheddar, mozzarella o parmesano.
- Beba suero de leche cultivado (buttermilk). Úselo al hornear.

Pruebe estos productos para ayudar a digerir los alimentos lácteos.

- Pregúntele a su proveedor de atención de la salud sobre productos como Lactaid™ y DairyEase™
- Puede tomar estas pastillas antes de comer helado, yogur y queso o de beber leche
- También puede obtener gotas para añadirle a la leche
- Puede comprar leche sin lactosa. WIC ofrece leche sin lactosa y leche de soya reforzada con calcio.

Si sigue teniendo problemas:

- Busque la lactosa oculta en los alimentos. Si encuentra en la etiqueta las palabras curd (cuajada), whey (suero de leche), milk by-products (subproductos de la leche), dry milk solids (sólidos secos de la leche) o non-fat dairy powder (polvo de leche sin grasa), el producto contiene lactosa.
- Consulte a su proveedor antes de tomar cualquier medicamento para la diarrea o los gases

Tome calcio adicional con vitamina D.

- Pregúntele a su proveedor y/o a su dietista qué tipo y qué cantidad debe tomar



You need three servings each day of foods rich in calcium. All milk foods are high in calcium.

If you can't drink milk or eat yogurt, try 5 ounces of cheese every day. If you do not like cheeses and other milk foods, or can't digest milk foods, choose three servings of non-milk foods with plenty of calcium. You may also need more vitamin D.

Milk and Milk Foods

Each serving of dairy food has about as much calcium as 1 cup of milk.

- 8 oz. yogurt, buttermilk, cultured milk
- 1 cup pudding or custard
- 1½ cups frozen yogurt or ice cream
- 1½ oz. cheese or 2 oz. processed cheese
- 2½ cups cottage cheese



You can also choose these non-milk foods that are rich in calcium. Each serving size has about as much calcium as 1 cup of milk. It is best to eat many sources of high-calcium food a day.

- One serving calcium-fortified cereal (a WIC food)
- 8 oz. tofu (a WIC food) or tempeh with calcium sulfate
- 8 oz. fortified soy milk (a WIC food) or rice milk
- 1 cup fortified orange juice (a WIC food)
- 3 oz. sardines with bones (a WIC food)
- 5 oz. salmon with bones (a WIC food)
- 2 tbsp. blackstrap molasses
- 1½ cups spinach and turnip greens
- 10 dried figs
- ¾ cup collard greens
- 3 cups okra
- 3¼ cups mustard greens, kale, or broccoli
- 7 medium corn tortillas made with lime or calcium carbonate
- 3 cups baked beans or peas (a WIC food)
- 4 oz. almonds
- 2 cups bok choy

Necesita tres porciones diarias de alimentos ricos en calcio. Todos los alimentos lácteos son ricos en calcio.

Si no puede beber leche o comer yogur, trate de comer 5 onzas de queso todos los días. Si no le gustan los quesos y otros alimentos lácteos, o no puede digerirlos, escoja 3 porciones de alimentos no lácteos con mucho calcio. Es posible que también necesite más vitamina D.

Leche y Alimentos Lácteos

Cada porción de alimentos lácteos tiene tanto calcio como 1 taza de leche.

- 8 oz. de yogur, suero de leche (buttermilk) o leche cultivada
- 1 taza de budín o natilla
- 1½ taza de yogur congelado o de helado
- 1½ oz. de queso o 2 oz. de queso procesado
- 2½ tazas de requesón



También puede escoger estos alimentos no lácteos ricos en calcio. Cada porción tiene aproximadamente tanto calcio como 1 taza de leche. Lo mejor es comer bastantes alimentos diferentes con mucho calcio todos los días.

- Cereal reforzado con calcio (1 porción)
- 8 oz. de tofu o de tempeh con sulfato de calcio (un alimento de WIC)
- 8 oz. de leche reforzada de soya o de arroz (un alimento de WIC)
- 1 taza de jugo de naranja reforzado (un alimento de WIC)
- 3 oz. de sardinas con huesos
- 5 oz. de salmón con huesos (un alimento de WIC)
- 2 cucharadas de melaza negra (blackstrap molasses)
- 1½ tazas de espinaca y de hojas de nabo
- 10 higos secos
- ¾ taza de col rizada
- 3 tazas de quingombó (okra)
- ¾ tazas de hojas de mostaza, berza o brócoli
- 7 tortillas medianas de maíz hechas con cal o carbonato de calcio
- 3 tazas de frijoles o chícharos horneados (un alimento de WIC)
- 4 oz. de almendras
- 2 tazas de col china (bok choy)

Background

The health care provider will determine if the client is anemic and diagnose the type of anemia. Anemia is a condition in which the body does not produce enough healthy red blood cells to provide oxygen to the tissues of the body. Anemia is more common during pregnancy due to increased blood volume and growth of the fetus and other maternal tissue. Iron deficiency is the most common cause of anemia in pregnancy. Anemia is a late stage of iron deficiency. It is estimated that 50% of women do not have adequate iron stores for pregnancy. Vitamin deficiencies of folic acid and B12 can result in a less common anemia known as megaloblastic anemia.

Why Iron Deficiency Matters

Iron deficiency is one of the most common nutritional deficiencies worldwide. Iron deficiency ranges from depletion of iron stores to iron deficiency anemia. Maternal anemia increases the risk of premature birth and low birth weight. Some studies report lower iron stores and poorer health among infants born to iron deficient mothers. These risks are greater if the client enters pregnancy anemic and is anemic during the first two trimesters. Women anemic early in pregnancy are also more likely to have inadequate weight gain. Anemia may put the mother at risk if excessive blood is lost during delivery and postpartum. Postpartum women often have depleted iron stores and may become anemic due to blood loss during delivery.

Signs of anemia

Signs of anemia include paleness, fatigue, dizziness, headache, shortness of breath, and chronic infections. Anemia and iron deficiency can affect the client's quality of life and her ability to cope with the stresses of pregnancy and a new infant.

Immediately refer the client to a health care provider and registered dietitian if no improvement is seen within one month after iron supplementation is prescribed, or if the client does not eat animal products.

Biochemical assessment of anemia

Measuring hemoglobin is a common screening method for iron deficiency anemia. Iron is required to make hemoglobin, the protein in the red blood cell that carries oxygen from the lungs to the body tissues. The provider may order other tests (such as serum ferritin) to measure iron storage and to rule out anemia from other causes

Who is most at risk for anemia?

Iron deficiency anemia is common during pregnancy. Women who are poor, African American, or have recently immigrated from a developing country have higher rates of anemia. Women may enter pregnancy with low iron stores due to:

- Heavy blood loss during menstruation
- Low energy due to poor diet, quality, and variety
- High intake of processed food
- Vegan diet or low protein diet
- High parity
- Short pregnancy interval
- Growth demands of adolescence
- Pregnant with multiples
- Frequent infections or chronic disease
- Intense exercise, especially distance running

Even women entering pregnancy with adequate iron stores often become iron deficient later in their pregnancy. All pregnant women should be advised to eat iron rich food and to take a supplement of iron and folic acid. Follow your clinic's protocol for assessment of anemia and supplement recommendations. See Prenatal Supplements – Vitamins and Minerals for guidelines on iron and folic acid supplementation.

Dietary Iron

Although iron absorption increases during pregnancy, the amount of iron needed during pregnancy is not easy to obtain by diet alone. The average diet contains only 10 to 15 mg per day and 27 mg a day is needed during pregnancy. The two forms of dietary iron are heme and non-heme.

Important facts about dietary iron

- Heme iron is well absorbed and found only in meat, poultry and fish.
- Non-heme iron is less well absorbed and found in foods such as dried beans, peas, iron fortified cereals, bread and pasta, dark green leafy vegetables, dried fruits, nuts, and seeds.
- Most food sources of iron come from non-heme sources, so increasing iron absorption is very important.
- Heme iron (from animal sources) and vitamin C rich foods enhance non-heme iron absorption.
- Cooking in cast iron cookware can increase iron in foods.
- Coffee, tea, and soda can decrease iron absorption.
- Milk, dairy products, or calcium supplements can decrease the amount of iron absorbed at a meal.

Steps to Take

Use these questions and interventions to assess and counsel the client to eat iron rich foods. See the Prenatal Vitamins and Minerals section for advice on iron and folic acid supplementation.

Iron Deficiency Anemia

Hematocrit <33% or hemoglobin <11 g/dL*

How many meals and snacks does she eat?

- Review the client's food intake. Is she eating enough nutritious food from each food group?
 - ◆ Assess her snack choices and encourage snacks with iron such as nuts, seeds, raisins, nut butters, fortified grains, and unprocessed meats.

* Smokers and those at high elevations require different criteria for anemia. Refer to the health care provider for specific criteria. Anemia may be masked by higher hemoglobin levels among smokers and those living at elevations of ~3,000 feet or higher.

- ◆ Snacks high in fat and sugar do not provide adequate iron and should not replace nutritious foods.
- Plot the client's weight on the appropriate weight gain grid to make sure she is eating the right amount of calories.

Is she eating iron rich foods?

- Review the client's dietary intake for iron rich foods and discuss the nutrition handouts, *Get the Iron You Need* and *Iron Tips*.
- Check to see if she is eating WIC foods with iron and vitamin C such as fish, dried beans, iron fortified breads and cereals, leafy green vegetables, and citrus fruits.
 - ◆ Organ meats are high in iron but should be limited to one serving per week.
 - ◆ For a list of heme and non-heme iron foods, see the Office of Dietary Supplements Iron Fact Sheet at www.ods.od.nih.gov/factsheets/Iron-HealthProfessional.

How many times a day does she have tea, sodas, coffee, and antacids?

- Advise the client to limit tea, soda, and coffee to in-between meals.
- Notify the health care provider about the client's antacid use.

Is she eating non-food items, ice, or have unusual food habits?

- Discuss any intake of dirt, clay, starch, ice, etc. Eating pica items is sometime seen with iron deficiency anemia (see *Pica* section).

Help the client identify health foods with textures she may crave, e.g., celery, carrots, pumpkin seeds, cold crunchy fruit, etc.

Other Nutritional Anemias

Elevated Mean Corpuscular Volume (MCV) may indicate anemia from folic acid vitamin B12 deficiency. Folic acid and vitamin B12 deficiency is much less common than iron deficiency anemia. The client's provider will determine if anemia is caused by folic acid or B12 deficiency.

Folic Acid Deficiency Anemia

This type of anemia is less common in the U.S. due to the folic acid fortification of many foods. Women coming from developing countries are at higher risk of folic acid deficiency. Other risk factors besides low dietary intake include alcohol, intestinal problems, and medication interactions. Folic acid deficiency is discussed under *Prenatal Supplements – Vitamin and Minerals*.

Steps to Take

- How often does the client consume fruits and vegetables?
- Is she taking her prenatal vitamin with folic acid each day?
- Check to see if she is eating folic acid fortified breads and cereals. Is she getting WIC foods?
- Encourage her to use WIC checks to buy folic acid rich foods like lentils, beans, fortified cereals and bread, green leafy vegetables, and citrus foods.
- Discuss the Nutrition handout, *Folic Acid – Every Woman, Every Day* in the Prenatal Supplements section.

Vitamin B12 deficiency anemia

The requirement for B12 is very low, but it is essential. Vitamin B12 is commonly found in meats, milk, cheese, and eggs. B12 is not present in plant foods. Vegan women are potentially at risk for B12 deficiency anemia if they do not supplement their diet.

Vitamin B12 in the Vegan Diet

www.vrg.org/nutrition/b12.php

Steps to Take

Does she eat animal foods or dairy products?

- Discuss the nutrition handout, *Get the Vitamin B12 You Need*.
- Review WIC foods with B12 such as milk, yogurt, cheese, fish, and eggs.

Does she choose to not eat animal foods or dairy products?

- Refer her to a health care provider and/or registered dietitian.
- Help vegan women select B12 rich foods she will eat such as fortified cereals, meat analogues, soymilk, some sources of nutritional yeast, and vitamin B12 supplements.
- Tempeh, miso, sea vegetables, and other plant foods are not reliable sources of B12.
- Discuss the handout, *When You are Vegetarian: What You Need to Know*.

Follow Up

Use the following to reassess the client's condition:

- Check her intake of iron supplements and prenatal vitamins. Make sure she is taking them properly.
- Check her intake of other nutrient supplements including vitamin B12 or folic acid.
- Assess for symptoms of pica (eating unusual or nonfood items).
- Check for WIC participation and use of iron, folic acid, and vitamin C rich foods.
- Assess discomforts that may have developed as a result of taking iron supplements (vomiting, constipation, or diarrhea).
- Check lab results on hemoglobin and hematocrit levels and whether they have improved.

Referral

Refer to a health care provider and/or registered dietitian if:

- The client's anemia has not improved within one month from the start of treatment.
- The client has a history of sickle cell disease or other medical disorders causing anemia.
- The client is unable or unwilling to take iron supplements due to discomforts.
- There is evidence of poor dietary intake of iron, folic acid, and vitamin C rich foods, even after counseling.
- There is evidence of vegan/vegetarian food practices with limited food choices.

CAUTION!

Advise the client to keep iron pills tightly sealed, stored, and out of the reach of any child. Iron poisoning may lead to death and is a major concern for small children.

References

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Get the Iron You Need

When you are pregnant, you need more iron

Your body uses iron every day. So every day you need more iron. You need iron to make red blood cells. This keeps you and your baby healthy. When you don't get enough iron, your baby has a higher chance of being born too early or too small. Eat iron rich foods and take a prenatal vitamin and mineral pill with iron every day.

Eat iron rich food and iron helpers. Which ones do you like?

- Highest iron sources: animal foods
 - Shellfish: clams, oysters (cooked)
 - Beef, pork, lamb
 - Chicken, duck
 - Fish, shrimp
 - Organ meats (no more than one time per week)

- Other iron rich foods-absorbed best when combined with animal foods
 - WIC-approved cereals
 - Lentils, beans, peas (dry or canned)
 - Dark green, leafy vegetables: spinach, swiss chard and collards
 - Iron fortified instant cereals
 - Blackstrap molasses
 - Pumpkin and squash seeds
 - Prune juice, dried fruit
 - Tomato paste
- Add iron helpers to your meal
 - Fruits with vitamin C: citrus, cantaloupe, strawberry, kiwi, mango, papaya
 - Vegetables with vitamin C: tomato, broccoli, cauliflower, bell peppers, chili peppers, cabbage
 - Vitamin C rich juices: orange, grapefruit, tomato, lemon/ lime (limit juices to no more than one half to one cup per day)
 - Cook in cast iron skillet and pans to get more iron

Eating the high iron way: Choose meat, other iron rich foods and iron helpers as part of your meals and snacks.



TAKE ACTION

Your ideas for eating the high iron way:



Consuma el Hierro que Necesita

Quando está embarazada, necesita más hierro

Su cuerpo usa el hierro todos los días. Entonces necesita más hierro todos los días. Necesita hierro para producir los glóbulos rojos de la sangre. Esto los mantiene sanos a usted y su bebé. Cuando no obtiene suficiente hierro, su bebé tiene mayor probabilidad de nacer demasiado temprano o ser demasiado pequeño. Coma alimentos ricos en hierro y tome una pastilla de vitaminas y minerales prenatales con hierro todos los días.

Coma alimentos ricos en hierro. ¿Cuáles le gustan?

1. Alimentos que contienen la mayor cantidad de hierro: alimentos de origen animal
 - Mariscos: almejas, ostras (cocidas)
 - Carne de res, puerco, cordero
 - Pollo, pato
 - Pescado, camarones
 - Vísceras (no más de una vez por semana)

2. Otros alimentos ricos en hierro, se absorben mejor cuando se combinan con alimentos de origen animal
 - Cereales aprobados por WIC
 - Lentejas, frijoles, chícharos (secos o enlatados)
 - Verduras de hoja verde oscuro: espinacas, acelgas y col rizada
 - Cereales instantáneos fortificados con hierro
 - Melaza de caña
 - Semillas de calabazas
 - Jugo de ciruela pasa, frutas desecadas
 - Pasta de tomate

3. Agregue ayudas de hierro a su comida
 - Frutas con vitamina C: cítricos, melón, fresa, kiwi, mango, papaya
 - Verduras con vitamina C: tomate, brócoli, coliflor, pimentón, chiles, col
 - Jugos ricos en vitamina C: naranja, toronja, tomate, limón/lima (limite los jugos a no más de media tasa por día)

Cocine en un sartén de hierro colado para obtener más hierro

Comer con mucho hierro: Elija una carne, un alimento rico en hierro y una ayuda de hierro.



TOMA ACCIÓN

Sus ideas para comer con mucho hierro:

1. Eat foods that are good sources of iron every day.

- Just eating a little meat with other foods helps your body get more iron. Add a small bit of meat to beans or a vegetable dish for more iron.
- Clams and oysters are loaded with iron. Always eat them cooked.
- If you don't eat animal foods, eat beans every day.
- To prepare dry beans, soak beans for several hours in cold water before you cook them. Pour off the water and use new water to cook the beans. Your body will take in more iron this way.

2. Eat vitamin C rich foods with iron rich foods to help your body use iron better.

- Vitamin C rich foods are "iron-helpers," which means they help your body use iron better. Eating an orange or strawberries with your breakfast cereal or adding some salsa to your taco helps you get more iron.
- Cook vitamin C rich foods and iron rich foods together for more iron. Try cooking beans with tomatoes or chilies.



3. Coffee, tea, and sodas may block iron from getting into your body.

- If you drink any coffee, tea, or soda (including decaffeinated), drink them between meals instead of with meals. These drinks can block iron from your body.

4. Cook foods in cast iron skillets, pots or pans to add extra iron to your food.

5. Follow your health care provider's recommendation about prenatal vitamins or iron supplements.

1. Coma alimentos que contienen mucho hierro todos los días.

- Con solo comer un poco de carne junto con otros alimentos ayuda a que su cuerpo obtenga más hierro. Agregue una pequeña cantidad de carne a los frijoles o un platillo de verduras para obtener más hierro.
- Las almejas y las ostras están llenas de hierro. Siempre cómalas cocidas.
- Si no come alimentos de origen animal, coma frijoles todos los días.
- Para preparar los frijoles secos, remójelos en agua fría durante varias horas antes de cocinarlos. Drene el agua y use agua nueva para cocinar los frijoles. De esa manera su cuerpo absorberá más hierro.

2. Coma alimentos ricos en vitamina C junto con los alimentos ricos en hierro para ayudar a su cuerpo a hacer mejor uso del hierro.

- Los alimentos ricos en vitamina C son “ayudas de hierro”, que significa que ayudan a su cuerpo a hacer mejor uso del hierro. Comer una naranja o fresas con sus cereales en el desayuno o agregar salsa a su taco le ayuda a obtener más hierro.
- Cocine los alimentos ricos en vitamina C y los alimentos ricos en hierro juntos para obtener más hierro. Pruebe cocinar frijoles con tomates o chiles.



3. El café, el té y los refrescos pueden bloquear la entrada de hierro a su cuerpo.

- Si toma café, té o refrescos (incluso los descafeinados), tómelos entre las comidas en lugar de con las comidas. Estas bebidas pueden evitar que el hierro se absorba en su cuerpo.

4. Cocine las comidas en sartenes u ollas de hierro colado para agregarle hierro adicional a sus comidas.

5. Siga las recomendaciones de su proveedor de atención médica para las vitaminas prenatales o suplementos de hierro.

Iron Helpers:

Foods rich in vitamin C or meats



Foods rich in iron



Your body
uses **more**
iron!

Foods rich in vitamin C

Vegetables

- Tomato
- Broccoli
- Cauliflower
- Bell pepper
- Chili pepper
- Cabbage

Fruits

- Orange
- Cantaloupe
- Grapefruit
- Strawberry
- Kiwi
- Mango
- Papaya

Juices

- Orange
- Grapefruit
- Tomato
- Lemon/lime

If you drink fruit juice, limit intake to no more than one cup per day.

Foods rich in iron

Meats

- Organ meats (liver, giblets); no more than once a week
- Beef
- Duck
- Lamb
- Shrimp
- Fish
- Shellfish, such as clams and oysters

Non-Meats

- WIC-approved cereals
- Fortified instant cereals
- Soybeans
- Pumpkin/squash seeds
- Dry beans, cooked
- Lentils
- Spinach
- Dark green, leafy vegetables such as collards and spinach
- Eggs
- Bread/tortillas
- Rice/pasta
- Tomato paste
- Prune juice
- Dried fruit

Read food labels!

Iron is added to many foods. Look for food labels that say “enriched” or “fortified.” Some foods that may have extra iron are bread, rice, tortillas, cereals, and pasta.

Vitamin C is added to some foods because we need to have it every day. Look for labels that say “added vitamin C.” Juices are a good example of a vitamin C enriched product. Check the label to see if each serving has 50% or more of the vitamin C that you need. However, juice is high in natural sugar, so **limit juice intake to no more than one cup per day.**

! Avoid buying fruit drinks and other sweetened drinks that are high in sugar. Look for labels that say “100% juice.”

Ayudas de hierro:

Alimentos ricos en vitamina C o carnes

Alimentos ricos en hierro



= ¡Su cuerpo usa **más** hierro!

Alimentos ricos en vitamina C

Verduras

- Tomate
- Brócoli
- Coliflor
- Pimentón
- Chiles
- Col

Frutas

- Naranja
- Melón
- Toronja
- Fresa
- Kiwi
- Mango
- Papaya

Jugos

- Naranja
- Toronja
- Tomate
- Limón/lima

Si usted bebe el jugo de fruta, limite el consumo a no más de una taza al día.

Alimentos rico en hierro

Carnes

- Vísceras (hígado, menudillos); no más de una vez por semana
- Carne de res
- Pato
- Cordero
- Camarones
- Pescado
- Mariscos, como almejas y ostras

Alimentos sin carne

- Cereales aprobados por WIC
- Cereales instantáneos fortificados
- Soya
- Semillas de calabaza
- Frijoles secos, cocidos
- Lentejas
- Espinaca
- Verduras con hojas de color verde oscuro, como col rizada y espinacas
- Huevos
- Pan/tortillas
- Arroz/pastas
- Pasta de tomate
- Jugo de ciruela pasa
- Fruta deshidratada

¡Lea las etiquetas de las comidas!

Se le agrega hierro a muchas comidas. Busque etiquetas que dicen “enriched” (enriquecido) o “fortified” (fortificado). Algunas comidas que pueden tener hierro agregado son pan, arroz, tortillas, cereales y pastas.

Se agrega la vitamina C a algunas comidas porque la tenemos que ingerir todos los días. Busque etiquetas que dicen “added vitamin C” (vitamina C agregada). Los jugos son un buen ejemplo de un producto enriquecido con vitamina C. Examine la etiqueta para ver si cada porción tiene 50% o más de la vitamina C que necesita. Sin embargo, el jugo tiene alto contenido de azúcar natural, así que debe **limitar el consumo de jugo a no más de una taza por día.**

! Evite comprar bebidas frutales y otras bebidas endulzadas con alto contenido de azúcar. Busque etiquetas que digan “100% juice” (100% jugo).



My Action Plan for Iron

Name: _____

Check the box for each step you are doing now to get enough iron. Check the boxes for the steps you plan to take. Write down other ways you plan to improve your iron intake.



Things that I can do to get enough iron every day

- Add one serving of vegetables such as spinach, broccoli, or leafy green lettuce to my diet most days of the week.
- Eat an orange or another citrus fruit with my iron rich foods.
- Try a fruit or vegetable from the iron rich food list that I have never tried before.
- Add one serving of lentils, black beans, pinto beans, or garbanzo beans to my diet most days of the week.
- Cook in a cast iron skillet or pan.
- Only drink tea, coffee, or soda in between meals to get the most iron from my food.
- Take my prenatal vitamin and mineral supplement daily and any iron pills my doctor prescribes for me.

My ideas for improving my iron intake:

Am Doing	Steps I Will Take
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Signature: _____

Date: _____

Nombre: _____

Marque la casilla para cada medida que está tomando ahora para obtener suficiente hierro. Marque las casillas para las medidas que piensa tomar. Escriba otras maneras que piensa mejorar su consumo de hierro.



Cosas que puedo hacer para obtener suficiente hierro todos los días

- Agregar una porción de verduras como espinacas, brócoli o lechuga de hojas verdes a mi dieta la mayoría de los días de la semana.
- Comer una naranja u otra fruta cítrica junto con mis alimentos ricos en hierro.
- Probar una fruta o verdura de la lista de alimentos ricos en hierros que nunca he probado.
- Agregar una porción de lentejas, frijoles negros, frijoles pinto o garbanzos a mi dieta la mayoría de los días de la semana.
- Cocinar en un sartén de hierro colado.
- Solo tomar té, café o refrescos entre las comidas para obtener la mayor cantidad de hierro de mis comidas.
- Tomar mi suplemento prenatal de vitaminas y minerales todos los días y cualquier pastilla de hierro que mi doctor me recete.

Mis ideas para mejorar mi consumo de hierro:

Estoy haciendo	Medidas que tomaré
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Firma: _____

Fecha: _____



Get the Folic Acid You Need

When You Are Pregnant, You Need More Folic Acid.

Make sure you get plenty of folic acid. It will:

- Help lower the chances of having a baby with birth defects
- Help you and your baby keep healthy
- Give your baby a healthy start on life

Here's how to get more folic acid.

Make sure you:

- Take your prenatal vitamins every day
- Eat grains and cereals fortified with folic acid. Read the labels. Look for the words folic acid or folate.
- Eat five or more fruits and vegetables every day
- Eat beans or lentils at least once a day
- Talk to your health care provider about any medicines you take. Some may make it hard for your body to use folic acid.

It is good to know:

- Folic acid and folate are the same vitamin
- Folic acid is added to foods
- Folate is found in foods naturally

Heat Can Destroy Folate

- Do not overcook vegetables
- Eat fruits and vegetables raw
- Steam or sauté vegetables
- Beans still have plenty of folate in them, even after they are cooked

Eat These Foods Rich in Folic Acid:

Grains and cereals are fortified with folic acid:

- Bread
- Rice
- Flour
- Grits
- Wheat germ
- Corn meal
- Farina
- Pasta
- Many kinds of breakfast cereals

Beans and lentils are high in folate:

- Black-eyed peas
- Lentils
- Split peas
- Garbanzo beans
- Kidney beans
- Lima beans
- Pinto beans
- Navy beans
- Black beans

Nuts and seeds are also high in folate:

- Peanuts
- Sunflower seeds



These fruits and juices are high in folate:

- Strawberries
- Orange juice
- Cantaloupe
- Avocado
- Papaya

Many vegetables are high in folate:

- Broccoli
- Asparagus
- Corn
- Okra

These greens are high in folate:

- Mustard greens
- Romaine lettuce
- Spinach
- Cooked turnip greens

Read the labels on breads and cereals. They may have added folic acid.

Ingredients: Rice, wheat gluten, sugar, defatted wheat germ, salt, high fructose corn syrup, dried whey, malt flavoring, calcium caseinate, **Vitamins and Minerals:** ascorbic acid (vitamin C), alpha tocopherol acetate (vitamin E), reduced iron, niacinamide, pyridoxine hydrochloride (vitamin B₆), riboflavin (vitamin B₂), thiamin hydrochloride (vitamin B₁), vitamin A palmitate, folic acid and vitamin B₁₂. To maintain quality, BHT has been added to the packaging.



PASOS A SEGUIR

Consuma el Ácido Fólico que Necesita

Cuando está Embarazada Necesita más Ácido Fólico.

Asegúrese de consumir suficiente ácido fólico. Porque:

- Ayuda a reducir las posibilidades que su bebé nazca con defectos de nacimiento
- Les ayuda a mantenerse sanos, tanto a usted como a su bebé
- Su bebé podrá tener un buen comienzo en su vida

Para conseguir más ácido fólico.

Debe hacer lo siguiente:

- Tome sus vitaminas prenatales todos los días
- Coma granos y cereales fortalecidos con ácido fólico. Lea las etiquetas. Busque las palabras "folic acid" o "folate" en la etiqueta.
- Coma 5 o más frutas y verduras diarias
- Coma frijoles o lentejas por lo menos una vez al día
- Consulte a su médico sobre las medicinas que toma. Algunas no dejan que el cuerpo use el ácido fólico.

Debe saber que:

- El ácido fólico y el folate son la misma vitamina
- El ácido fólico es lo que le agregan a ciertos alimentos
- El folate es lo que los alimentos contienen naturalmente

El Calor uede Destruir el Folate

- No cocine demasiado las verduras
- Coma frutas y verdura frescas
- Cocine verduras al vapor o salteadas
- Los frijoles contienen mucho folate, aún después de cocinar los

Coma Productos Ricos en Ácido Fólico:

Granos y cereales que están fortalecidos con ácido fólico:

- Pan
- Arroz
- Harina
- Sémola
- Trigo integral
- Harina de maíz
- Farina
- Pasta
- Algunos cereales secos

Los frijoles y las lentejas son ricas en folate:

- Frijoles de punto negro
- Lentejas
- Chícharo seco
- Garbanzos
- Frijoles rojos grandes
- Habas
- Frijoles pintos
- Frijoles rojos
- Frijoles negros

Las nueces y semillas también son ricas en folate:

- Cacahuates
- Semillas de girasol



Frutas y jugos ricos en folate son:

- Fresas
- Jugo de naranja
- Melón
- Aguacate
- Papaya

Hay muchos vegetales ricos en folate:

- Brócoli
- Espárragos
- Elotes
- Okra

Vegetales verdes ricos en folate son:

- Hojas de mostaza
- Lechuga romana
- Espinacas
- Hojas de nabo cocidas

Lea las etiquetas de las cajas de cereales y los paquetes de pan. Tal vez le agregaron ácido fólico.

Ingredients: Rice, wheat gluten, sugar, defatted wheat germ, salt, high fructose corn syrup, dried whey, malt flavoring, calcium caseinate, **Vitamins and Minerals:** ascorbic acid (vitamin C), alpha tocopherol acetate (vitamin E), reduced iron, niacinamide, pyridoxine hydrochloride (vitamin B6), riboflavin (vitamin B2), thiamin hydrochloride (vitamin B1), vitamin A palmitate, folic acid and vitamin B12. To maintain quality, BHT has been added to the packaging.

Folic Acid: Every Woman, Every Day

When is folic acid important for me?

Folic acid is good for all women, even if they don't plan on getting pregnant. It is especially important to have enough folic acid in your body **before** you get pregnant and during the first months of pregnancy.

What kind of birth defects may folic acid prevent?

Taking folic acid before you get pregnant lowers your chances of having a baby with serious birth defects of the brain or spinal cord. It may also lower your chances of having a baby with birth defects of the heart, lip or mouth.



What are the other benefits of folic acid?

You need folic acid for the growth and repair of every cell in your body. Since hair, skin, and nails grow every day, folic acid is really important.



Folic Acid

Every Woman, Every Day

For more information about
Folic acid, please e-mail:

For English: askus@marchofdimes.com
or visit www.marchofdimes.com

For Spanish: preguntas@nacersano.org
or visit www.nacersano.org



Folic acid is a B-vitamin your body needs every day.

And, if you get pregnant, it lowers your chances of having a baby with a birth defect.

How can I get enough folic acid every day?

There are two ways to get the 400 micrograms (mcg) of folic acid your body needs every day:

- **Eat one serving of a cereal that has all the folic acid you need every day.** Many cereals do not have enough folic acid, so it is important to read the nutrition label on the box.

OR

- **Take a vitamin pill that has all of the folic acid you need every day.**



Supplement Facts		
Serving Size: One Tablet		
Amount Per Serving		% Daily Value
Vitamin A	5000 IU	100%
Vitamin C	60 mg	100%
Vitamin D	400 IU	100%
Vitamin E	30 IU	100%
Vitamin K	25 mcg	31%
Thiamin (B1)	1.5 mg	100%
Riboflavin (B2)	1.7 mg	100%
Niacin	20 mg	100%
Vitamin B6	2 mcg	100%
Folic Acid	400 mcg	100%
Vitamin B12	0 mcg	100%



How can I find the amount of folic acid on a label?

1. Find the nutrition label on the side of a cereal box or vitamin bottle.
2. Look for the words “folic acid” or “folate” in the left column.
3. Look for number “100%” in the right column. It is important that the number say “100%” of your “daily value” for “folic acid” or “folate”.

Nutrition Facts		
Serving Size: 1 cup (55g)		
Servings Per Container: About 12		
Amount Per Serving	(Name of Cereal)	with 1/2 cup skim milk
Calories	170	210
Calories from Fat	10	10
Total Fat	1g*	2%
Saturated Fat	0g	0%
Polyunsaturated Fat	0g	0%
Monounsaturated Fat	0g	
Cholesterol	0mg	1%
Sodium	240mg	10%
Potassium	360mg	10%
Total Carbohydrate	41g	16%
Dietary Fiber	5g	20%
Sugars	20g	
Other Carbohydrate	16g	
Protein	4g	
Vitamin A	10%	15%
Vitamin C	0%	0%
Calcium	100%	110%
Iron	100%	100%
Vitamin D	10%	25%
Vitamin E	100%	100%
Thiamin	100%	100%
Riboflavin	100%	110%
Niacin	100%	100%
Vitamin B6	100%	100%
Folic Acid	100%	100%
Vitamin B12	100%	110%
Pantothenic Acid	100%	100%
Phosphorus	10%	25%
Magnesium	10%	10%
Zinc	100%	100%
Copper	8%	8%

Acido Fólico: Cada Mujer, Cada Día

¿Cuándo es el ácido fólico importante para mí?

El ácido fólico es bueno para todas las mujeres, aunque no planeen embarazarse. Es especialmente importante tener suficiente ácido fólico en su cuerpo antes de quedar embarazada y durante los primeros meses del embarazo.

¿Qué clase de defectos de nacimiento puede prevenir el ácido fólico?

Tomar ácido fólico antes de embarazarse reduce el riesgo de tener un bebé con serios defectos de nacimiento del cerebro o de la columna vertebral. También puede reducir el riesgo de tener un bebé con defectos de nacimiento del corazón, labio o boca.



¿Cuáles son los otros beneficios del ácido fólico?

Usted necesita ácido fólico para el crecimiento y reparación de cada célula en su cuerpo. El cabello, la piel y las uñas crecen cada día y, por eso, el ácido fólico es muy importante.



Acido Fólico

Cada Mujer, Cada Día



Para más información sobre el ácido fólico, envíe un correo electrónico a preguntas@nacersano.org o visite www.nacersano.org.



PUB. #411 (2012)

Acido fólico es una vitamina B que su cuerpo necesita diariamente.

Si usted se embaraza, esta vitamina puede reducir el riesgo de tener un bebé con un defecto de nacimiento.

¿Como puedo obtener diariamente suficiente ácido fólico?

Hay dos maneras en que usted puede obtener los 400 microgramos (mcg) de ácido fólico que su cuerpo necesita diariamente:

- **Comer una porción de un tipo de cereal que contiene todo el ácido fólico que usted necesita diariamente.** Muchos cereales no contienen suficiente ácido fólico, así que es importante leer la etiqueta de nutrición al lado de la caja.

0

- **Tomar una vitamina suplementaria que contiene todo el ácido fólico que necesita diariamente.**



Supplement Facts		
Serving Size: One Tablet		
Amount Per Serving		% Daily Value
Vitamin A	5000 IU	100%
Vitamin C	60 mg	100%
Vitamin D	400 IU	100%
Vitamin E	30 IU	100%
Vitamin K	25 mcg	31%
Thiamin (B1)	1.5 mg	100%
Riboflavin (B2)	1.7 mg	100%
Niacin	20 mg	100%
Vitamin B6	2 mg	100%
Folic Acid	400 mcg	100%
Vitamin B12	0 mcg	100%

¿Como puedo encontrar la cantidad de ácido fólico en la etiqueta de nutrición?

1. Encuentre la etiqueta de nutrición al lado de una caja de cereal o un frasco de vitaminas.
2. Busque las palabras “folic acid” (ácido fólico) or “folate” (folato) en la columna a la izquierda.
3. Busque el porcentaje “100%” en la columna a la derecha. Es importante que el porcentaje sea 100% de su “daily value” (necesidad diaria) para “ácido fólico” o “folate”.



Nutrition Facts		
Serving Size: 1 cup (55g)		
Servings Per Container: About 12		
Amount Per Serving	(Name of Cereal)	with 1/2 cup skim milk
Calories	170	210
Calories from Fat	10	10
Total Fat 1g*	1%	2%
Saturated Fat 0g	0%	0%
Polyunsaturated Fat 0g		
Monounsaturated Fat 0g		
Cholesterol 0mg	0%	1%
Sodium 240mg	10%	13%
Potassium 360mg	10%	16%
Total Carbohydrate 41g	14%	16%
Dietary Fiber 5g	20%	20%
Sugars 20g		
Other Carbohydrate 16g		
Protein 4g		
Vitamin A	10%	15%
Vitamin C	0%	0%
Calcium	100%	110%
Iron	100%	100%
Vitamin D	10%	25%
Vitamin E	100%	100%
Thiamin	100%	100%
Riboflavin	100%	110%
Niacin	100%	100%
Vitamin B6	100%	100%
Folic Acid	100%	100%
Vitamin B12	100%	110%
Pantothenic Acid	100%	100%
Phosphorus	10%	25%
Magnesium	10%	10%
Zinc	100%	100%
Copper	8%	8%



Pregnant women need vitamin B12

If you don't get enough vitamin B12, you could get vitamin B12 anemia. A deficiency in vitamin B12 can also damage your nervous system.

Vitamin B12 is found in animal foods such as meat, milk, and eggs. If you don't eat these foods, talk to your health care provider; you may need more vitamin B12.

How can I get more vitamin B12?

- Eat animal foods like milk, cheese, eggs, or meat.
- Eat soy foods fortified with vitamin B12 such as some kinds of tofu. Read the label to be sure it has B12.
- Ask your health care provider if you should take vitamin B12 pills or shots.

If you don't eat animal products:

- You need to take a vitamin B12 supplement; ask your health provider.
- Tempeh, miso, sea vegetables, and other plant foods are not reliable sources of vitamin B12.
- Use vitamin B12 fortified soymilk, vitamin B12 fortified meat analogues (food made from wheat gluten or soybeans to resemble meat, poultry, or fish), vitamin B12 fortified energy bars, and vitamin B12 supplements.
- Use nutritional yeast such as Vegetarian Support Formula (Red Star T-6635+).
- Talk to a registered dietitian to make sure you are getting the vitamin B12 you and your baby need.



Las mujeres embarazadas necesitan vitamina B12

Si no obtiene suficiente vitamina B12 podría tener anemia de vitamina B12. Una deficiencia de vitamina B12 también puede dañar su sistema nervioso.

La vitamina B12 se encuentra en alimentos de origen animal, como la carne de res, la leche y los huevos. Si no come estos alimentos, hable con su proveedor de atención médica, es posible que necesite más vitamina B12.

¿Cómo puedo obtener más vitamina B12?

- Coma alimentos de origen animal, como la leche, el queso, los huevos o la carne de res.
- Coma alimentos de soya fortificados con vitamina B12, como algunos tipos de tofú. Lea la etiqueta para verificar que tiene B12.
- Pregúntele a su proveedor de atención médica si debería tomar pastillas o darse inyecciones de vitamina B12.

Si no come alimentos de origen animal:

- Tiene que tomar un suplemento de vitamina B12; pregúntele a su proveedor de atención médica.
- El tempeh, el miso, las verduras de mar y otros alimentos de origen vegetal no son fuentes confiables de vitamina B12.
- Use leche de soya fortificada con vitamina B12, sustitutos de carne fortificados con vitamina B12 (alimentos hechos de gluten de trigo o soya que parecen ser carne de res, aves o pescado), barras energéticas fortificadas con vitamina B12 y suplementos de vitamina B12.
- Use levadura nutricional como por ejemplo Vegetarian Support Formula (Red Star T-6635+).
- Hable con un nutricionista titulado para verificar que está obteniendo la cantidad de vitamina B12 que usted y su bebé necesitan.

Prenatal Supplements: Multivitamin and Multi-minerals

Vitamin and mineral requirements increase during pregnancy and lactation. It is possible for women to get most of the extra vitamins and minerals they need through a balanced and varied diet. Supplementation of iron, folic acid, and iodine is recommended. Many pregnant women do not meet the recommended dietary intake of these nutrients.

Lack of resources for a varied and balanced diet, a busy lifestyle, nausea, fatigue, and lack of knowledge are a few factors that may result in a woman not getting the nutrients she needs. Initially and each trimester, assess the client's diet and compare it to *MyPlate for Moms* to determine diet adequacy and other factors that may impact her nutritional status.

Who should take prenatal vitamins and minerals?

The Institute of Medicine (IOM) and the Academy of Nutrition and Dietetics recommend a standard prenatal vitamin and mineral supplement for all pregnant women with any of the following conditions or lifestyle choices:

- Poor quality diet
- Vegan diet
- Iron deficiency anemia
- Pregnant with multiples
- Heavy smoking
- Drug or alcohol abuse
- Bariatric surgery

Prenatal Supplement Recommendations For All Women

Iron, folic acid, and iodine

All women should receive routine supplementation of 30 mg of iron per day to maintain iron stores and prevent anemia. To treat anemia, women may take

Recommended contents of a prenatal supplement*

Vitamins

Vitamin B6	2 mg
Folate (Folic Acid) .4 mg	400 mcg*
Vitamin C	50 mg
Vitamin D 5 mcgb	200 IU

Minerals

Calcium	250 mg
Iron	30 mg
Zinc	15 mg
Copper	2 mg

*The current recommendation is that all women of childbearing age consume 400 mcg/day of folic acid in supplements or fortified foods.

The above is adapted from the Institute of Medicine, *Nutrition During Pregnancy: Parts I and II*. Washington, DC: National Academy Press, 1990. This supplement formulation was suggested prior to the American Thyroid Association recommendation that all pregnant women receive 150 mcg/day of iodine supplements.

higher doses of iron as prescribed by her provider. Women taking more than 30 mg of elemental iron per day should take a daily prenatal vitamin with zinc and copper.

All women who are able to become pregnant and who are pregnant are advised to take .4 mg (400 mcg) of folic acid, eat folic acid fortified foods, and eat a diet rich in folic acid, with foods such as dark green leafy vegetables, legumes, and citrus fruits. A dose of 400 mcg of folic acid per day consumed during the preconception period and the first trimester has been shown to reduce the incidence of certain birth defects.

Pregnant women who do not consume dairy products or restrict their salt intake may be at risk for iodine deficiency. The American Thyroid Association recommends that all pregnant women receive 150 mcg per day of iodine supplements (the Daily Reference Intake (DRI) for pregnancy).

Taking prenatal vitamins cannot compensate for poor food habits. Women need nutrients that are not included in prenatal vitamins. To be well nourished, encourage pregnant women to eat a wide variety of nutritious foods at every meal.

Prenatal vitamin and mineral cautions

Excess vitamin and mineral intake can lead to toxicity and congenital defects. Counsel the client to take one only prenatal vitamin daily and to keep the pills away from children. The IOM has set DRIs for nutrients needed during pregnancy and lactation. Prenatal supplements that offer 100% of the U.S. Recommended Dietary Allowances (RDA) are safe. The DRIs also set Tolerable Upper Intake Limits (UL), the highest level of daily intake possible that will likely not pose a health risk. Educate clients to not exceed the ULs established for vitamins and minerals. For example, high vitamin A supplementation has caused birth defects. Review the handout, *Take Prenatal Vitamins and Minerals*.

Barriers and Incentives for Taking Prenatal Supplements

Reports suggest that half of all pregnant and lactating women take a prenatal supplement. Women who are poor, less educated, and non-white tend to not take supplements regularly. When women were asked why they did not take prenatal supplements regularly, common barriers included:

- Fears and experiences of uncomfortable side effects (nausea, gagging, vomiting, constipation)
- Complicated dose schedules and instructions
- Lack of understanding about the benefits of use
- Poor communication with health care providers

Incentives for taking supplements included:

- Affordability and convenient supply
- Reinforcement by the health care provider
- Altering dose to minimize discomforts

Dietary Reference Values for pregnancy and lactation at: <http://nationalacademies.org/hmd/activities/nutrition/summarydri/dri-tables.aspx>

Steps to Take

Ask the client what supplements she is taking. What supplement/dosage did her provider recommend?

If she is not taking supplements as recommended, discuss barriers she is facing and help her with ideas to overcome the barriers. Review *Take Prenatal Vitamins and Minerals* and ask:

- Are you having unpleasant side effects from the pills? If so, what are they?
- How important do you think prenatal vitamins and minerals are for your baby's health? For your health?
- What dosage/regimen did your health care provider recommend?
- Where can you keep your vitamins so they are away from children?
- Where can you keep your vitamins so it is easy for you to remember to take them?

Other vitamin and mineral supplements

The client's provider will prescribe or recommend additional supplements as needed. Assess the client's diet to identify inadequate nutrient intake. If she does not consume any dairy, it may be hard for her to get the calcium she needs. See Lactose Intolerance for a list of calcium rich foods and suggestions for tolerating lactose.

For calcium and iron supplements, refer to the handouts, *If You Need Iron Pills or You May Need Extra Calcium*. Folic acid information is found in *Iron Deficiency and Other Anemias*.

Calcium

Calcium is needed by the body to form strong bones and teeth and maintain good muscle function. Calcium supplements are used to supply calcium when absorption from diet alone is inadequate. Calcium supplements may cause gas, bloating, or constipation. Excess calcium supplementation can cause kidney stones and reduce zinc and iron absorption.

Pregnant women need a total of 1,000 mg of calcium per day from diet and/or supplementation. Pregnant women between the ages of 14 to 18 need 1,300 mg of calcium. Absorption of calcium is highest in doses equal to or less than 500 mg. If the client gets her calcium primarily from supplements, the 1,000 mg calcium dose should be split into two doses. The health care provider will recommend the amount and type of calcium should the client need it. Assess how much calcium she consumes from diet and supplements and advise her to not take more than her provider recommends.

Some calcium supplements and antacids may contain high levels of lead. Check for a “lead free” label or get further information from a pharmacist, registered dietitian, or the Natural Resources Defense Council (www.nrdc.org).

How much calcium do calcium supplements contain?

Type/Elemental Calcium/Dose

Non Chewable

950 mg Calcium Citrate, 200 mg

Tablets

1,000 mg Calcium Lactate, 140 mg

1,200 mg Calcium Gluconate, 108 mg

Chewable Tablets

500 mg Calcium Carbonate, 200 mg

750 mg Calcium Carbonate, 300 mg

317 mg Calcium Carbonate, 127 mg

64 mg Magnesium Hydroxide

Liquids

200 mg Calcium Carbonate/ml, 80 mg/ml

Iron

All pregnant women should take 30 mg of elemental iron daily. Prenatal supplements usually contain this amount. Iron supplements are used to prevent iron deficiency anemia and maintain an adequate supply of iron in the pregnant woman's body. The tolerable UL for iron is 45 mg for women who have adequate iron stores. Some women report constipation, stomach upset, and nausea from iron supplements. If this is the case, discuss any side effects the client is having and refer her to a health care provider.

Pregnant women who have iron deficiency anemia need 60 to 120 mg of elemental iron daily. Women taking over 60 mg of iron need additional zinc and copper. The health care provider will recommend the correct amount and type of iron for the client. Supplemental iron comes in two forms: ferrous and ferric. Ferrous iron is best absorbed.

Iron supplements come in tablets, liquid, and time-release pills (less well absorbed). It is recommended that iron is taken in two or three equally spaced doses. If supplemental iron causes discomfort, talk to the provider about changing the type of iron, reducing the daily dose, or taking the dose intermittently, not daily. Hemoglobin generally increases after 2 to 3 weeks of supplementation.

How much iron do iron supplements contain?

Amount/Type of Elemental Iron/Milligrams of Iron per Tablet

Tablets

*195 mg Ferrous Fumarate, 65 mg
325 mg Ferrous Sulfate, 60 mg
300 mg Ferrous Gluconate, 35 mg*

Time Release

*160 mg dried Ferrous Sulfate, 50 mg
150 mg Ferrous Gluconate, 50 mg (with stool softener)*

Chewable

100 mg, 33 mg

Liquids

*220 mg Ferrous Sulfate, 44 mg (5% alcohol)
330 mg Ferrous Gluconate, 35 mg*

Vitamin D

Both diet and exposure to sunlight help maintain healthy vitamin D levels. Vitamin D is only found in a few foods. Fish oils and fatty fish like salmon, tuna, and mackerel are the best sources; beef liver, egg yolks, cheese, and mushrooms provide small amounts. Vitamin D is added to milk but not usually to other milk products like yogurt or ice cream. Some ready-to-eat cereal and orange juice is fortified with vitamin D.

Ultraviolet light from the sun helps people make vitamin D. It is easier for people with lighter skin pigment to make vitamin D than people with darker skin pigment. Experts recommend five to 30 minutes of sun exposure each day between the hours of 10 a.m. and 3 p.m. Toxicity to the vitamin can occur with excess supplement levels but not from food or the sun.

Who is at risk for vitamin D deficiency?

- African American and Mexican American women are at higher risk for vitamin D deficiency.
- Limited sun exposure can reduce vitamin D levels, particularly among people with more pigment in their skin.
- Obese individuals who have undergone gastric bypass surgery may become deficient due to lack of absorption.
- 400 IU of a vitamin D supplement is recommended for all breastfed infants.

Vitamin D recommendations for pregnant and lactating women and breastfed infants

Recommended Daily Allowance	600 IU (15 mcg)
Tolerable Upper Limit	4000 IU (100 mcg)
Breastfeed Infants- RDA	400 IU day (10 mcg)

Source: Office of Dietary Supplements, Dietary Supplement Fact Sheet www.ods.od.nih.gov/factsheets/VitaminD-HealthProfessional/

Steps to Take

Make sure the client is getting sufficient vitamin D

- Ask if she is taking a prenatal vitamin supplement. If not, refer to the health care provider to ensure she has adequate vitamin D levels.
- Does she eat fatty fish? Recommend she eat salmon and tuna offered by the WIC program at least weekly.
- If she is taking vitamin D, make sure it is the recommended dose (400 to 600 IU) and does not exceed 4,000 IU.

Does the client get sun exposure?

Women who remain indoors all day or wear long robes and head covering are at risk for insufficient vitamin D.

- Encourage women to get five to 30 minutes of sun exposure between 10 a.m. to 3 p.m. each day on their face, arms, or legs.
- Apply sunscreen after initial sun exposure.

Does she plan to breastfeed?

- The American Pediatric Association recommends all breastfed infants are supplemented with 400 IU of vitamin D during exclusive breastfeeding, regardless if the woman is taking vitamin D supplements.
- Advise her to talk to her provider about getting enough vitamin D postpartum.

Herbal and dietary supplements

Many women take supplements that come from plants or plant parts. These products are often labeled “natural,” leading women to believe they are safe. It is important to understand that the safety and effectiveness of herbal and dietary supplements are not regulated. Even herbs that are used in cooking may cause problems when they are used in a concentrated form. Some herbs are definitely known to be toxic during pregnancy, such as blue cohosh and pennyroyal. Other herbal and dietary supplements can cause interactions with medicine or contain contaminants.

The American Academy of Pediatrics recommends that pregnant women limit herbal tea consumption to 2-8 ounce servings per day and that they use filtered tea bags, not loose leaf tea.

Steps to Take

- Advise the client to discuss use of any herbal or dietary supplement with her health care provider.
- When completing a nutrition assessment, always ask the client what herbal supplements, teas, or other natural remedies she takes.
- Ask the client what others have told her about using supplements during pregnancy and breastfeeding.

Resources

The Office of Dietary Supplements

www.ods.od.nih.gov/

National Center for Complementary and Alternative Medicine (NCCAM)

www.nccam.nih.gov/

Herbs at a Glance

www.nccam.nih.gov/health/herbsataglance.htm

Brief fact sheets describing potential benefits and cautions for several herbs.

Time to Talk (NCCAM)

www.nccam.nih.gov/timetotalk

An educational campaign to encourage clients and their health care providers to discuss the use of complementary practices.



Take Prenatal Vitamins and Minerals

Prenatal vitamins help you and your baby grow and stay healthy, but be careful when using them:

- Keep your prenatal vitamin and mineral pills out of reach of children.
- If children eat them, they can get very sick or even die.
- If your child does swallow any of your pills, call California Poison Control right away at 1-800-222-1222 and visit www.calpoison.org.



Taking prenatal vitamins and minerals safely:

- Use prenatal vitamins and minerals that are 100% of the U.S. RDA
- Take only one tablet a day. If you take more, it can be harmful.
- Take your prenatal pill with water or juice. Do not take with milk, cheese, or yogurt.
- Take your prenatal pill at bedtime or between meals.

Possible vitamin and minerals discomforts:

- Constipation
- Stomach sickness
- Diarrhea

Talk to your health care provider about your discomforts. Your provider can help find a prenatal vitamin and mineral that works best for you.

TAKE ACTION

My plan to take my prenatal vitamins and minerals:

I will take my prenatal pill at this time: _____

I will remember to take my prenatal pill each day by: _____

I will keep my pills safe from children by: _____

If my pills make me feel uncomfortable, I will contact: _____

When I run out of prenatal pills, I will: _____



Tome Vitaminas y Minerales Prenatales

Las vitaminas prenatales les ayudan a usted y a su bebé a crecer y mantenerse saludables, pero debe tener cuidado cuando las use:

- Guarde sus pastillas de vitaminas y minerales prenatales fuera del alcance de los niños.
- Si los niños las comen, se pueden enfermar mucho o incluso morir.
- Si su hijo traga alguna de sus pastillas, llame de inmediato a Sistema para el Control de Intoxicaciones y Envenenamientos de California (California Poison Control) al 1-800-222-1222 y visite www.calpoison.org.



Cómo tomar las vitaminas y minerales prenatales de manera segura:

- Use vitaminas y minerales prenatales de contienen 100% de la cantidad diaria recomendada (RDA) de los EE.UU.
- Tome una sola tableta por día. Si toma más, puede ser dañino.
- Tome su pastilla prenatal con agua o jugo. No la tome con leche, queso o yogur.
- Tome su pastilla prenatal a la hora de dormir o entre las comidas.

Posibles malestares debido a las vitaminas y minerales:

- Estreñimiento
- Malestar estomacal
- Diarrea

Hable con su proveedor de atención médica sobre sus malestares. Su proveedor le puede ayudar a encontrar la pastilla de vitaminas y minerales prenatales mejor para usted.

TOMA ACCIÓN

Mi plan para tomar mis vitaminas y minerales prenatales:

Tomaré mi pastilla prenatal a esta hora: _____

Recordaré tomar mi pastilla prenatal todos los días haciendo lo siguiente: _____

Mantendré las pastillas prenatales alejadas de los niños haciendo lo siguiente: _____

Si mis pastillas me causan malestar, me comunicaré con: _____

Cuando se me acaben las pastillas prenatales, haré lo siguiente: _____



STEPS TO TAKE

If You Need Iron Pills

Iron pills may help you and your baby grow and stay healthy, but be careful when using them:

- Keep your iron pills away from children. It only takes a few iron pills to kill a small child.
- If your child swallows any iron pills, call 911 or the California Poison Control right away at 1-800-222-1222 and visit www.calpoison.org.

Take only the iron pills your health care provider tells you that you need:

- If you take more than one pill, take each pill three or four hours apart.
- Do not take iron with milk, yogurt, cheese, or other milk foods.
- Try to take iron between meals.
- Do not stop taking the iron without telling your health care provider.

Call your health care provider and ask for advice:

- If you vomit or feel sick to your stomach. You may need to take your iron pills with food or at bedtime. Talk to your provider about the type of iron you take and how much you take.
- If you get diarrhea. You may need to take less iron.
- If you get constipated. It's a good idea to eat high fiber foods like whole grains and vegetables. Drink more fluids. If this fails, ask about a stool softener.
- Let your provider know if you get hemorrhoids or have other concerns.

After your baby comes:

- If you were anemic or iron deficient during pregnancy, you should probably take iron for three months after your baby comes.



TAKE ACTION

My plan for taking my iron supplements:

The number of iron pills I will take each day: _____

I will take my iron pill at these times of the day: _____

I will keep my iron safe from children by: _____

If the iron makes me feel uncomfortable, I will contact: _____



Si Necesita Pastillas De Hierro

Las pastillas de hierro pueden ayudarles a usted y a su bebé a crecer y mantenerse saludables, pero debe tener cuidado cuando las use:

- Mantenga sus pastillas de hierro alejadas de los niños. Unas pocas pastillas de hierro pueden matar a un niño pequeño.
- Si su hijo traga alguna de sus pastillas de hierro, llame al 911 o al Sistema para el Control de Intoxicaciones y Envenenamientos de California (California Poison Control) de inmediato al at 1-800-222-1222 y visite www.calpoison.org.

Tome solo las pastillas de hierro que su proveedor de atención médica le diga que necesite:

- Si toma más de una pastilla, tome cada una con tres o cuatro horas de separación.
- No tome las pastillas de hierro con leche, yogur, queso u otros alimentos que contengan leche.
- Trate de tomar el hierro entre las comidas.
- No deje de tomar el hierro sin decírselo a su proveedor de atención médica.

Llame a su proveedor de atención médica y pida asesoramiento:

- Si vomita o siente malestar estomacal. Es posible que tenga que tomar sus pastillas de hierro con comida o a la hora de dormir. Hable con su proveedor sobre el tipo de hierro que toma y cuánto hierro toma.
- Si tiene diarrea. Es posible que tenga que tomar menos hierro.
- Si tiene estreñimiento. Le conviene comer alimentos con alto contenido de fibra, como los granos integrales y las verduras. Tome más líquido. Si no funciona, pregúntele a su proveedor si puede tomar un ablandador de heces.
- Infórmele a su proveedor si tiene hemorroides u otras inquietudes.

Después de que nazca su bebé:

- Si estuvo anémica o con deficiencia de hierro durante el embarazo, probablemente deba tomar hierro por tres meses después de que nazca su bebé.



TOMA ACCIÓN

Mi plan para tomar mis suplementos de hierro:

La cantidad de pastillas de hierro que tomaré por día: _____

Tomaré mis pastillas de hierro en estos horarios: _____

Mantendré las pastillas de hierro alejadas de los niños haciendo lo siguiente: _____

Si el hierro me causa malestar, me comunicaré con: _____



You May Need Extra Calcium

Calcium helps you and your baby grow and stay healthy, but be careful when using calcium supplements:

- Keep your calcium pills out of reach of children.
- If your child does swallow any, call the California Poison Control right away at
- 1-800-222-1222. You can visit their website at www.calpoison.org anytime.



If you are not getting enough calcium in your food:

- Talk to your health care provider about taking calcium pills.
- Take your calcium pills just as your provider tells you to.
- If there is more than one pill, take one every 3 to 4 hours. Do not take all the pills at one time.
- Do not take calcium at the same time as your prenatal vitamins or iron tablets.
- Do not take more than 1,000 mg of calcium a day.
- It is best to take a dose no bigger than 500 mg

You may have problems when taking calcium:

- You may get constipated or have diarrhea. Ask your health care provider for help.
- If you take too many calcium pills, you could get kidney stones. Take only what your health care provider recommends.

Stay away from some kinds of calcium pills:

- Do not use calcium phosphate. Your body does not use the calcium in it very well.
- Do not take oyster shells, bone meal, or dolomite pills.
- Some calcium pills and antacids have lead in them. Ask your pharmacist for safe choices.

Es Posible Que Necesite Calcio Adicional



El calcio les ayuda a usted y a su bebé a crecer y mantenerse sanos, pero debe tener cuidado cuando tome suplementos de calcio:

- Guarde sus pastillas de calcio fuera del alcance de los niños.
- Si su hijo llega a tragar alguna pastilla, llame al Sistema para el Control de Intoxicaciones y Envenenamientos de California (California Poison Control) de inmediato al
- 1 (800) 222-1222. Puede visitar su sitio web en cualquier momento en www.calpoison.org.

Si no está obteniendo suficiente calcio de las comidas:

- Hable con su proveedor de atención médica sobre las pastillas de calcio.
- Tome sus pastillas de calcio exactamente como le indique su proveedor.
- Si tiene que tomar más de una pastilla, tome una cada 3 a 4 horas. No tome todas las pastillas al mismo tiempo.
- No tome el calcio al mismo tiempo que sus vitaminas prenatales o tabletas de hierro.
- No tome más de 1,000 mg de calcio por día.
- Es mejor no tomar una dosis de más de 500 mg

Puede tener problemas cuando tome calcio:

- Puede tener estreñimiento o diarrea. Pídale ayuda a su proveedor de atención médica.
- Si toma demasiadas pastillas de calcio, puede tener cálculos renales. Tome solo lo que recomiende su proveedor de atención médica.

No tome ciertos tipos de pastillas de calcio:

- No tome fosfato de calcio. Su cuerpo no usa muy bien el calcio en este tipo de pastilla.
- No tome pastillas de cocha de ostras, harina de huesos o dolomita.
- Algunas pastillas de calcio y antiácidos contienen plomo. Pídale a su farmacéutico que le dé opciones seguras.

Background

Pica is craving and consuming nonfood items with little or no nutritional value, starting in early pregnancy. Some pica items may include clay, dirt, laundry starch, cornstarch, ice, coffee grounds, gravel, mothballs, cigarette butts, paint chips, paper, pottery (“tierra”), or other substances. The eating of clay or dirt is a form of pica called geophagia. Dirt, clay, cornstarch, and ice cubes are the most commonly craved items. Women may also eat store-bought substances such as magnesium carbonate. Magnesium carbonate blocks can be bought at swap meets and at neighborhood pharmacies and botanicas (herbal medicine shops).

Some pica items may contain toxic substances, block or damage the intestines, harm tooth enamel, cause infections such as parasites, and displace nutrient-rich foods in the diet. Pica may result in poor nutrition intake or nutrient absorption by the body, resulting in fewer nutrients reaching the baby. Medical emergencies and death can result if the craved substances are toxic, contaminated with lead or mercury, or if items block or perforate the intestines. Eating lead contaminated items like pottery, paint chips, paper, and dirt can cause fetal lead poisoning.

Pica occurs in pregnant women of any age, race, culture, geographic area, or income level. It is unclear what causes pica, but certain conditions increase the risk for pica. Pica may be associated with iron deficiency anemia, but not all pica users are iron or nutrient deficient. Studies suggest that pica occurs more frequently among pregnant women with a history of childhood pica, pre-pregnancy pica, or a family history of pica. Stress may play a role in pica behavior.

Pica is the most common eating disorder among individuals with developmental disabilities. Some pregnant women claim to enjoy the taste and texture of dirt or clay and eat it as a daily habit. Pica is considered normal in some social groups. Patients

Refer immediately to health care provider if a woman is eating nonfood items that may be harmful to her and her baby.

may deny pica when questioned and it is important to ask about pica in a nonjudgmental way.

Steps to Take

Use these questions and interventions to assess and counsel your client:

Ask if she eats dirt, clay, starch, or other nonfood items by using open ended questions such as:

- *Some women crave things that are not food when they are pregnant. Tell me about cravings you have now or have had in the past for things like laundry starch, cornstarch clay, dirt or other items that are not eaten for food.*
- *Some women eat starch to help with nausea. What do you eat to help with nausea?*

If yes, then ask her how often and how much she eats. Share concerns about pica.

- Questions like: *How many days does a box of corn starch last? How many cups of ice do you eat a day?* will help you find out the amount of pica items eaten.
- Discuss the concerns about the pica in simple terms. Ask how she feels and what she knows about the effects of eating nonfood items.
- Use the *Possible Problems from Pica during Pregnancy* section to explain some of the potential problems with eating these nonfoods

Find out more about the items she eats. Does she like the smell, taste or texture? Does she feel that she needs to satisfy her craving?

- Encourage the woman to talk about her feelings and reasons for craving the pica item

- Find out if her family and friends accept pica as a normal and healthy practice
- Help her understand the danger of eating nonfood items

Is she willing to stop eating these items and try substitutes?

- Encourage healthy food substitutes to satisfy cravings for texture or taste
- Suggest raw vegetables, oranges, hard candy, pretzels, sour pickles, and gum instead of pica items

Does she eat ice or freezer frost? How much?

- If the client eats more than one cup per day, evaluate for anemia
- Ask her to try eating crisp fruits and vegetables, or frozen grapes and berries instead of large quantities of ice

Does she eat enough from each food group? Is she skipping meals?

- Encourage her to eat a balanced diet. Review the MyPlate for Moms servings and amounts. Check her weight gain progress.
- Check to see if she is iron deficient. Make sure she takes the recommended supplements.

Does she report constipation, gas, bloating, or back or abdominal pain? Is she unable to stop eating these substances?

- Report her physical complaints and pica practice to the health care provider immediately

POSSIBLE PROBLEMS FROM PICA DURING PREGNANCY

Pica Item	Content	May Result In
Ice	Water	Iron deficiency anemia*
Baking soda	Sodium alkali	Excess sodium load, alkalosis
Cigarette butts	Nicotine	Nicotine poisoning
Clay, dirt	Bacteria, parasites, lead or mercury	Infections, lead or mercury poisoning, intestinal blockage, infection, or death
Paint chips, colored	Lead	Lead poisoning
Paper (lead content)	Lead	Lead poisoning
Coffee grounds	Caffeine	Caffeine poisoning
Mothballs and toilet bowl freshener	Naphthalene/paradi, Chlorobenzene	Poisoning, hemolytic anemia
Laundry starch, cornstarch, flour	Non-nutritional starch	Low nutrient intake, excess calories
Lemons	Citric acid	Erodes tooth enamel

*Small bits of ice are not a problem. Ice eating does not cause anemia. However, anemic women may crave large quantities of ice. If the woman eats more than one cup per day, evaluate for anemia. If not anemic, reevaluate each trimester.

(Adapted from M. Story, 1990)

Follow Up

Use the following to reassess the client's condition.

- Reassess the pica practices, amounts taken, and frequency
- Praise her for any positive changes made
- Try to help her list other foods that may help stop the pica practice
- Check for nausea and review tips for preventing nausea if present
- Check for iron deficiency anemia, especially if eating ice or freezer frost
- Set new goals for making behavioral changes

Referral

Refer to health care provider and registered dietitian if behavior has not changed and the item contains toxic or infectious substances and/or may result in a medical or nutrition problem. In some cases a referral for psychosocial services may be indicated.

References

Kettaneh, A. *Pica and Food Cravings in Patients with Iron Deficiency Anemia*. *American Journal of Medicine*. 118 (2): 185-188, 2005.

Simpson, E., Mull, D. Longley E, East, J., *Pica during pregnancy in low-income women born in Mexico*. *West Journal of Medicine*. 173(1): 20–24, 2000.

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Inadequate financial resources can affect the quality and the quantity of food available in a client's household. Lack of access to affordable food can strain limited resources even further. If food is limited, it is often the client who skips meals or eats less nutritious foods to provide for other family members. The nutrition assessment should identify food resources and any problems the client may have obtaining enough food. If the client or members of her family are not getting enough nutritious food or skipping meals, they are considered food insecure. Education and counseling on food buying, storage, and preparation can help increase food-buying power. It is important that each client knows about the food assistance and nutrition education programs in her community and that low-income women are encouraged to participate in them.

Emergency food assistance is helpful but is not a long-term solution for adequate food and nutrition. Home or community gardening and access to neighborhood grocery stores, farmers markets, group buying clubs, and food cooperatives provide long-lasting alternatives to improve food-buying power.

Helping the client gain access to affordable food is critical for her food security. Participating in food programs helps supply healthy and nutritious food. Refer women to local food resources including the following state programs:

- **CalFresh:** Federally known as the Supplemental Nutrition Assistance Program (SNAP), this program issues monthly electronic benefits to buy food at approved stores and many farmers markets. Women can apply for benefits in their county Apply in your county or online at E-Benefits California website. Each county may have a different way to apply for CalFresh benefits. Refer clients to the CalFresh website: <http://www.cdss.ca.gov/inforesources/calfresh> for application forms and information.

If the client cannot afford to buy food, see Psychosocial guidelines for financial concerns.

- **Women, Infants, and Children Program (WIC)** is a federally funded health and nutrition program for pregnant women, new mothers, infants, and children. WIC provides checks for buying healthy supplemental foods. For more information see WIC in First Steps and visit www.wicworks.ca.gov.
- **Emergency Food Assistance Program (EFAP)** provides United States Department of Agriculture (USDA) commodities to county food banks for distribution to eligible individuals and families. For information on eligibility and location of county food banks, go to <http://www.cdss.ca.gov/inforesources/EFAP>.
- **Food Banks and Recovery Organizations** help clients by providing a list of food banks throughout California. For more information, visit www.calrecycle.ca.gov/reuse/Links/Food.htm.

Steps to Take

Use these questions and interventions to assess clients' situations and offer education, support, and needed referrals.

Assess food security

If she answers yes to any of these questions she is considered food insecure:

- Does she worry that her food runs out before she has money to buy more?
- Does her food run out before she has money to buy more?
- Can she afford to eat a healthy balanced diet?

If she answers yes to any of these questions, she is considered to have very low food security:

- Does she eat less than she feels she should due to lack of food?

- Has she cut the size of meals or skipped meals for three months or more?

Assess the client's food intake and food sources

- Complete a food recall and assess the client's food intake using *MyPlate for Moms*.
- Identify any food group gaps. Ask what resources she has available to get the food she needs (family, churches, food banks, etc.).
- Ask if other factors such as lack of transportation, refrigeration, cooking facilities, etc. impact her access to getting, storing, or cooking the food she needs.
- Is she enrolled in the WIC program, CalFresh, EFAP, or any other food assistance program? If not, make referrals as needed. Some program applications are online and in many languages. California WIC referral forms for Pregnant Women; Postpartum/Breastfeeding women; and Pediatrics <https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/HealthCareProviders.aspx#>
- Refer the client to other food assistance programs or charities in your community. Call 211 for more information about local resources.
- Offer information on food resources for other family members.

Where does she shop for groceries?

- Discuss the Nutrition handout, *Tips for Healthy Food Shopping*. Encourage her to compare prices and shop for the best value in the stores accessible to her.
- Identify a nearby farmers market where she can use SNAP and WIC benefits.
- If she does not have access to an affordable market, offer information on transportation.

Who does the shopping and who prepares the meals? Does she buy many convenience food items?

- Discuss the Nutrition handout, *You Can Buy Healthy Food on a Budget*.
- If someone else buys the food, ask if they can join her at her next visit to discuss food selection.

How does she feel about her food preparation skills? Would she like to learn more?

- Refer to the Expanded Food and Nutrition Education Program (EFNEP) if available.
- If she eats out often, suggest quick and easy meals to prepare at home.
- Discuss nutritious and less expensive choices at her favorite eating spots.

Follow Up

- Complete a Food Recall at her next visit to assess for adequate food intake.
- Check to see if referrals made were helpful. If she didn't follow up on referrals, discuss barriers and solutions.

Resources

California WIC Program

www.wicworks.ca.gov/

1-888-WIC-WORKS (1-888-942-9675)

California WIC referral forms for Pregnant Women;
Postpartum/Breastfeeding women; and Pediatrics

[https://www.cdph.ca.gov/Programs/CFH/DWICSN/
Pages/HealthCareProviders.aspx#](https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/HealthCareProviders.aspx#)

Network for a Healthy California

[https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/
NEOPB/Pages/Program-Landing2.aspx#](https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/NEOPB/Pages/Program-Landing2.aspx#)

*For SNAP education materials and links to state and
county initiatives.*

Expanded Food and Nutrition Education Program (EFNEP)

<http://efnep.ucanr.edu/>

*Contact EFNEP for nutrition education opportunities.
EFNEP is available in 24 California counties.*

Certified California Farmers Market locations

<https://www.cdfa.ca.gov/is/i & c/cfm.html>

National Hunger Hotline

www.whyhunger.org/findfood

1-866-3 HUNGRY (1-866-348-6479)

For referral to food resources and programs.

*The Financial Concerns section in the Psychosocial
Guidelines also has a food resource section.*

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Tips for Healthy Food Shopping

STEPS TO TAKE

You don't have to spend a lot of money to get the foods you need to keep healthy.

Plan before you shop

- Check store ads, coupons, websites, and free phone apps for sales and savings.
- Plan out meals for a week using foods in season for best prices.
- Make a shopping list and stick to it.
- Compare prices at discount stores, farmers markets, and ethnic or specialty stores.
- Join the store savings club for additional discounts.

At the store

- Shop around the outer aisles of stores. This is where the healthier foods are placed.
- Avoid the aisles with highly processed, less nutritious food.
- Buy cheese in blocks instead of pre-sliced.
- Choose frozen vegetables without sauces or spices, they cost less and have less salt.

Buy foods in bulk, such as rice, beans, oatmeal, or pasta

- Buy plain food items such as a bag of rice instead of boxed rice mixes with spices. Buy fresh potatoes instead of instant potatoes.
- Choose whole chicken or a bulk size bag of chicken pieces.
- Make sure that buying items in bulk saves money.

Buy store brands and specials

- Look for "two for one" specials and use WIC checks for "buy one, get one free" offers.
- Check out food company websites for free coupons.
- Use free phone apps for coupons and discounts.
- Look for healthy foods that you often eat in stores' weekly specials.
- Buy generic or store brands and compare unit prices. The store brand is often less expensive than the name brand for the same quality product.

Avoid impulse buys

- Look for checkout lines without candy and junk food.
- Shop when you are not hungry.
- Shop without your children when you can. Candies and toys are often put at children's eye level.
- Only use coupons to buy foods you normally eat.

When you get home

- Store perishable food right away and use food before it goes bad.
- Make extra food and freeze it to eat later.
- Plan for leftovers. For example, serve grilled chicken one night and chicken soup the next.



TAKE ACTION

My plans for healthy eating on a budget are:



Consejos Para Comprar Alimentos Saludables

No tiene que gastar mucho dinero para obtener los alimentos que necesita para mantenerse sana.

Planifique antes de comprar

- Consulte los avisos de las tiendas, cupones, sitios web y aplicaciones gratis para el teléfono para encontrar ofertas y descuentos.
- Planifique las comidas para toda una semana usando los alimentos en temporada para obtener los mejores precios.
- Haga una lista de compras y no se desvíe de la misma.
- Compare los precios en las tiendas de descuento, los mercados de frutas y verduras al aire libre (farmers markets) y tiendas étnicas o especializadas.
- Inscríbase en el club de ahorro de la tienda para obtener descuentos adicionales.

En el supermercado

- Compre en las secciones en los extremos de las tiendas. Allí es dónde se colocan los alimentos más saludables.
- Evite las secciones con comidas muy procesadas y menos nutritivas.
- Compre queso de bloque en lugar del que ya viene cortado de antemano.
- Elija verduras congeladas sin salsas o especias, cuestan menos y tienen menos sal.

Compre alimentos al por mayor, como por ejemplo arroz, frijoles, avena o pastas

- Compre alimentos sin sabores agregados, como por ejemplo una bolsa de arroz en lugar de cajas de arroz mezcladas con especias. Compre papas frescas en lugar de puré instantáneo.
- Elija pollos enteros o una bolsa grande de pollo trozado.
- Verifique que ahorrará dinero si compra los alimentos al por mayor.

Compre las marcas de la tienda y las ofertas

- Busque ofertas de “dos por uno” y use cheques de WIC para comprar uno y obtener uno gratis.
- Visite los sitios web de las compañías que venden los alimentos para obtener cupones gratis.
- Use aplicaciones gratis para el teléfono para obtener cupones y descuentos.
- Busque alimentos saludables que come con frecuencia en las ofertas de la semana de la tienda.
- Compre marcas genéricas, o la marca de la tienda, y compare los precios de las unidades. A menudo la marca de la tienda es menos costosa que el nombre de marca en la misma calidad de productos.

Evite las compras impulsivas

- Busque líneas de caja sin dulces o comida chatarra.
- Haga las compras cuando no tenga hambre.
- Haga las compras sin sus hijos cuando sea posible. Los dulces y juguetes a menudo se colocan a la altura de los ojos de los niños.
- Solo use cupones para comprar alimentos que come normalmente.

Cuando llegue a su casa

- Guarde los alimentos perecederos de inmediato y úselos antes de que se pongan feos.
- Haga comida de más y congélela para comer más adelante.
- Planifique lo que va a hacer con las sobras. Por ejemplo, sirva pollo asado una noche y caldo de pollo al día siguiente.

TOMA ACCIÓN

Mis planes para comer alimentos saludables dentro de mi presupuesto son:



You Can Buy Healthy Food on a Budget



Bread, cereal, rice, and pasta

- Eat hot or cold low-sugar cereals, such as oatmeal and other WIC-approved cereals.
- Corn tortillas, plain popcorn, or whole grain crackers make good choices.
- Choose whole grain foods, such as whole wheat bread, brown rice, and pasta.
- Buy grains such as rice, rolled oats, and quinoa in bulk and store in airtight containers.

Fruits and vegetables

- Fresh fruits and vegetables in season are best. Check out produce stands and farmers markets for better prices and fresher products.
- Most of the time you can find good prices for fresh foods such as potatoes, sweet potatoes, greens, carrots, onions, and cabbage.
- Bananas, oranges, apples, raisins, and prunes are almost always a good buy.
- Wash and chop your own lettuce for salads.
- Look for the largest bag of vegetables in the frozen food section for the best value.

Dairy

- Try powdered milk for cooking.
- If you have too much milk or cheese, freeze the extra for later.
- Buy a large container of plain yogurt and add fruit. You will save money and your homemade version has fewer calories and less sugar.

Meat, poultry, fish, beans, and other protein foods

- Buy canned or dried beans. Also try lentils, split peas, or black-eyed peas.
- Try going meatless at some meals.
- Buy larger packages of meat and divide into meal-size portions. Freeze for later use.
- Buy less expensive meat and eat 3- to 4-ounce portions.
- Try eggs, bean soups, peanut butter, peanuts, or tofu.
- Canned tuna or chicken is good for sandwiches, enchiladas, salads, or casseroles.
- Make or cook pizza at home, rather than eating out.

Fats

- Use small amounts of vegetable oils for cooking.
- Avoid butter, lard, or shortening.



Panes, cereales, arroz, y pastas

- Coma cereales fríos o calientes que no contienen mucha azúcar, como la avena.
- Tortillas de maíz, galletas de soda o de graham, palomitas de maíz, o pretzels son buenas elecciones.
- Escoja alimentos con granos integrales, como el pan de trigo integral.

Frutas y verduras

- Frutas y vegetales frescos de la temporada son mejor. Compare precios de los puestos con frutas frescas y los mercados al aire libre.
- La mayor parte del tiempo puede comprar papas, camotes, vegetales verdes, zanahorias, cebollas, y repollo a buen precio.
- Plátanos, naranjas, manzanas, pasas, y ciruelas pasas casi siempre están a buen precio.
- Lave y corte su propia lechuga para ensaladas.

Productos con leche

- Pruebe la leche en polvo.
- Compre yogur simple, sin sabor.

Carne, pollo, pescado, frijoles, y otros alimentos con proteína

- Tal vez le gusten los frijoles (pintos, rojos, negros, blancos, o rosados). También debe probar lentejas, gandules, o chícharos.
- Pruebe los huevos, caldos de frijoles, mantequilla de maní, cacahuates, o tofu.
- Compre patas de pavo, atún enlatado, o pollos enteros. Compre la carne en oferta especial.
- Haga su propia pizza en casa, en vez de salir a comer.

Grasas

- Use aceite vegetal para cocinar.
- No cocine con mantequilla, ni manteca de puerco o de vegetal.



You Can Stretch Your Dollars: Choose These Easy Meals and Snacks

You Can Make These Quick and Easy Meals.

Try:

- Bean and cheese burritos
- Eggs with salsa and tortillas
- Rice and beans with tortillas
- Spaghetti with tomato sauce

You might like:

- Lentil or bean soup
- Barley soup with carrots and beef
- Vegetable beef stew

Think about having:

- Baked potato with cheese and broccoli
- Vegetable and cheese lasagna
- Pasta salad with vegetables
- Homemade cheese and vegetable pizza

It's easy to make:

- Tuna noodle casserole
- Stir-fried tofu and vegetables
- Chili with cornbread

You may like these sandwiches:

- Egg salad sandwich
- Tuna salad sandwich
- Peanut butter and jelly sandwich
- Chicken salad sandwich



Try these salads:

- Three-bean salad
- Fruit salad. Use fruits in season.
- Green salads. Wash and cut your own lettuce mixture. You can dry the lettuce and store it in the refrigerator.
- Rice or couscous salad with chicken and fruit

Crackers can be good. What about:

- Graham crackers with milk
- Crackers and cheese
- Tuna or peanut butter and crackers

You may like these healthy cookies:

- Low-fat cookies
- Oatmeal cookies
- Rice cakes
- Fig or fruit bars

You may like:

- Apples and peanut butter
- Carrots and other fresh vegetables
- Fruit canned in juice or water
- Fresh fruit (in season)
- Fruit or vegetable juice

You can try:

- Fruit popsicles
- Frozen yogurt
- Sherbet

How about:

- Yogurt
- Custard
- Pudding

You may want to try:

- Corn tortillas with cheese and salsa
- Cereal with milk
- Popcorn
- Bread sticks
- Pretzels





Puede Estirar Su Dinero: Prepare Comidas Y Bocadillos Fáciles Y Sencillos

Puede Preparar Comidas Rápidas y Fáciles de Hacer.

Pruebe:

- Burritos de frijoles y queso
- Huevos con salsa estilo mexicano y tortillas
- Arroz y frijoles con tortillas
- Espagueti con salsa de tomate

Tal vez le guste:

- La sopa de lentejas o de frijoles
- Sopa de cebada con zanahorias y carne de res
- Estofado de res con verduras

Piense que pueden comer:

- Papas horneadas con queso y brócoli
- Lasaña de vegetales y queso
- Ensalada de pasta con vegetales
- Pizza hecha en casa con vegetales y queso

Es fácil hacer:

- Caserola de atún con fideos
- Tofu con vegetales al estilo chino
- Chili (frijoles con carne) con pan de maíz

Tal vez le apetezcan estas tortas:

- Torta de huevos cocidos con mayonesa
- Torta de ensalada de atún
- Sandwiches de mantequilla de maní con jalea
- Torta de pollo desmenuzado con mayonesa



Pruebe a hacer ensaladas como:

- Ensalada de ejotes, frijoles y garbanzos
- Ensalada de frutas. Use frutas frescas de la temporada.
- Ensaladas verdes. Lave y corte su propia mezcla de lechugas. Puede secar la lechuga, y guardarla en el refrigerador.
- Ensalada de arroz con pollo y fruta

Las galletas de soda son buenas. Qué le parecen:

- Las galletas dulces de graham con leche
- Galletas de soda con queso
- Atún o mantequilla de maní con galletas de soda

Tal vez prefiera estas galletas nutritivas:

- Galletas bajas en grasa
- Galletas dulces de avena
- Tortitas de arroz esponjado (rice crackers)
- Galletas con relleno de higos o fruta

Tal vez le guste:

- La mantequilla de maní con manzanas
- Zanahorias y otros vegetales frescos
- Frutas enlatadas en jugo o en agua
- Fruta fresca que de la temporada
- Jugos de fruta o verduras

Puede probar:

- Las paletas de fruta (helados)
- Yóгур congelado
- Sorbete de frutas

Y qué le parece:

- El yóгур
- Flan
- Pudín

Tal vez quiera probar:

- Quesadillas con chile
- Cereal con leche
- Palomitas de maíz
- Palitroques
- Pretzels



Background

Not having a stove, refrigerator, or means of food storage presents special challenges for meeting nutritional needs and keeping food safe. Assess the client's access to cooking facilities, including small appliances and food storage. The client may need help finding sites for hot meals and for acquiring alternate housing. Assist the client by becoming familiar with foods provided by the WIC program that can be used without refrigeration or cooking facilities.

Steps to Take

Use the following questions and interventions to assess and counsel the client.

How Many Meals and Snacks Does She Eat (Include All Foods and Beverages)?

- Do a 24-Hour Food Recall and assess food intake using the MyPlate for Moms
- If her eating patterns are erratic and she does not have access to food, refer her to any community assistance programs or charities she may be eligible for

Does She Have a Working Stove, Oven, Refrigerator, Freezer, and Storage Facilities?

- Discuss her needs with the health care provider to search for available resources
- If allowed, recommend use of small appliances such as hot plates, toaster ovens, etc. to prepare food
- Review the handout *When You Cannot Refrigerate: Choose These Foods*
- Review the handout *Tips For Cooking and Storing Food*
- Refer to community agencies that serve meals or provide needed appliances

The health care provider is responsible for appropriate referrals for safe shelter and other resources as determined during the assessment.

Is She Enrolled in the WIC Program?

- If not, make a referral to WIC. Use California WIC referral forms for Pregnant Women; Postpartum/Breastfeeding women; and Pediatrics <https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/HealthCareProviders.aspx#>
- Recommend that she not purchase all WIC foods at once and that she select foods that don't require refrigeration, such as dried milk, dried cereals, and canned juices
- Help her problem-solve storage methods for the WIC foods she receives, e.g., wrapping cheese tightly in plastic, using a cooler, storing cereals in air tight containers, etc.

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STEPS TO TAKE

When You Cannot Refrigerate: Choose These Foods

There Are Safe Foods You Can Eat, Even When You Cannot Refrigerate

When you buy canned food, buy the size of can that your family will eat at one meal, so there are no leftovers. If cooking rice, pasta, or cereal, cook only what your family will eat at one meal, so there are no leftovers needing refrigeration.

Milk, Yogurt, and Cheese:

- Buy dry milk powder. When you make it, use it in a few hours.
- Make instant pudding with dry milk
- Buy canned processed cheese
- Buy a small carton of cottage cheese or yogurt. Eat it the same day you buy it.

Meat, Poultry, Fish, Beans, and Other Protein Foods:

- Peanut butter and nuts are good to have on hand
- Buy single servings of sardines or tuna. Use small cans of chili beans, baked beans, or refried beans.
- Buy canned garbanzo, kidney, or pinto beans
- Hard boil eggs. Eat them the same day.

Fats:

- Use vegetable oils

Fruits and Vegetables:

- Eat fresh fruits and vegetables
- Choose small-sized canned fruits, like applesauce or peaches
- Try canned vegetables
- Eat dried fruits: raisins, apricots, dates, figs, or prunes
- Buy small sized fruit and vegetable juices

Grains, Cereals, Rice, and Pasta:

- Buy instant rice, pasta, or noodles that only need hot water
- Eat hot cereals such as Cream of Wheat™, oatmeal, and grits
- Buy dry foods such as cereals, breads, and tortillas
- You could also buy bagels, crackers, pretzels, and rice cakes





Si No Tiene Refrigerador: Escoja Estos Alimentos

Hay Alimentos que no se Necesitan Refrigerar

Cuando compre comida enlatada, compre la medida de lata que su familia puede comer en una comida. De ese modo, no habrán sobras. Cuando cocine arroz, pasta o cereal, cocine sólo lo que su familia se puede comer a la hora de la comida. De esa manera no habrán sobras que necesiten refrigeración.

Leche, Yóгур, y Queso:

- Compre leche en polvo. Cuando la prepare, úsela en un par de horas.
- Prepare pudín instantáneo con leche en polvo
- Compre queso procesado en lata
- Compre un envase pequeño de requesón o yóгур. Cómaselo el mismo día en que lo compró.

Carne, Pollo, Pescado, Frijoles, y Otros Alimentos Con Proteína:

- Tenga mantequilla de maní y nueces a la mano
- Compre latas pequeñas de sardina o atún. Use latas pequeñas de chili con frijoles, y frijoles horneados o refritos en lata.
- Compre latas de garbanzos, o de frijoles rojos o pintos
- Prepare huevos cocidos. Cómaselos el mismo día.

Grasas:

- Use aceite vegetal

Frutas y Vegetales:

- Coma frutas y vegetales frescos
- Compre latas chicas de frutas enlatadas, como puré de manzana o duraznos
- Pruebe los vegetales en lata
- Coma frutas secas: pasas, chabacanos, dátiles, higos o ciruelas pasas
- Compre latas chicas de jugos de frutas y vegetales

Granos, Cereales, Arroz, y Pastas:

- Compre arroz, pastas o fideos instantáneos que sólo necesitan agua caliente para su preparación
- Coma cereales calientes como la crema de trigo, avena, y sémola
- Compre alimentos secos como cereales, panes, y tortillas
- Compre también bagels, galletas de soda, pretzels, y tortitas de arroz esponjado





Tips For Cooking and Storing Foods

If you do not have a stove, use small appliances for cooking, like:

- Hot plate
- Electric fry pan
- Crockpot
- Toaster oven
- Rice cooker
- Microwave
- Hot pot

Cook for only one meal at a time.

Here are tips to keep foods fresh:

- Keep food in the driest and coolest spot in the room
- Do not store food near heaters or under sinks
- Fill a cooler with ice to keep foods cold without a refrigerator. This works for cheeses, milk, cold meats, yogurt, eggs, and vegetables.
- Wrap cookies and crackers in sandwich bags or store them in airtight jars or boxes

It's important to:

- Keep all food covered and off the floor
- Tightly close bags of bread, bagels, or tortillas. That keeps them fresh and keeps out pests.
- Open food boxes with care. Close them tightly every time you use them.
- Store sugar, dried fruit, or nuts in screw-top jars. You can also try clean coffee cans with lids.
- Throw away spoiled food in plastic bags. Keep it away from other foods.



Consejos Para Cocinar Y Guardar Comida

Si no tiene estufa, use aparatos domésticos para cocinar, como:

- Parrilla eléctrica
- Sartén eléctrico
- Olla eléctrica (crockpot)
- Horno para tostar
- Olla de vapor para hacer arroz
- Microondas
- Cafetera eléctrica para hervir agua

Prepare sólo lo que se va a comer a la hora de la comida.

Sugerencias para mantener fresca la comida:

- Mantenga la comida en el lugar más seco y fresco que tenga en el cuarto
- No guarde la comida cerca de calentadores, o debajo del fregadero
- Si no tiene refrigerador, llene una hielera de cubitos de hielo para mantener fría la comida. Es muy útil para quesos, leche, carnes frías, yóгур, huevos y vegetales.
- Envuelva las galletas dulces y las de soda en bolsas de sandwiches o guárdelas en un envase y sáquele el aire



Es muy importante que:

- Tape toda la comida, y que no la ponga en el suelo
- Cierre bien las bolsas del pan, bagels, o tortillas. La comida se conserva fresca, y no le entran bichos.
- Abra las cajas de comida con cuidado. Ciérrelas bien cada vez que las use.
- Almacene el azúcar, frutas secas, o nueces, en frascos con tapas que queden apretadas. Las latas limpias de café con tapas plásticas son muy útiles.
- Tire la comida que se le arruine, y póngala en bolsas plásticas. Manténgala lejos de la otra comida.

Background

Keeping food safe is a key part of healthy eating, a healthy pregnancy, and a positive birth outcome. Women need to follow safe food handling and preparation practices in their homes to avoid harmful bacteria, viruses, parasites, mold, and other toxins.

The outcome of a foodborne illness can be severe or even fatal. Pregnant women and their unborn children are more susceptible to foodborne infection, especially to listeriosis, salmonellosis, and toxoplasmosis. Most foodborne infections are the result of improper food handling and preparation. Extra caution is needed during pregnancy. The resources provided below offer clear facts on many food safety topics.

Three Primary Foodborne Risks

Listeriosis is a rare foodborne illness caused by the consumption of unpasteurized soft cheeses. Infected infants can suffer mental retardation, blindness, paralysis, or death. Hispanic women have higher listeriosis infection rates and this is most likely due to a higher consumption of unpasteurized soft cheeses. Unlike most bacteria, listeria can live in refrigerated temperatures.

Toxoplasmosis is caused by a parasite found in raw and undercooked meat, unwashed fruits and vegetables, contaminated water, dust, soil, cat boxes, and any cat feces. Eating or handling undercooked meat, especially pork, lamb, or venison is a risk. Touching the mouth after handling cat litter or soil contaminated with cat feces can cause infection. Toxoplasmosis can result in hearing loss, cognitive disabilities, blindness, and death. Women considering pregnancy should take all precautions to prevent this infection prior to and during pregnancy.

Methylmercury is a toxic metal that is especially high in large fish such as shark, tilefish, king mackerel, and swordfish. High levels of mercury are harmful for the developing fetal nervous system. However, eating fish is recommended as part of a healthy diet and most

When to call the doctor

A pregnant woman should contact her medical provider if she develops flu-like symptoms (chills, nausea, vomiting, diarrhea, abdominal pain or cramps, stiff neck, severe headache, fever).

Americans eat far less fish than the recommended 12 ounces per week. The omega-3 fatty acids, eicosapentaenoic acid (EPA), and docosahexaenoic (DHA) in fish have many reported health benefits for women and improved outcomes in infants such as cognitive and visual development. Evidence shows that the benefits of eating a variety of fish outweigh the risk of methylmercury, a heavy metal found in varying amounts in fish.

Other chemicals in fish

Fish may contain other chemicals harmful to the fetus. Check local advisories to learn about the safety of the fish caught in local lakes, rivers, and coastal areas. Advisories recommend the type, size, and amount of fish safe to eat for pregnant and lactating women and their children. In general, eating smaller, non-predatory fish from a variety of locations is best in small serving sizes (3 to 4 ounces). If there is no advice available, limit consumption to 6 ounces per week of smaller fish from local waters and don't eat other fish during that week. See the Office of Environmental Health Hazard Assessment for Safe Eating Guidelines, an Advisory Map, and General Advice to reduce exposure to chemicals in sport fish.

Other foodborne infections

Proper food handling, preparation, and storage will keep most food safe. Women should take the same precautions when eating out as eating at home. To avoid food infection, advise the client to follow the four basic food safety principles: clean, separate, cook, and chill. See Fight Bac! for fact sheets on each of these principles. The Food Safe Families Campaign Toolkit provides downloadable food safety materials that you can customize for your organization.

Steps to Take

Does the client have adequate access to a refrigerator, freezer, stove, and oven?

- Assess if the client has the facilities and equipment she needs to keep hot foods hot (over 140°F) and cold foods cold (40°F or below). If she does not, review the handout, *Don't Get Sick From the Food You Eat* and help her seek needed resources.
- Does she have a thermometer to check her refrigerator and freezer temperatures?

Safe food handling and preparation practices

- Review the handout, *Checklist for Food Safety*
- Ask how she prepares her food to make sure she avoids cross contamination of raw meat with vegetables.
- Ask if she uses a food thermometer when cooking animal protein. Explain that the color of the meat or clear juices are not indicators of a safe cooking temperature.
- Provide information on safe minimal temperatures for cooking, cooling, and freezing.
- Ask which foods she keeps out at room temperature. Advise her to throw away prepared food, meats, and dairy products that have been left out more than two hours. Check to make sure she defrosts meat and other foods in the refrigerator, not on the counter.
- Ask if she washes produce before putting it away in the refrigerator. This is especially important for melons.

Avoiding listeriosis and other foodborne illnesses

Ask if the client is following these safe food practices:

- Consumes only pasteurized milk and foods made from pasteurized milk; raw milk and unpasteurized soft cheeses (feta, queso blanco, queso fresco, Brie, Camembert, blue-veined cheeses, and panela) are not safe

See Safe Minimum Cooking Time Chart- Minimum Cooking Temperatures chart

www.foodsafety.gov/keep/charts/mintemp.html

- Drinks juice that is frozen, canned, or pasteurized
- Heats deli and luncheon meats, such as bologna, cold cuts, and hotdogs to steaming hot to kill listeria
- Only eats safe canned patés and fish-based products and avoids unsafe foods:
 - ◆ Refrigerated patés or meat spreads
 - ◆ Refrigerated smoked seafood such as lox or other smoked, dried, cured, or kippered fish, unless it is in a cooked dish like a casserole
- Doesn't eat any bean, alfalfa, mung, or other raw sprouts.

Avoiding toxoplasmosis

- Is the client following safe food handling and preparation practices? Advise her to wash all produce, cook meat to a safe internal temperature, and always keep raw meat separate from other foods.
- Other precautions include washing hands after touching soil, sand, raw meat, cat litter, or unwashed vegetables.
- Does she have a cat? She should not clean the litter box. If she does not have anyone else to do this, advise her to wear disposable gloves and to clean the box each day.
- Is she around outdoor cats? Outdoor cats are more likely to carry this parasite. Avoid stray cats, especially kittens.

When in doubt, throw it out. Food will not always smell or look bad.

Avoiding methylmercury toxicity

- Review *Eating Fish Safely – Tips*
- Stress that eating fish is recommended for her health and for her infant’s brain development. Limit consumption to 12 ounces per week of a variety of fish.
- Suggest low mercury fish such as canned light tuna, salmon, pollock, shrimp, or catfish.
- Advise her to never eat shark, tilefish, king mackerel, or swordfish. Limit albacore tuna to 6 ounces per week.
- Refer her to California Fish Advisories if she is eating any sport fish.
- Find out if she is eating sushi containing raw fish, sashimi, or any raw shellfish. Raw fish is not considered safe during pregnancy.
- Advise her that WIC tuna and salmon is a healthy choice.

Resources

The University of California Agriculture and Natural Resources (Cooperative Extension)

www.ucanr.edu

State and county offices that can provide education and resources on food safety:

Foodsafety.gov

www.foodsafety.gov

1-800-SAFEFOOD

Gateway to federal food safety information, including food recall information.

Food Safety for Pregnant Women

<http://www.foodsafety.gov/risk/pregnant/>

USDA Meat and Poultry Hotline

1-888-MP Hotline (1-888-674-6854)

mphotlien.sis@usda.gov

“Ask Karen”

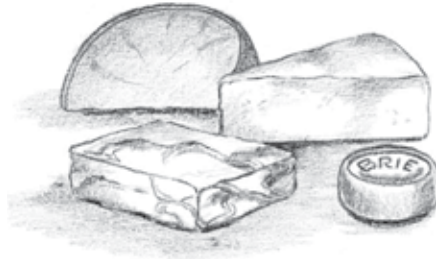
www.fsis.usda.gov

A FSIS web-based automated response system

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Don't Get Sick From The Food You Eat



Here's how

You can get sick when you eat foods that are not safe. This can harm you or your baby.

If you eat unsafe foods, you may get sick days or weeks later.

Call your doctor or clinic if you have:

- Chills
- Fever
- Headache
- Diarrhea
- Stomach ache

Don't eat or drink these raw foods:

- Unpasteurized milk or foods made from raw milk
- Unpasteurized fruit or vegetable juice
- Raw or uncooked eggs
- Raw meat or poultry, as well as uncooked hotdogs
- Raw fish or shellfish such as sushi, oysters, or shrimp

Some cheeses can be dangerous. Don't eat unpasteurized Mexican-style cheeses:

- Queso blanco
- Queso fresco
- Queso asadero
- Cotija
- Ranchero
- Queso enchilado

Stay away from these cheeses if they are not pasteurized:

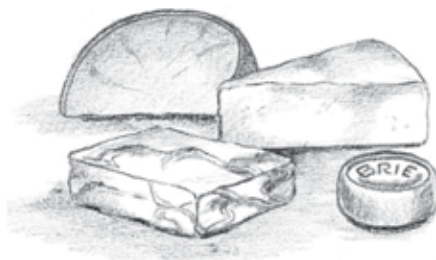
- Feta
- Brie
- Camembert
- Blue veined cheese such as Roquefort

Cook your meat well. Don't eat:

- Undercooked meat, poultry, fish, or eggs
- Uncooked hot dogs or paté
- Stay away from cold cuts from the deli counter (such as bologna); heat all deli meats and hot dogs until they are steaming hot

Before you cook or serve fruits or vegetables:

- Take away the outer layer of the leafy vegetables
- Wash fresh fruits and vegetables under running water with a clean vegetable brush. Take extra caution with melons. Wash thoroughly and store uneaten melon in the refrigerator.



Le sugerimos cómo evitarlo

Se puede enfermar con comer alimentos que son peligrosos. Pueden hacerle daño a usted o a su bebé. Si come algún alimento peligroso, tal vez no lo note hasta que pasen unos días o semanas.

Llame a su médico o a la clínica si tiene:

- Escalofríos
- Fiebre
- Dolor de cabeza
- Diarrea
- Dolor de estómago

No coma ni se tome ninguno de estos alimentos crudos:

- Leche sin pasteurizar, o productos lácteos de leche cruda
- Jugos de frutas o vegetales sin pasteurizar
- Huevos crudos
- Carne o pollo crudo, ni tampoco salchichas sin cocinar
- Pescado o mariscos crudos, como el sushi, ostras, o camarones

Algunos quesos pueden ser peligrosos. No coma quesos Mexicanos, como:

- Queso blanco
- Queso fresco
- Queso asadero
- Cotija
- Queso ranchero
- Queso enchilada

Evite los quesos siguientes:

- Feta
- Brie
- Camembert
- Queso Roquefort con las venitas azules

Cocine bien la carne. No coma:

- Carne, pollo, pescado, o huevos que no estén bien cocinados
- Salchichas crudas (hot dogs)
- Paté crudo (hígados de pollo)
- Evite las carnes frías del Deli (de la carnicería), como el salchichón (bologna). O caliéntelas hasta que suelten vapor.

¡Lave sus frutas y vegetales! Antes de cocinar, o servir frutas o vegetales:

- Quíteles las hojas de afuera a las lechugas, repollos y vegetales parecidos
- Enjuáguelos y lávelos bien
- Lave las frutas o vegetales frescos bajo la llave del agua



Checklist for Food Safety

STEPS TO TAKE

To keep you and your baby safe, follow these four food safety practices: Clean, Separate, Cook, and Chill.

1. **Keep everything clean:**

- Wash your hands and the surfaces where you prepare and store food often.
- Wash fresh fruits and vegetables under running water using a vegetable brush.
- Replace used or dirty dishcloths and sponges every day.
- Always wash your hands using hot water and soap after using the bathroom, changing a diaper, or touching a pet.

2. **Separate**, don't cross contaminate:

- Keep raw meat, poultry, fish (and their juices), and eggs away from ready-to-eat food.
- Use a separate cutting board for meat, poultry or fish.
- Clean cutting boards after each use and replace when showing signs of wear.
- If you cut meat, wash the knife in hot soapy water before you cut raw foods such as vegetables and fruit.
- Store meat on the bottom shelf of the refrigerator so juices don't mix with other foods.

3. **Cook** to proper temperatures. You cannot tell food is safe by looking!

- Use an instant-read thermometer to cook foods to safe minimum temperatures.
 - ◆ Chicken, turkey, leftovers, casseroles: 165°F
 - ◆ Ground meat, egg dishes: 160°F
 - ◆ Red meat, pork, and fish with fins: 145°F
- Keep hot foods hot (at least 140°F).
- Cook eggs until the yolk and white are firm. Do not eat raw eggs.

4. **Chill:** Keep cold foods cold at no more than 40°F:

- Put leftovers in shallow containers, cover, and store in the refrigerator immediately.
- Do not defrost or cool any food on the counter. Bacteria can grow quickly.
- Thaw frozen foods in the refrigerator or the microwave. Food thawed in a microwave should be cooked immediately.
- Throw away any food that sits out more than two hours.

TAKE ACTION

To keep my food safe I will:



Lista De Verificación Para La Seguridad De Los Alimentos

Para que usted y su bebé no corran peligro, siga estas cuatro prácticas de seguridad para los alimentos: Limpie, separe, cocine y enfríe.

1. Mantenga todo limpio:

- Lávese las manos y las superficies en las que prepara y guarda la comida frecuentemente.
- Lave las frutas y verduras frescas bajo agua corriente con un cepillo para lavar verduras.
- Reemplace los paños de cocina y esponjas usados o sucios todos los días.
- Lávese siempre las manos con agua caliente y jabón después de usar el baño, cambiar un pañal o tocar una mascota.

2. Separe, no contamine los alimentos al mezclarlos:

- Mantenga las carnes, aves y pescados crudos (y sus jugos), y los huevos, alejados de la comida lista para comer.
- Use una tabla de cortar separada para la carne, aves o pescado.
- Limpie las tablas de cortar después de cada uso y reemplácelas cuando muestren indicios de estar gastados.
- Si corta carne, lave el cuchillo con agua caliente y jabón antes de cortar alimentos crudos como verduras y frutas.
- Guarde la carne en la repisa más baja del refrigerador para que los jugos no se mezclen con otros alimentos.

3. Cocine a las temperaturas adecuadas. ¡No puede saber si una comida es segura con solo mirarla!

- Use un termómetro de lectura instantánea para cocinar comidas a temperaturas mínimas seguras.
 - ◆ Pollo, pavo, sobras, platos al horno: 165°F
 - ◆ Carne molida, comidas con huevo: 160°F
 - ◆ Carne de res, puerco y pescado con aletas: 145°F
- Mantenga calientes las comidas calientes (por lo menos a 140°F).
- Cocine los huevos hasta que la yema y la clara estén firmes. Nunca coma huevos crudos.

4. Enfríe: Mantenga frías las comidas frías, a no más de 40°F:

- Coloque las sobras en envases poco profundos, cúbralas y guárdelas en el refrigerador de inmediato.
- No descongele ni enfríe ninguna comida en la mesada. Las bacterias pueden crecer rápidamente.
- Descongele las comidas congeladas en el refrigerador o en el microondas. La comida que se descongela en el microondas se debe cocinar de inmediato.
- Deseche cualquier comida que quede afuera por más de dos horas.

TOMA ACCIÓN

Haré lo siguiente para que mi comida sea segura:



STEPS TO TAKE

Lower Your Chances of Eating Food with Unsafe Chemicals in Them

Many things around us are not safe. If you eat unsafe food, it can cause serious problems for you or your baby.

Here are some things you can do to protect yourself and your baby. This is very important when you are pregnant.

Eat many different kinds of food:

- When you eat many kinds of food, you lower the chance of eating something unsafe

Be careful of mushrooms:

- Never eat mushrooms you pick yourself. They could be deadly.
- To be safe, eat only mushrooms you buy in a store or restaurant

When you are pregnant:

- Eat fish no more than once a week or so
- Do not eat shark or swordfish
- Do not eat raw shellfish or fish

It is safer to eat fish when you:

- Eat smaller fish. The bigger the fish, the older they are. Big fish are more likely to have chemicals in them that could cause serious health problems for you or your baby.
- Trim the skin and fat from fish
- Eat only the fillet. Do not eat the organs or guts of fish or shell fish.
- Bake, broil, steam, or grill fish on a rack. Throw away the juices from the fat.
- Cook fish or shellfish at least four to six minutes

Pay attention to the fish safety rules:

- Call your local health department to see if there are fishing areas you should stay away from. Pay attention to signs that say "do not fish."
- Find out and follow all the fish health advisories given by the Office of Environmental Health Hazard Assessment (OEHHA)
- If you gather shellfish, be sure to follow all the rules. You may see signs that say NOT to gather mussels, clams, oysters, and scallops. Pay attention to these signs. These shellfish may have toxins that may be harmful or even kill you. Cooking will not destroy these toxins.
- Do not gather mussels from May 1 through October 30 in California
- **Call 1-916-324-7572 or check out OEHHA's website at www.oehha.ca.gov. Select "Fish," then press the arrow key to "Advisories."**
- **Call toll-free at 1-800-553-4133 for more information about shellfish.**





Reduzca La Posibilidad De Comer Alimentos Con Químicos Dañosos

PASOS A SEGUIR

Hay muchas cosas que nos rodean que son peligrosas. Si come algún alimento peligroso, puede causarle serios problemas a usted y a su bebé.

Le damos consejos para que pueda protegerse usted y a su bebé. Esto es muy importante cuando está embarazada.

Coma comidas y alimentos variados.

- Al comer comidas y alimentos variados, reduce el riesgo de comer algo dañino

Cuidado con los hongos.

- No coma hongos que usted ha cosechado o encontrado. Pueden ser venenosos.
- Para más seguridad, sólo coma hongos que compra en el mercado o en un restaurante

Durante el embarazo:

- No coma pescado más de una vez por semana, más o menos
- No coma tiburón o pez espada
- No coma mariscos ni pescado crudo

Es más seguro comer pescado cuando:

- Come pescados pequeños. Entre más grande el pescados más viejo. Los pescados grandes tienden más a tener químicos que pueden ser dañinos para usted y su bebé.
- Quítele la piel y la grasa al pescado
- Coma sólo el filete. No se coma los órganos o intestinos del pescado o mariscos.
- Hornée el pescado. Hágalo a la parrilla o al vapor, o póngalo en el asador. Tire la grasa.
- Cocine el pescado y los mariscos, por lo menos, de 4 a 6 minutos

Atenta con los reglamentos de seguridad con respecto al pescado.

- Llame al Departamento de Salud más cercano para información sobre las áreas de pescar que debe evitar. Obedezca los letreros que le dicen que no le permiten pescar.
- Averigüe y acate los avisos de salud con respecto al pescado publicados por la oficina llamada Office of Environmental Health Hazard Assessment (OEHHA)
- Si le gusta atrapar mariscos, siga los reglamentos. Si hay avisos que dicen que no debe pescar mejillones, almejas, ostras y escalopas, no lo haga. Hay mariscos que contienen materias tóxicas que pueden hacerle daño o causarle la muerte. Las toxinas no se destruyen al cocinarlos.
- No atrape mejillones en California, del primero de mayo al 30 de octubre.
- **Llame al 916-324-7572 o visítelos por el internet al sitio www.oehha.ca.gov. Seleccione "Fish" (pescado), y apunte la flecha a la palabra "Advisories" (avisos).**
- **Si necesita más información sobre mariscos, llame gratis a la línea 1-800-553-4133**





Tips For Keeping Foods Safe



Keep hot food hot:

- Measure the inside temperature of cooked foods. You can buy meat thermometers at the store. Stick the thermometer in the meat you are cooking. This measures the temperature inside of the meat.
- Boil, bake, or roast foods at high temperatures. The inside temperature should be at least 145°F. Whole poultry should be cooked to 180°F. Make sure that all foods are cooked all the way through. This kills most bacteria.
- Cook hamburgers until they are brown on the inside (160°F). Make sure there is no pink in the juices.
- Reheat sauces, soups, and gravy to a boil
- Heat leftovers until steaming hot
- For take-out food, eat it within two hours

Keep cold food cold:

- Cooked foods should be stored at 40°F or below. Or freeze it right away.
- Look for "Safe Handling Instructions" on packages of meat and poultry
- Milk products and meats should be stored at 40°F or below

At potlucks and picnics, keep hot foods hot and cold foods cold!



Remember: Keep everything clean.

- Wash hands, counter tops, and utensils with hot, soapy water
- Use a separate cutting board for raw meat, poultry, or fish. Wash the cutting board in hot, soapy water each time you use it.
- Wash all fresh fruits and vegetables before you eat them

Buy safe food and handle it safely:

- Never leave food out of the refrigerator for more than two hours
- Do not buy dirty or cracked eggs
- Use pasteurized milk and pasteurized milk foods
- Keep uncooked meat, fish, or poultry away from vegetables and other foods
- When you marinate raw meat, fish, or poultry, put it in the refrigerator. Do not let it sit on the counter.
- Thaw meat, fish, and poultry in the refrigerator. Do not thaw it at room temperature. Do not let it drip on other foods in the refrigerator.

When in doubt, throw it out:

- Bad food will not always smell or look bad



Mantenga caliente la comida caliente:

- Mida la temperatura de las comidas que cocina. Puede comprar un termómetro para carne en la tienda. Inserte el termómetro en la carne que está cocinando. De esa forma puede medir la temperatura interna de la carne.
- Hierva, hornee o ponga la carne en el asador a temperaturas altas. La temperatura interna debe de ser por lo menos 145°F. El pollo se debe cocinar a 180°F. Asegúrese de cocinar bien toda la comida. De ese modo, puede matar la mayoría de bacterias que pueda tener.
- Cocine la carne molida hasta que esté café por dentro (160°F). Asegúrese que el jugo que suelta la carne no se vea de color rosado.
- Recaliente hasta hervir las salsas, caldos, y salsa espesa (gravy) que se hace del jugo de la carne
- Recaliente las sobras hasta que suelten vapor de tan calientes
- Termínese la comida preparada que compra, antes de que pasen 2 horas

Mantenga la comida fría bien helada:

- Los alimentos cocinados se deben guardar a una temperatura de 40°F o menos. O debe congelarla de inmediato.
- Lea las etiquetas en los paquetes de carne y pollo bajo "Safe Handling Instructions" (Instrucciones para el Cuidado de este Producto)
- Los productos lácteos y carnes deben guardarse a una temperatura de 40°F o menos

En los potlucks y días de campo mantenga caliente la comida caliente, y fría la comida fría.



Recuerde: Mantenga todo limpio:

- Lávese las manos, los mostradores, y sus utensilios con agua caliente y jabón
- Tenga una tabla especial para sólo cortar la carne, el pollo y el pescado crudo. Lave la tabla con agua caliente y jabón cada vez que la use.
- Lave todas las frutas y verduras antes de usarlas y comerlas

Compre comida nutritiva, y manténgala fresca:

- Nunca deje comida afuera del refrigerador por más de 2 horas.
- No compre huevos sucios ni quebrados.
- Use leche y productos lácteos pasteurizados.
- Mantenga la carne, pescado o pollo crudo lejos de sus verduras y otras comidas.
- Si pone a marinar carne, pescado o pollo crudo, guárdelos en el refrigerador. No la deje sobre el mostrador de la cocina.
- Descongele la carne, pescado, y pollo en el refrigerador. No los descongele a la temperatura ambiental. No deje que goteen sobre otras comidas que tiene en el refrigerador.

Si tiene sus dudas, mejor tírela:

- La comida no siempre huele mal ni parece estar mala, aunque ya esté pasada.

Background

A vegetarian diet is defined as one that does not include meat, poultry (or fowl), seafood, or products containing these foods. People adopt vegetarian eating habits for a variety of reasons including health, religion, ethics, environmental concerns, finances, personal choice, etc. There are many variations of vegetarian eating and some are more restrictive than others.

The Academy of Nutrition and Dietetics recognized the 2009 American Dietetic Association (ADA) Vegetarian Position Statement. It is under revision. It states that a well planned vegetarian diet is appropriate for individuals during all life stages, including pregnancy and lactation. Studies support that a vegetarian diet can be nutritionally adequate in pregnancy and lactation and result in positive maternal and infant health outcomes. Supplements or fortified foods may be needed to support the needs of some pregnant and lactating vegetarians because some vegetarian diets are more restrictive than others.

It is always important to find out what a client means when she states she is vegetarian. Some people decide to move in the direction of becoming vegetarian by eliminating certain flesh foods and continuing to eat others, such as chicken and/or fish. Although a small percentage of pregnant women are vegetarian, the number of women leaning toward vegetarian eating habits is increasing.

Common Vegetarian Terms

The wide variability of dietary practices among vegetarians makes individual assessment of dietary adequacy essential. Lacto-ovo vegetarian and vegan are two common terms used to describe vegetarian eating.

The term lacto-ovo vegetarian refers to people who eat dairy products (lacto) and eggs (ovo) but avoid all animal flesh such as beef, chicken, lamb, pork, fish, and shellfish. People may choose to eat both dairy

“Vegans” (vegetarians who avoid all animal products) should be referred to the registered dietitian and/or health care provider to plan a diet that includes adequate calories and nutrients for pregnancy.

products and eggs or limit one and not the other.

Vegans, or total vegetarians, avoid all foods of animal origin, including all animals, birds, fish, eggs, and dairy foods. Of the people who call themselves vegetarian, 30 to 40% of them follow a vegan diet. Some vegans also stop using all products that contain animal products, including leather, soaps made from animal fat, and products that have gelatin, such as Jell-O® and marshmallows.

The registered dietitian plays a key role in educating vegetarian clients about the sources of specific nutrients, food purchasing and preparation, dietary modifications, and supplements to meet needs during pregnancy, lactation, and postpartum.

When a lacto-ovo vegetarian’s calorie intake is adequate, protein intake is usually also adequate. Most lacto-ovo vegetarians can follow the MyPlate for Moms recommendations and substitute plant protein sources for animal proteins and calcium and vitamin D fortified soy or rice milk for dairy products.

Many other vegetarian eating patterns exist; some people restrict their diet to fruit, others only eat food that can be eaten uncooked. Any severe dietary restriction requires a referral to the registered dietitian.

Special Concerns for Pregnancy

Pregnant and breastfeeding vegetarians can get all the nutrients and calories they need and have a healthy, thriving baby. Avoiding meat does not put a woman at nutritional risk as long as she consumes adequate calories, protein, calcium, iron, vitamin B12, vitamin D, zinc and other nutrients from food sources, fortified foods, and/or supplements. Most lacto-ovo vegetarians can use *MyPlate for Moms* by

selecting plant-based proteins listed in the meat and beans group. Pregnant and lactating vegans may need education and support to get nutrients easily obtained in meat and dairy foods, particularly calcium, vitamin B12, iron, and possibly essential fats. Additional supplemental iron is recommended for all pregnant women. It is important to respect the client's food choices and provide support, education, and referrals to the registered dietitian as needed.

Protein

The client can easily consume the additional 25 grams of protein that is needed during pregnancy by eating plant protein to meet her energy needs. High plant protein foods include beans, tofu (made from soy beans), lentils, peanut butter, and all nuts and seeds, including milk made from soy beans, rice, and nuts. Wheat, rice, barley, and oats contain protein and protein is also present in lesser amounts in vegetables. Adding dairy products and/or eggs to the diet makes it easier to obtain adequate protein but it is not essential to meeting protein requirements. Many women get the extra protein they need by eating more of the protein rich foods they usually eat. For example, adding 1½ cups of beans, lentils, or tofu, or 2½ cups of soy milk or two large bagels provides 25 grams of additional protein to support pregnancy. It is important to eat several servings of a variety of beans, grains, nuts, and seeds each day.

It was once believed that plant proteins needed to be combined, or eaten together at each meal to benefit the body. This is no longer believed to be true, but it is important for the vegetarian client to eat a wide variety of plant-based proteins and to consume an adequate amount each day.

Vitamins and Minerals: Calcium, B12, Vitamin D, and Iron

Women who do not eat meat, poultry, fish, eggs, or dairy products require careful dietary assessment and planning. If the woman chooses not to include

dairy products, refer her to her medical provider and registered dietitian to discuss calcium foods and supplement sources, and to assess her B12 and vitamin D intake. Some vegetarian women may need supplemental vitamin D if they have a low intake of vitamin D fortified foods and limited sun exposure.

Iron from plant foods is not as well absorbed by the body as iron from animal foods so vegetarians need to eat more iron-rich food than non-vegetarians. A good source of vitamin C increases iron absorption from beans, green vegetables and grains. (See *Prenatal Vitamins and Minerals, Iron, and Calcium* in the "Nutrition" guidelines). Vitamin B12 is another concern as meat, dairy, and eggs offer the only reliable source of this vitamin. Nutrients limited by a vegan diet are not addressed here as they require the skills of a registered dietitian.

Teenage Vegetarians

A pregnant or breastfeeding teenager with lacto-ovo vegetarian habits can meet the protein and iron requirements with careful planning and supplementation. Teen lifestyle and eating habits may make obtaining an adequate vegetarian or vegan diet difficult. Referral to the registered dietitian is highly recommended to assess caloric and nutrient adequacy of vegetarian teenagers.

Steps to Take

Determine if the client eats eggs and/or dairy foods and the amount eaten. Refer vegans or people with other restrictive food habits to a registered dietitian for assessment, education, and meal planning. Follow the following steps for lacto-ovo vegetarians:

- Assess the overall quality of food intake and do not assume vegetarians eat a healthy diet. Complete a 24-Hour Dietary Recall and compare your findings with *MyPlate for Moms*. Assist the client in making any needed changes in her food choices.

- Determine the client's eating frequency. It is important for all pregnant women to eat every three to four hours throughout the day. Advise vegetarian women to include foods high in plant protein for each meal and snacks. See the handout *When You Are a Vegetarian: What You Need to Know*.
- Assess nutrient supplement use. Lacto-ovo vegetarians may follow the same recommendations for prenatal vitamin and mineral use as non-vegetarians; no other supplements should be necessary unless she does not consume an adequate diet.
- Assess the pregnant client's rate of weight gain by plotting it on the weight gain grid. If her weight gain is lower than expected, assess her food intake and follow guidelines for low weight gain. (See *Weight Gain During Pregnancy* in the "Nutrition" guidelines.)
- Assess the client's diet for other sources of calcium if dairy products are not consumed. See the *Lactose Intolerance* section of the "Nutrition" guidelines for alternative sources of calcium. Encourage drinking calcium and vitamin D fortified soy or rice milk and eating tofu. These are all WIC foods.
- If daily dairy and eggs are not included in the diet, refer to a registered dietitian

Follow Up

Use the following steps to reassess your client's condition:

- Assess food intake at each trimester or more often as needed
- Praise the woman for improvements she makes in her food intake
- Assess the woman's weight gain at each visit and intervene as necessary

- If food intake is severely inadequate or restrictive, refer to the registered dietitian and health care provider

Resources

Vegetarian Nutrition Resource List

2008 - A compilation of resources on vegetarian nutrition, including pregnancy, breastfeeding, and infant feeding. Information listed is all available on the web and includes articles, pamphlets, magazines, newsletters, and books.

<http://fnic.nal.usda.gov/lifecycle-nutrition/vegetarian-nutrition>

The Vegetarian Resource Group

Vegetarian and vegan information, recipes, product information, menu plans, pamphlets (some available in Spanish).

www.vrg.org

Vegetarian Meal Planning

Kaiser Permanente, 2006.

[http://mydoctor.kaiserpermanente.org/ncal/Images/Vegetarian%20Meal%20Planning%20\(98538\)_tcm75-14768.pdf](http://mydoctor.kaiserpermanente.org/ncal/Images/Vegetarian%20Meal%20Planning%20(98538)_tcm75-14768.pdf)

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Mangels, R. *Vegetarian Diets During Pregnancy*. Women and Reproductive Nutrition Report. Winter, 2000.

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When You Are a Vegetarian: What You Need to Know

STEPS TO TAKE

Keep Healthy Without Eating Meat

If you do not eat meat or animal-based foods, you need to eat a wide variety of plant foods to get the nutrients you need for pregnancy and breastfeeding.

Every day, eat at least six to seven plant protein servings like beans, tofu, nuts, seeds, and peanut butter, and at least six to eight whole grains like rice, pasta, wheat, and other grains.

It also helps to eat dairy and eggs. That will give you more protein choices and important vitamins and minerals like calcium, vitamin D, and B12.

Check the plant protein food ideas below that you could try:

Eat legumes (beans and peas) and grains to boost protein:

- Rice and beans
- Cornbread and black-eyed peas
- Corn tortillas and beans
- Lentil soup and whole wheat crackers
- Tofu and brown rice
- Lentils and pasta
- Baked beans and whole wheat bread
- Humus and pita bread
- Whole wheat breads, flours, pastas, brown rice and whole oats
- Follow *MyPlate for Moms* and select servings of plant proteins and/or eggs and dairy



Eat nuts and seeds every day:

- Tofu with peanuts and broccoli
- Trail mix with peanuts and sunflower seeds
- Split pea soup and whole wheat walnut bread
- Peanut butter on English muffins
- Sesame seeds sprinkled on rice, vegetables, and salads
- Pasta salad with walnuts and sunflower seeds
- Sunflower seeds and almonds in fruit salads and on top of cereals

Add plant protein to vegetable dishes:

- Gumbo with okra, corn, and lima beans
- Collards and pinto beans
- Tofu and stir-fried vegetables
- Green leafy salad with garbanzo beans
- Vegetable soup with barley and red beans

Select these plant protein foods from WIC:

- Tofu and tempeh
- Calcium and vitamin D fortified soy milk
- Beans (dry or canned), lentils and peas
- Peanut butter

Take your prenatal vitamin and mineral pill every day:

- Talk to your health care provider about whether or not you need extra vitamin B12. A good source of B12 is Red Star Vegetarian Support Formula nutritional yeast.
- You may also need extra iron, calcium, zinc, or vitamin D



PASOS A SEGUIR

Manténgase sana sin comer carne

Si no come carne o alimentos de origen animal necesita comer una amplia variedad de alimentos vegetales para obtener los nutrientes que necesita para el embarazo y para dar pecho.

Coma todos los días al menos seis a siete porciones de proteínas vegetales, como frijoles, tofú, nueces, semillas y crema de cacahuate y al menos seis hasta ocho cereales integrales, como arroz, pasta, trigo y otros granos.

También ayuda comer alimentos lácteos y huevos. Eso le dará más opciones de proteínas y de vitaminas y minerales importantes, como calcio y vitaminas D y B12.

Marque las ideas de alimentos con proteínas vegetales a continuación que le gustaría probar:

Coma legumbres (frijoles y chícharos) y granos para aumentar las proteínas:

- Arroz y frijoles
- Pan de maíz y frijoles de carete
- Tortillas de maíz y frijoles
- Sopa de lentejas y galletas de sal de trigo integral
- Tofú y arroz integral
- Lentejas y pasta
- Frijoles horneados y pan de trigo integral
- Humus y pan árabe (pita)
- Panes, harinas, pastas, arroz y avena integrales
- Siga *MyPlate for Moms* (*MiPlato para Mamás*) y escoja porciones de proteínas vegetales y/o huevos



Si Es Vegetariana: Lo Que Necesita Saber

Coma nueces y semillas todos los días:

- Tofú con cacahuates y brócoli
- Frutos secos mezclados, con cacahuates y semillas de girasol
- Sopa de chícharos desecados y pan integral con nueces de nogal
- Crema de cacahuate en English muffins
- Semillas de ajonjolí sobre arroz, verduras y ensaladas
- Ensalada de pasta con nueces de nogal y semillas de girasol
- Semillas de girasol y almendras en ensaladas de frutas y sobre cereales

Añada proteínas vegetales a platos de verduras:

- Gumbo con quingombó (okra), elote y frijoles blancos
- Col rizada y frijoles pintos
- Tofú y verduras salteadas
- Ensalada verde con garbanzos
- Sopa de verdura con cebada y frijoles colorados

Elija estos alimentos de proteínas vegetales de WIC:

- Tofú y tempeh
- Leche de soya reforzada con calcio y vitamina D
- Frijoles (desecados o enlatados), lentejas y chícharos
- Crema de cacahuate

Tome su vitamina prenatal y su pastilla de minerales todos los días:

- Hable con su proveedor de atención de la salud sobre si necesita o no tomar vitamina B12 adicional. Una buena fuente de vitamina B12 es la levadura nutritiva llamada Red Star Vegetarian Support Formula.
- Es posible que también necesite hierro, calcio o zinc y vitamina D adicionales

Background

Human milk is the normal food for infants and contains complete nutrition for infant growth and development. The American Academy of Pediatrics (AAP) states that all infant milk formulas “differ markedly” from human milk. The AAP recommends exclusive breastfeeding (feeding only breast milk) for the first six months and continued breastfeeding for at least one year as normal infant feeding. Appropriate complementary foods may be added slowly after six months. Infant formula or any other food cannot replace human milk, nor provide the infant with the same protection from illness.

Breastfeeding benefits are understood by most women. The risk of not breastfeeding for infants and for women is less well understood. Infants who are not breastfed risk increased illness and infection in early life and increased risk of developing a number of health problems in later life. When mothers do not breastfeed they are at increased risk for breast and ovarian cancer, type 2 diabetes, and postpartum depression.

Most Women in California Choose Breastfeeding

The majority of women in California want to breastfeed but many do not get the help and support they need to continue breastfeeding. Women report that barriers such as returning to work, embarrassment, and lack of support make it difficult to continue breastfeeding.

The rates of breastfeeding in California are measured in different ways. The Newborn Screening (NBS) program collects in-hospital feeding practices and reports on how many mothers are breastfeeding exclusively or partially breastfeeding (giving some breast milk). Efforts to increase breastfeeding rates are paying off. Nine out of ten newborns received some breast milk. Only half of the breastfed newborns received only breast milk; half of breastfed newborns received formula.

For more information on the differences between breastfeeding and giving non-human milk such as formula, see www.womenshealth.gov/breastfeeding.

Mothers who do not exclusively breastfeed in the hospital are less successful breastfeeding at home. Mothers who are African-American, Hispanic, have less education, and lower income tend to not breastfeed exclusively. Teenaged mothers breastfeed less than non-teen mothers across all ethnic and racial groups. Teens can breastfeed if given the help they need to face barriers at home, school, or work. California breastfeeding rates are higher than many states but fall short of the Healthy People 2020 goals for the nation: www.healthypeople.gov

Breastfeeding Influences and the Need for Support

Women need help learning to breastfeed and need support to continue breastfeeding. Women are strongly influenced by their families and communities. If mothers, sisters, and friends did not breastfeed, many mothers have no one to turn to for support and correct information. Women who start breastfeeding can face social and cultural barriers that prevent them from breastfeeding as long and as exclusively as planned. CPSP services should include breastfeeding education, encouragement, support, and referrals during pregnancy and in the early postpartum period. WIC, La Leche League, lactation experts, and local breastfeeding coalitions also help women start and sustain breastfeeding.

“Baby Friendly” Practices

Many studies show that women are more likely to breastfeed when they deliver in hospitals that have “baby friendly” practices. The 10 critical baby friendly steps create a hospital environment that supports the woman and her baby getting off to a good start at breastfeeding. See *Breastfeeding Resources* for information about baby friendly hospital practices and the California hospital breastfeeding model.

CPSP Breastfeeding Services: Roles and Responsibilities

It is important to base breastfeeding education and support on the woman's individual concerns, questions, and experiences. Steps that will help:

- **Keep learning:** Stay up-to-date on evidence-based breastfeeding practices and information to offer women consistent and accurate information. This chapter offers step-by-step guidance and discusses new findings and resources.
- **Be credible:** Women seeking breastfeeding advice trust health professionals when they are confident, knowledgeable, calm, and show empathy and respect. Be a good listener and be truthful.
- **Integrate breastfeeding education, support and encouragement throughout pregnancy and postpartum:** At a minimum, CPSP practitioners should discuss breastfeeding at assessment, reassessments, and postpartum. Breastfeeding rates improve when women receive ongoing breastfeeding education, attend classes, and follow up shortly after delivery.
- **Create a breastfeeding friendly climate:** Educate all CPSP staff to answer basic breastfeeding questions. Provide a comfortable and private place for breastfeeding mothers. Have lactation experts available by referral. Lactation experts who meet qualifications for CPSP practitioners and are on the CPSP application may bill for CPSP services.
- **Be aware of formula company marketing:** The word "formula" sounds scientific, modern, easy, and safe. Help women understand formula companies' marketing messages (convenient, easy, etc.) and educate them about questionable claims, such as, "formula promotes improved brain development."
- **Do not promote formula in your facility:** Companies are marketing formula and discouraging breastfeeding when they offer free formula, pamphlets, pens, and gift bags. Refuse these items in your clinic and do not give them to clients. To identify formula promotions in your practice, go to this website: www.dshs.state.tx.us/wichd/lactate/PDF/ScavengerHunt.pdf.
- **Work with others in your community who support breastfeeding:**
 - ◆ WIC offers mother-to-mother support through the Breastfeeding Peer Counseling Program. Women are offered support by an International Board Certified Lactation Consultant (IBCLC) when help is needed. Breastfeeding mothers receive more WIC food checks. Get to know your local WIC agency staff and learn what services are available. See online *WIC materials* under "Resources."
 - ◆ The Adolescent Family Life Program provides breastfeeding support and education and helps teens overcome breastfeeding barriers faced at home, school, and work.
 - ◆ Join a local breastfeeding coalition. Most counties in California have a breastfeeding coalition that works to support breastfeeding and eliminate breastfeeding barriers. Find local coalitions at: www.californiabreastfeeding.org.
 - ◆ Visit the hospitals your clients use. Meet the staff and learn about their breastfeeding services. Develop a system to find out when CPSP clients deliver.
 - ◆ Visit local breastfeeding support groups to learn about their services
- **Respect a woman's choice to use formula:** Refer the woman to WIC for infant formula and for postpartum food checks. The decision to breastfeed is the woman's. Your role is to assess

breastfeeding desires and barriers, to validate her choices and concerns, and to offer correct information, support, and referrals. Even if the woman plans to formula feed, offer education that breastfeeding is the normal feeding choice and provide more information as desired.

Talking to your Clients about Breastfeeding

- Talk about breastfeeding by asking open-ended questions. Practice asking questions like: *What have you heard about breastfeeding? What questions do you have about feeding your baby?*
- Validate her concerns and reflect back to her that many women have concerns about breastfeeding. See *Tips for Addressing Perceived Breastfeeding Barriers* to help you discuss tips and suggestions for commonly perceived barriers and concerns.
- Give information based on her needs and concerns. It is easy to overwhelm women with too much information. Let her know that breastfeeding is the normal way to feed babies and that most women are able to provide for all their babies' needs for the first six months with only their milk. Calling breast milk "perfect" or "special" may be negative for some women.
- Treat each woman with respect. Pay attention to each woman's needs and concerns.

Steps to Take

The following step-by-step guidance follows the changes women experience during pregnancy and postpartum as their bodies prepares to breastfeed. The guidance offers open-ended questions and responses to validate common breastfeeding concerns.

Initial CPSP Assessment

Steps to Take Early in Pregnancy

Early in pregnancy women have many questions and concerns about their pregnancy and their future. Provide simple and positive messages and allow the woman to direct the discussion. Develop an individualized plan to address the woman's breastfeeding questions, concerns, and needs throughout the pregnancy and document this in the medical record.

Early in Pregnancy:

- **Assess breastfeeding intention and confidence.** Most pregnant women have thought about whether they would like to try breastfeeding. You do not need to ask the woman to make a decision about breastfeeding. Women do not need to reach a final decision about their feeding choice until the baby arrives. Start by asking how she feels about breastfeeding and feeding infants to learn about her attitudes and intentions. Validate her concerns. Practice asking open-ended questions in your own words:
 - ◆ *Many women think about how they will feed their baby early in their pregnancy, what thoughts are you having?*
 - ◆ *Women like breastfeeding for different reasons. What are some reasons you might like it? What are some reasons you might not like it?*
 - ◆ *How confident do you feel about breastfeeding?*
 - ◆ **Validate any fears.** *Yes, many women worry they cannot return to work and breastfeed. We can talk about that if you'd like.*

- **Assess breastfeeding experience.** Find out what breastfeeding experience she has and how that influences her attitudes about breastfeeding. Ask if anyone close to her has breastfeeding experience, both positive and negative.
 - ◆ *How did you feed your last baby? What was your experience like?*
 - ◆ *Who do you know that has breastfeeding experience? What have they told you about breastfeeding?*
 - ◆ *Validate positive and negative experiences. Many mothers wonder if they can breastfeed if they had a difficult time breastfeeding another baby.*
- Assess breastfeeding knowledge and sources of information. Allow the client to talk freely without feeling she has to make a feeding decision. Find out what she knows, wonders and would like to learn about breastfeeding. Let the woman guide what you share and the educational methods you use.
 - ◆ *What have you heard about breastfeeding?*
 - ◆ *What are two questions you have about feeding your baby breast milk?*
 - ◆ *How would you most like to learn more about feeding your baby?*
 - ◆ **Validate.** *There are many opinions and ideas about breastfeeding. It can be very confusing.*
- Assess breastfeeding support and encouragement. Some women care most about their mothers' opinions about breastfeeding. For others it may be the opinion of their husband/partner or friends. Allow the woman to talk about the breastfeeding opinions of those closest to her and how their opinions affect her.
 - ◆ *Who in your life is most supportive of you breastfeeding? Who is least supportive?*
 - ◆ *Who can you count on for breastfeeding support?*
 - ◆ *Would the people closest to you be mostly positive or negative about you breastfeeding?*
 - ◆ **Validate.** *Women can feel alone when their family is not supportive of them breastfeeding.*
- Assess and educate about breast changes. Reassure the woman that her breasts may be tender to the touch during the first trimester of pregnancy. Explain that her breasts will probably grow throughout the pregnancy to prepare for breastfeeding. Show diagrams and pictures of the changing breast if she is interested.
 - ◆ *What changes are you noticing in your breasts?*
 - ◆ *What would you like to know about the changes in your breasts?*
 - ◆ **Validate.** *Sometimes it seems that your body is just changing for no reason.*

Reassessment—Second Trimester

Steps to Take

Second trimester is a good time to discuss the woman's questions, concerns, and plans for breastfeeding. Women need basic breastfeeding information to make an informed decision. Discuss the risks of not breastfeeding. Provide community resources. Help her fill out the handouts *My Action Plan for Breastfeeding* and *My Breastfeeding Resources*.

- **Offer breastfeeding education and information.** Ask the woman how she likes to learn and schedule her for a class, or for a one-to-one session. Ask what she has learned about breastfeeding from WIC and what else she would like to learn. See *Tips for Addressing Breastfeeding Concerns* for simple and direct responses for common concerns.

Based on her questions, share basic breastfeeding information:

- ◆ **No special preparation to breastfeed is needed for most women.** Advice to “toughen up” nipples is outdated. If the woman is concerned about her nipples going inward (inverted nipples) or having flattened nipples (not protruding), refer her to a lactation expert. Flat and inverted nipples usually correct themselves as the infant breastfeeds.
- ◆ **Very few women cannot breastfeed.** Ninety-five percent of women are physically able to breastfeed. There are some women who should not breastfeed due to medical complications or because of risk to the baby. See *Who Should Not Breastfeed* later in the chapter.
- ◆ **Most women make enough milk.** Producing enough breast milk is a common worry; it is not a common problem. A woman needs to know that the more often and effectively she breastfeeds, the more milk she will make. This is especially important during the first two weeks after delivery.
- ◆ **How milk production works.** Every time the baby breastfeeds and drains the breast, hormones are released that signal the mother’s body to make more milk. When most of the milk is removed from the breast, especially by the baby, more milk is made. When babies are given any bottles, even bottled breast milk, the breasts make less milk. Feeding with bottles prevents the baby from signaling the woman’s body to make more milk. A mother can trust the baby to breastfeed when the baby is hungry and stop when satisfied. Timed or scheduled feedings are not recommended.
- ◆ **Breast or nipple size does not matter.** Women with any size breast can make enough milk, even for twins or triplets. If mothers are worried about their breasts or nipples, (e.g., breast size, scars on breasts, or previous breast surgery) refer them to a lactation expert. See *Breastfeeding after Breast Surgery* later in this chapter. Refer women who are obese or have gestational diabetes to a lactation expert.
- ◆ **Women have the right to breastfeed in public and express and store milk at work.** California state law protects women’s right to breastfeed in public. Working women are protected by the Lactation Accommodation Law that requires employers to offer unpaid break time and a separate room or space (not a toilet stall) to express milk. Women concerned about public breastfeeding can wear loose tops that are easy to pull up or cover with a light blanket.
- ◆ **Family members can bond with the baby.** There are many roles that fathers, partners, and family members can play in the baby’s life that are not feeding related. Playing with the baby, singing, reading stories, taking baby on walks, bathing, massaging, rocking, and changing the baby are ways family members can enjoy being with the baby. Once the baby is 6 months old, others can offer appropriate foods after the baby has breastfed.
- **Identify breastfeeding support and resources.** Help the woman fill out *My Breastfeeding Resources* to identify community resources.
 - ◆ Help the woman identify family, friends, and neighbors who breastfed successfully and can provide her with support. Help her cope with any who oppose her breastfeeding.
 - ◆ Encourage the woman to attend group education, mother-to-mother support meetings, or consult with a lactation expert. WIC offers many education and support resources.
 - ◆ Use *My Action Plan for Breastfeeding* to plan for breastfeeding education and support.

■ **Assess and educate about breast changes.** The middle months of pregnancy bring many breast changes. Explain how breast changes prepare her breasts to feed her baby and that she should wear a comfortable and supportive bra. Discuss the following:

- ◆ **Increase in breast size.** Some women report an increase of four to six inches and one to three cup sizes. The breasts may change even more after delivery.
- ◆ **Darkening of the pinkish-brown skin around the nipple** (areola) and veins become more visible due to increased blood circulation to the breasts.
- ◆ **Leaking colostrum any time after 24 weeks.** Some women may leak colostrum, but others do not. Discuss the importance of colostrum as the baby's first food and as protection against disease. It is vital that premature babies receive colostrum.
 - *What changes are you noticing in your breasts now?*
 - *You may notice a yellowish clear liquid coming from your breast, it is colostrum. What have you heard about it?*
 - **Validate.** *Yes, it can feel strange to experience so many changes.*

■ **Discuss how her partner and others close to her feel about her breastfeeding.**

Assure the woman that breastfeeding is not a barrier to intimacy with her partner. Invite the woman to bring her partner and family to breastfeeding classes and education.

- ◆ *How does your partner feel about breastfeeding? What concerns do they have?*
- ◆ **Validate.** *Sometimes our families are not as supportive as we would like and that can feel bad.*

Reassessment–Third Trimester

Steps to Take

As the woman's delivery date approaches, she may have many issues to discuss about childbirth and breastfeeding. Rigid teaching about breastfeeding positions and timing is not recommended.





During the Third Trimester Provide the Following Information and Support:

- **Childbirth and preparing for breastfeeding.** Ask the woman about her birthing concerns, validate her feelings, and offer education. Help her schedule a hospital tour and complete a birth plan. Review *My Action Plan for Breastfeeding* and *My Breastfeeding Resources*.
 - ◆ **Help her create a birth plan** to share with the health care provider and hospital staff. At a minimum the birth plan should include:
 - Plans to place the baby on the breast immediately after birth and keep the baby between the mother's breasts the first hour after delivery
 - Plans to keep the baby in the same room so she can feed the baby often and have skin-to-skin contact
 - Plans to have a supportive family member with her and her baby
 - Plans to avoid bottles, formula, or other fluids, pacifiers, and artificial nipples
 - ◆ Birth plan examples in English and in Spanish are in STT as handouts.

- ◆ **Planning for help after delivery.** Ask who can help her with baby care, household chores, shopping, and meals the first few weeks after delivery. If she lacks support, connect her with community resources.
- **Continue talking about breastfeeding, validating concerns and offering education.**
Ask open-ended questions and statements:
 - ◆ *What questions do you have about breastfeeding?*
 - ◆ *What about breastfeeding concerns you?*
 - ◆ *How confident are you feeling about breastfeeding? What would help you feel more confident?*
 - ◆ *Thinking about going back to work and breastfeeding seems to trouble you.*
 - ◆ **Validate.** *Many women wonder how they can both breastfeed and return to work.*
- **Starting breastfeeding.** Share the Laid Back Breastfeeding approach for early breastfeeding. This laid back position relaxes the mother and encourages the baby's feeding instinct and reflexes. The mother's breast drains better and there is less nipple tenderness. See pictures and video on this site: www.biologicalnurturing.com
 - ◆ Mothers sit back in a fully supported semi-reclined position
 - ◆ Baby is on top of the mother's body, tummy to tummy fully supported by gravity so that the mother's hands are free
 - ◆ Mothers follow baby sucking and body movements, not the clock, for feeding time
 - ◆ Mothers offer the breast frequently and do not have to wait for the baby to fully wake to feed
- **Baby behavior and feeding cues.** Help mothers and their support team follow the baby's cues to start and stop breastfeeding. Talk about feeding cues before delivery so the mother

knows what to expect. Rigid teaching about breastfeeding positions and feeding schedules are not recommended. Teach women to follow baby's cues. See the *Secrets of Baby Behavior* website: www.secretsofbabybehavior.com.

- **Signs that breastfeeding is going well.** Women can feel confident their babies are getting the nutrition they need. Unlike bottle feeding, one can't see how many ounces breastfed babies are consuming. Fear that the baby is not getting enough milk can lead to unneeded formula use that decreases milk supply.
 - ◆ Discuss the WIC handout *A Guide to Breastfeeding* to increase breastfeeding confidence. The handout explains the minimum number of wet and dirty diapers and explains changes in the baby's stools during the first week.
 - ◆ Teach mothers how to fill out the *Breastfeeding Checklist for My Baby and Me*. The handout helps mothers know if things are going well or when to call the baby's health care provider and the lactation expert.
- **Explain the need for small, frequent feedings** due to the infant's stomach size. Use actual food items or objects to help women understand that frequency of breastfeeding is related to infant stomach size and growth as shown in the graphic below:

1 Day	2 Days	3 Days	4 Days	5 Days	6 Days	7 Days	2 Weeks	3 Weeks
								
Cherry		Walnut		Ping Pong Ball		Chicken Egg		

NOTE: The graphics displayed in this table are not true to size. Please refer to the actual food items/objects to estimate sizes.
Source: www.beststart.org/resources/breastfeeding/pdf/breastfdeskref09.pdf

■ **What to expect.** Between birth and the first four to six weeks there are many changes in the milk's appearance, the woman's breasts, and the baby's feeding patterns and growth. Use the chart, such as WIC's *A Guide to Breastfeeding* to talk about early breastfeeding. This chart was developed for CPSP practitioners and for mothers who like to learn by reading.

■ **Breastfeeding/lactation assistance resources.** Help the woman complete *My Breastfeeding Resources*. Make sure the toll-free numbers are working and the hours of operation are listed. Follow your protocols for contacting the mother at the hospital. Introduce her to lactation experts before she delivers.

■ **Breast changes.** By the third trimester the woman's breasts will continue to grow. Many women will secrete colostrum and have enlarged bumps around the areola. Women will need to buy well-fitting nursing bras. She may need to purchase a different size bra after delivery.

- ◆ Check to see that she has had a breast examination
- ◆ Assure her she can breastfeed if her nipples are flat or inverted. Refer her to a lactation expert if she is concerned.
- ◆ Refer the women to stores that offer free bra fittings

■ **Preparing to return to work or school.** Women receiving California State Disability Insurance are eligible for six weeks of paid family leave. (See: www.paidfamilyleave.org)

- ◆ Ask the woman if she needs help understanding her work place or school policies and California laws that protect a woman's right to breastfeed or express milk at work
- ◆ Review the handout *Breastfeeding and Returning to Work or School*

- ◆ Help the woman identify childcare options close to her work or school

Postpartum Assessment

Steps to Take

It is a good idea to instruct women to call, text, or email you after they deliver to make sure they get the support and help needed to get off to a good breastfeeding start. Follow these steps:

■ **Assess that breastfeeding is going well:**

- ◆ Schedule a breastfeeding check-up for the woman soon after delivery to see that breastfeeding is going well for the woman and the baby. Review the handout *Breastfeeding Checklist for My Baby and Me* to check if breastfeeding is going well.
- ◆ Discuss the WIC handout *A Guide to Breastfeeding*
- ◆ If she is exclusively breastfeeding, praise the woman and assure her that she can continue to breastfeed without giving formula. Breast milk is all her baby needs until he/she is 6 months old.
- ◆ If she is supplementing with formula, ask how much she is giving and encourage her to continue breastfeeding. Refer her to WIC or a lactation expert.
- ◆ Encourage her to seek help early for concerns
Ask and listen closely:
 - *How do you think breastfeeding is going?*
 - *What do you like about breastfeeding? What are you finding difficult?*
 - *How confident are you that you can continue to breastfeed? What would help your confidence increase?*

■ About how many wet and dirty diapers does the baby have each day?

- ◆ Ask if the baby has the minimum number of wet and dirty diapers as listed on the chart below. By day three the stools should be lighter in color. After day five, stools should be mustard or yellow colored and watery with soft curds. If the baby has fewer wet or dirty diapers than listed on the chart, refer to the baby's health care provider.

MINIMUM NUMBER OF WET AND DIRTY DIAPERS		
Age of Baby	Minimum Number of Wet Diapers*	Minimum Number of Dirty Diapers*
1 day old	1	1
2 days old	2	2
3 days old	3	2
4 days old	4	3
5 days old	5	3
6 days old	6	4
7 days old	7	4

Source : WIC Handout: <https://www.cdph.ca.gov/Programs/CFH/DWICSN/CDPH%20Document%20Library/Families/FeedingMyBaby/Guide-to-Breastfeeding.pdf>

*Babies usually urinate and have a bowel movement in the same diaper so fewer than the minimum diapers may not be a problem. Always refer any concerns to the health care provider.

■ How many times in 24 hours does the baby breastfeed? How many hours does the baby sleep at one time? Early breastfeeding basics:

- ◆ It is normal for new babies to feed often. Newborns' small stomachs cannot hold much milk. Short, frequent feedings are normal. Babies may breastfeed on one side per feeding.
- ◆ It is normal for babies to feed on an irregular

schedule. Babies may feed many times over a short period (cluster feeding) and then take a longer break between feedings.

- ◆ It is normal for a baby to feed 10 or more times in 24 hours. Help mothers plan for frequent feedings.
 - ◆ It is not normal for a baby less than 4 months to sleep more than five hours at a time between feedings.
 - ◆ Discuss the baby's behavior and help the woman identify her baby's hunger cues (see "Resources" - *Baby Behavior*).
 - ◆ Talk about growth spurts. Let the woman know her baby will breastfeed more often during growth spurts. Frequent feedings will increase the woman's milk supply.
 - ◆ Some women are exhausted and overwhelmed about feeding the baby at night. Ask the woman how she is feeling. Would she like to talk about her feelings?
- ### ■ Is the infant fed supplemental formula or using pacifiers?
- Anything other than breastfeeding can reduce the mother's milk production.
- ◆ Ask the woman if she was advised to offer formula and by who
 - ◆ Ask if she is concerned her baby is not getting enough milk. If she says yes, ask what concerns her.
 - ◆ If she would like to resume exclusive breastfeeding, refer her to a lactation expert
 - ◆ Pacifiers or artificial nipples are not recommended during the first month because they can meet the infant's sucking needs without providing food. Less breastfeeding may reduce the amount of milk she makes.
- ### ■ Are other solid foods and liquids, besides breast milk or infant formula given?
- ◆ Anything other than breast milk or formula may be harmful for the infant

and less nourishing than breast milk.

Recommendations for anything other than breast milk or formula before 6 months of age should come from the health care provider.

- ◆ Assure the woman that the baby's nutritional needs are met by breastfeeding alone until the baby is 6 months old. The baby also needs 400 micrograms of supplemental vitamin D daily.

■ **How does the woman know the baby is hungry and wants to breastfeed?**

Babies have instincts and reflexes to help them breastfeed. The baby sends cues even when in a drowsy and non-awake state that they are ready to feed. Encourage mothers to feed baby at the earliest sign. Crying is a late cue that the baby is hungry. Baby hunger cues include:

- ◆ Lip smacking or puckering lips
- ◆ Rooting, keeping hands near the mouth
- ◆ Bends arms and legs

Assure the woman that following the baby's cues to eat helps babies learn to regulate their own appetite now and in the future. Breastfeeding on cue will not "spoil" a baby; it is the way babies should be fed. Breast milk changes during the course of a feeding. The last milk, the hind-milk, has a higher fat content and most new babies drift off to sleep while nursing.

■ **How many hours does the baby sleep at one time?**

It is normal for babies to feed often at night. Women need to expect night feedings for at least the first four months. Supplementing with formula to get baby to "sleep through the night" is not recommended because it reduces breast milk supply.

- ◆ Ask the woman how long she expects her baby to sleep between feedings. Discuss normal baby feeding and sleeping patterns with her.

- ◆ If the baby is not sleeping as expected, ask the woman about caffeine. Drinking over two to three cups of coffee could interfere with the baby's sleep patterns.
- ◆ Encourage the woman to rest when the baby sleeps
- ◆ Ask if anyone close to her advises her to give formula or cereal to help baby sleep more. Explain that giving formula can decrease her milk supply.

■ **Is breastfeeding comfortable for the woman?**

Pain while breastfeeding is a sign that the baby is not latched on well. If the woman has pain during feeding or between feedings or if she has any bleeding or visible cracks of the nipples, refer to a lactation expert.

■ **If the baby is latching on well?** Check to see that:

- ◆ The woman sits back in a fully supported semi-reclined position
- ◆ Holding the baby "tummy to tummy"
- ◆ The woman feeds her baby based on cues rather than a timed schedule
- ◆ The woman offers the breast often and knows she does not have to wait until the baby is fully awake to feed
- ◆ The woman's nipples are not tender

■ **Assess the woman's food intake** using the *MyPlate for Moms* handout or www.ChooseMyPlate.gov for an individualized food plan www.choosemyplate.gov/supertracker/createprofile.aspx

- ◆ Refer all women to WIC for education, breastfeeding support, and food checks
- ◆ Complete a 24-Hour Recall or food frequency and compare her intake to *MyPlate for Moms* (See *Assessing Nutrition Intake*)
- ◆ Help her complete *MyPlate for Moms* to set healthy eating goals

- ◆ Check the woman's weight. Losing 2 to 4 pounds per month after one month postpartum will not affect milk supply. Losing more than 4 to 5 pounds a month after the first month postpartum may decrease milk production.
 - ◆ Recommend 8 to 12 ounces of a variety of fish or sea food each week. See *Food Safety* for safe fish choices.
 - ◆ Assess folic acid intake and recommend 400 mcg of folic acid fortified foods and/or 400 mcg of a folic acid supplements. See *Supplements- Folic Acid*.
 - ◆ Review the handout, *Nutrition and Breastfeeding, Common Questions and Answers*
- **Does the woman use any harmful substances?**
- Alcohol, tobacco, street drugs, some prescription drugs, and some over the counter drugs can get into the woman's milk in harmful amounts.
- ◆ **Ask** the woman what prescription and over the counter drugs she is taking. Check for safety.
 - ◆ **Assess** what substances the woman is using and in what amounts. Consult with the baby's health care provider to assure safety for the woman and her baby.
 - ◆ **Advise** women of the dangers of substances in her milk and make appropriate referrals
 - ◆ **Refer** to local resources to help her quit using substances. If she needs to temporarily stop breastfeeding, a lactation expert can help her maintain her milk supply by pumping.
- **Is the woman using tobacco?**
- ◆ Explain that stopping smoking is best for her and her baby's health. It is still better for her baby to breastfeed, even though she smokes. Breast milk will help her baby to recover from respiratory infections, which are more likely because she smokes.
 - ◆ Encourage her to quit and refer her to the California Smokers' Helpline: 1-800-NO BUTTS. If she cannot quit, smoking less will lower the baby's exposure to nicotine.
 - ◆ Advise her to breastfeed before smoking to reduce the amount of nicotine in her system. Nicotine can reduce her milk production and is not good for the baby.
 - ◆ She should never smoke anywhere around her baby or other children
 - ◆ The baby should never sleep in a bed with anyone who smokes. Smoking is a major risk factor for Sudden Infant Death Syndrome (SIDS) and fires. Smokers' hair, breath, and skin expose the baby to harmful chemicals.
 - ◆ Discuss keeping her baby away from secondhand smoke and tobacco residue
- **Is the woman drinking alcohol?**
- ◆ Ask and assess how often and how much alcohol she drinks
 - ◆ Advise her if she drinks more than one drink per day (one drink equals 12 ounces beer or 1½ ounces alcohol or 5 ounces wine), her alcohol intake may be harmful
 - ◆ Advise her that alcohol will not improve her milk quality or quantity
 - ◆ If she drinks alcohol she should wait three hours before breastfeeding or expressing milk to avoid alcohol in her milk. Limit to one drink per day.
 - ◆ If she does drink, her infant should be in a safe place with nondrinking caregivers
 - ◆ Refer to the health care provider if she has more than one drink a day

■ Does the woman plan to return to work or to school?

- ◆ California employers are required to provide a private space for expressing breast milk, other than a toilet stall, and must provide a sufficient number of breaks. See California laws supporting breastfeeding:
www.cdph.ca.gov/HEALTHINFO/HEALTHYLIVING/CHILDFAMILY/Pages/CaliforniaLawsRelatedtoBreastfeeding.aspx
- ◆ Review the handout *Breastfeeding and Returning to Work or School*
- ◆ Review her rights to breastfeed and pump at work. See *Working and Breastfeeding: It Can Work*
<http://www.breastfeedingworks.com/>

- If the woman is returning to school, ask if she has talked to school staff about breastfeeding or pumping at school
- Does she have access to a breast pump? See “Resources” for breast pump information.
- Provide her with a card that ensures her rights to breastfeed in California:
www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/InformationonRighttoBreastfeedinPublicCard.aspx

Additional Breastfeeding Information

Breastfeeding Is Generally Recommended When:

- The woman is ill. Many mothers fear they will expose their babies to the illness when they feel sick. They have likely exposed their baby to the illness before they knew they were sick. Breast milk contains antibodies which may shorten or help baby avoid the illness. Mothers should try to get rest and drink fluids during common illnesses. If she must stop breastfeeding while sick, refer her to a lactation expert or WIC to help her maintain her milk production.

Note: If the mother is using substances, the child may suffer from inadequate care or endangerment and should be referred to the health care provider. Exposing children to illicit drugs is considered child endangerment and is a mandated report to social services. Follow your agency protocols.

- If the mother takes prescription or over-the-counter drugs. Many over-the-counter and prescription medications are safe, but some are not. She should check with the baby’s health care provider. Some cold or allergy medicines may reduce milk supply. Milk supply usually returns once women stops taking them. If a mother is told to stop breastfeeding due to medication, she can talk to her health care provider about a safe alternative. Refer her to a lactation expert or WIC to help her maintain her milk supply.
- If the infant is ill. Babies need mother’s milk even more if they are sick. Their mother’s breast milk has the nutrients and antibodies needed to fight illness. For more information on breastfeeding during illness, visit www.illli.org/NB/NBmaternalillness.html.
- Physically active mothers can breastfeed. Exercise does not interfere with quality or production of breast milk.

Breastfeeding Is Not Recommended in Rare Situations:

Refer the woman to her health care provider for the following:

- If the infant is diagnosed with galactosemia
- If the woman has active untreated tuberculosis she must stay away from her baby until she has taken her prescribed therapy for about two weeks. Her health care provider and her baby’s provider will decide when it is safe for her to be near her baby. During this time, mothers must pump and throw away their milk. Once the medication is working, she may breastfeed. Refer women with tuberculosis to a lactation expert.

- If the mother has HIV/AIDS, she must give her baby formula
- If the mother needs to have chemotherapy or radioactive medications, she cannot breastfeed. In some cases she can “pump and dump” and return to breastfeeding when advised by the health care provider.
- If the mother is using street drugs, including marijuana, or is drinking excessive alcohol she should not breastfeed. The substances will pass into the breast milk. Some substances, such as alcohol, leave her milk as her blood alcohol level returns to normal, others may require that she pump and discard the milk for a period of time. Refer the woman to her baby’s health care provider and a lactation expert.

Finding Professional Breastfeeding Support

- Many WIC sites have International Board Certified Lactation Consultants (IBCLCs) on staff. IBCLCs have the highest level of practical knowledge and skill in breastfeeding support. A board certified lactation consultant has the letters IBCLC after his/her name.
- Contact the closest Breastfeeding Coalition or Breastfeeding Coordinator to identify breastfeeding support resources in your community (<http://californiabreastfeeding.org/coalition-information/>)
- Help women identify professionals who have breastfeeding knowledge, such as WIC staff, certified lactation consultants, public health nurses, registered dietitians, pediatricians, family practice physicians, and obstetrician/gynecologists
- Identify local phone numbers that woman can call for breastfeeding information. See *My Breastfeeding Resources* for a list of professional and community resources.

See LactMed, a free online database for drugs and lactation- www.toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT.

- Share breastfeeding help lines with clients:
 - ◆ National Breastfeeding Helpline: 1-800-994-9662
Trained breastfeeding peer counselors can help answer common breastfeeding questions by phone. The helpline is available from 9 a.m. to 3 p.m. Eastern Standard Time (three hours earlier than California).
 - ◆ La Leche League: 1-877-4-LALECHE (24-hour, toll free) . For California La Leche groups: www.llli.org/web/california.html

Milk Banks

- If a mother is unable to breastfeed, her infant can still receive human milk. Milk banks provide pasteurized breast milk for babies when their mothers are unable to supply their own breast milk. Medi-Cal may pay for the milk and requires a physician’s prescription. Provide breast pump information for mothers planning to continue breastfeeding.

Referral

(For currently pregnant and breastfeeding)

Refer the woman to **her primary health care provider** if the following situations occur. Note that this list is not complete.

- She has had breast or chest surgery or injury across her breast(s) and wants to breastfeed
- She has a medical condition and believes she cannot breastfeed
- She uses medication and believes she cannot breastfeed

- She has red areas or bumps on her breasts or pain or bleeding in her nipples
- She has breast pain that lasted more than 72 hours

Refer the woman to her **infant's primary health care provider** if any of the following situations occur. Note that this list is not complete.

- The infant is breastfed and has not been given vitamin D supplements
- The infant over the age of 6 days does not produce more than six wet and/or dirty diapers or the stools are not yellow in color
- The infant has one of the following symptoms:
 - ◆ A dry mouth
 - ◆ Red-colored urine
 - ◆ Yellow skin or the whites of the eyes are yellow (symptoms of jaundice)
 - ◆ Does not wake up and eat at least ten times in 24 hours
 - ◆ Loses more than 10% of his/her body weight or the infant's weight does not return to original birth weight by 10 to 14 days
- The infant is ill
- The infant has an allergic reaction
- The mother is worried about her baby

Refer the woman to a **registered dietitian** in the following situations:

- She is concerned about feeding the infant certain food items
- She is vegan or has a nutritional deficiency
- She has a condition requiring medical nutrition therapy

Refer the woman to a **lactation expert** if she:

- Has flat or inverted nipples and wants to breastfeed
- Has had breast or chest surgery or injury across her breast and wants to breastfeed
- Has pain while breastfeeding, or engorgement lasting longer than 24 hours
- Has trouble with the baby latching and positioning
- Cannot hear swallowing sounds by the time the infant is 48 hours of age
- Stopped breastfeeding, but wants to start again
- Is using herbal remedies
- Was instructed to stop breastfeeding by her health care provider but does not want to stop

Refer the woman to a **lactation expert** if the infant:

- Refuses to breastfeed for more than six hours, or if the infant is too sleepy to breastfeed
- Has lost more than 7% of birth weight (if more than 10%, refer to health care provider)
- Breastfeeds for longer than one hour after milk supply is established
- Appears hungry after breastfeeding

Adapted from:

WIC Breastfeeding Peer Counselor Training
<https://lovingsupport.fns.usda.gov/content/peer-counseling-training>

California WIC referral forms for Pregnant Women; Postpartum/Breastfeeding women; and Pediatrics
<https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/HealthCareProviders.aspx#>

Breastfeeding Resources and Publications for Clients and Health Professionals

Recommended Breastfeeding Publications

(all are free and some are available in bulk)

■ **Your Guide to Breastfeeding (2011)**

This easy-to-read publication provides women the how-to information and support needed to breastfeed successfully. It explains why breastfeeding is best for baby, mom, and society and how loved ones can support a mother's decision to breastfeed. Expert tips and pictures help new moms learn how to breastfeed and how to overcome common challenges. The wisdom of real moms is shared in personal breastfeeding stories. www.womenshealth.gov/publications/our-publications/breastfeeding-guide

Earlier versions are available in Spanish and Chinese and for African-American (in English), and American Indian and Alaska Native Women (in English).

Recommended WIC Breastfeeding Publications:

- **A Guide to Breastfeeding** – this guide contains easy text and good pictures of breastfeeding positions

English: <https://www.cdph.ca.gov/Programs/CFH/DWICSN/CDPH%20Document%20Library/Families/FeedingMyBaby/Guide-to-Breastfeeding.pdf>

Spanish: <https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Program-Landing1.aspx>

Resources for Pumping and Storing Breast Milk and Returning to Work or School:

- **Breastfeeding and Returning to Work or School**
English: <https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Program-Landing1.aspx>
Spanish: <https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Program-Landing1.aspx>
- **Working and Breastfeeding: It Can Work**
<http://www.breastfeedingworks.com/>
- **A Mother's 10 Steps to Successful Breastfeeding: Even if your hospital isn't Baby Friendly** **handout**
English: <http://breastfeedla.org/wp-content/uploads/sites/2/2013/12/A-Mothers-10-Steps-to-Breastfeeding-2013.pdf>
Spanish: <http://breastfeedla.org/wp-content/uploads/sites/2/2013/12/A-Mothers-10-Steps-to-Breastfeeding-2013.pdf>
- **How does Formula Compare to Breastmilk?**
English: <https://www.cdph.ca.gov/Programs/CFH/DWICSN/CDPH%20Document%20Library/Families/FeedingMyBaby/FormulaComparedToBreastmilk.pdf>
Spanish: <https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Program-Landing1.aspx>

Baby Behavior Resources

- **Baby Fact Sheet - Baby Cues from North Dakota**
www.ndhealth.gov/familyhealth/MCH/babyfacts/feedingcues.pdf

Baby Behavior Resources

■ Baby Fact Sheet - Baby Cues from North Dakota

http://www.ndhealth.gov/familyhealth/publications/parentingnewsletter/parenting_birthto12months.pdf

■ WIC Baby Behavior Booklet

http://www.ndhealth.gov/familyhealth/publications/parentingnewsletter/parenting_birthto12months.pdf

■ California Food Guide – Normal Infant Feeding 0-12 months

<https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Families/FeedingMyFamily/FeedingMyBaby.aspx>

Recommended Breastfeeding Websites

- Breastfeeding: www.womenshealth.gov/breastfeeding
Easy to read information for professionals and breastfeeding clients.
- California Department of Public Health breastfeeding website: www.cdph.ca.gov/breastfeeding
- California Breastfeeding Coalition: www.californiabreastfeeding.org.
This website contains information on active city and county breastfeeding coalitions.
- American Academy of Pediatrics, Childhood Health Topics, Breastfeeding: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Breastfeeding/Pages/Benefits-of-Breastfeeding.aspx>
- La Leche League International: www.llli.org
- Secrets of Baby Behavior: www.secretsofbabybehavior.com

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Lawrence, Ruth A. *Breastfeeding: A Guide for the Medical Profession*. St. Louis: Mosby, 2010.

Mohrbacher, Nancy. *Breastfeeding Answers Made Simple: A Guide for Helping Mothers*. Hale Pub L P, 2010.

Wiessinger, Diane, West, Diana, and Pitman, Teresa. *Womanly Art of Breastfeeding*, 8th Edition, La Leche League International – Random House Publishing, 2010.

Breastfeeding and Medication

Hale, Thomas W. *Medications and Mothers' Milk*. Hale Publishing L. P., 2012.

Lactmed : <http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>

You can also download a free app from this website.

Breastfeeding Concerns	Suggested Responses/Tips
	<i>To correct misinformation, all members of the health care team need to share consistent and accurate breastfeeding information.</i>
Lacks Information	<ul style="list-style-type: none"> ■ Ask the woman what she knows and would like to know about breastfeeding. Early on, discuss breastfeeding as the normal choice for feeding babies and the risks of not breastfeeding for mothers, babies, children, families, and communities. ■ Discuss breastfeeding each trimester using “Steps to Take” and offer counseling and handouts based on the woman’s questions and concerns. ■ Explain breast pumps and talk to her about getting one from WIC, a hospital or elsewhere ■ Tell the woman that professional breastfeeding support is available after delivery. See the <i>My Breastfeeding Resources</i> handout for support.
Fears She Does Not Have Enough Milk	<ul style="list-style-type: none"> ■ Women of all ages make breast milk that is similar in quality ■ Newborns only need a small amount of milk because their stomachs are so small (See the stomach size graphic in the breastfeeding chapter) ■ It is normal for infants to wake up and feed multiple times throughout the day and night because of their small stomach and their rapid growth ■ Making breast milk does not depend on breast size. Feeding often and not using pacifiers and other nipples in the first month helps produce enough breast milk. ■ The best way to keep track of milk production is keeping track of the baby’s weight gain over time. Show the woman the handout, <i>A Guide to Breastfeeding</i>. Some weight loss is normal in the first week. See <i>Referrals</i> for when to refer to a health care provider.
Experiences Pain or Has Trouble Latching On or Positioning	<p>If done correctly, breastfeeding should not hurt, but may cause some tenderness at first.</p> <ul style="list-style-type: none"> ■ Pain can be a sign of incorrect latching or positioning at the breast ■ See <i>My Breastfeeding Resources</i> to contact a lactation expert if there is pain or difficulty latching and positioning

Breastfeeding Concerns	Suggested Responses/Tips
	<p><i>To correct misinformation, all members of the health care team need to share consistent and accurate breastfeeding information.</i></p>
<p>Believes Baby Prefers Formula</p>	<ul style="list-style-type: none"> ■ Breast milk is preferred because it is much healthier than formula, provides skin-to-skin contact, and is digested more easily than formula ■ Babies don't prefer the taste of formula; they may prefer that bottled milk flows out quickly ■ If a bottle must be used to feed a baby, it is best to choose a nipple that does not pour the milk out fast and is about the size of the mother's own nipple. Feeding should follow the baby's cues of hunger and fullness. ■ If the woman is making little milk, the baby will look for a source of food. Refer as this may be a sign she is not making enough milk.
<p>Believes Giving Formula Is Easier than Breastfeeding</p>	<p>Breastfeeding may seem harder than providing formula at first. At about six weeks, most mothers report it is easier, less work, and cheaper than formula feeding.</p> <ul style="list-style-type: none"> ■ Breastfeeding does not require warming, setting up, or bottle cleaning ■ All babies need to be held during feedings. Propping bottles is not safe. ■ The woman can return to work or school and use a pump to express milk for her baby while they are separated. Breast pumps are available from WIC or can be rented if the mother is not eligible for WIC. ■ Mothers who breastfeed do not need to carry bottles, clean water, or formula with them when they travel. They do not have to prepare bottles at night. ■ Mothers who breastfeed can save money on formula costs and can get extra free food for them from WIC and stay on WIC up to one year ■ Breastfed babies are healthier than formula-fed babies. This means fewer doctor visits, trips to the hospital, missed work days, and better lifelong health. ■ The use of formula requires special care. Making a mistake mixing and storing formula can make babies sick. Formulas have been recalled in the past due to production errors that could harm babies. ■ In emergency situations, breast milk is the safest food for a child

Breastfeeding Concerns	Suggested Responses/Tips
	<i>To correct misinformation, all members of the health care team need to share consistent and accurate breastfeeding information.</i>
Is Embarrassed to Breastfeed in Public	<p>Validate the woman's feelings that many mothers feel embarrassed to breastfeed in public. Reassure her that it gets easier with practice. Tell her that women have a legal right to breastfeed in any public place. Show pictures of women breastfeeding discretely. The woman can:</p> <ul style="list-style-type: none"> ■ Practice breastfeeding discretely in front of a mirror to find a technique that works for her ■ Breastfeed before leaving and right after coming home from short trips ■ Watch baby cues and breastfeed before the baby becomes fussy. It is easier to feed a baby that is calm and not crying. ■ Breastfeed in the car, a dressing room, or in a women's lounge area ■ Wear clothes that cover well, such as shirts that pull up from the waist or can be unbuttoned from the bottom. Use a shawl or baby blanket. ■ If the woman is still uncomfortable, recommended pumping breast milk at home and using a bottle with expressed milk in public
Is Scared Her Body Will Change	<ul style="list-style-type: none"> ■ Breasts change due to pregnancy, not breastfeeding. Sagging may occur over time and is caused by many factors: genetics, pregnancy, aging, and gravity. ■ Breasts may become slightly larger when breastfeeding because they are producing milk, but this change is usually temporary ■ Breastfeeding may help the woman return to pre-pregnancy weight faster than if she formula feeds

Breastfeeding Concerns	Suggested Responses/Tips
	<p><i>To correct misinformation, all members of the health care team need to share consistent and accurate breastfeeding information.</i></p>
<p>Has to Return to Work or School</p>	<p>Let the woman know that she can breastfeed and return to work or school. Encourage her to discuss her plans with her employer or school as early as possible. Are her employers aware of breastfeeding and pumping at work laws? Provide tips for breastfeeding and returning to work or school.</p> <p>The woman can:</p> <ul style="list-style-type: none"> ■ Breastfeed her baby at work/school if child care is close by ■ Express breast milk by regularly pumping during breaks at work or school. Discuss laws that support pumping milk at work. ■ Provide bottles of expressed milk a few weeks before returning to work or school to prepare baby for the bottle ■ Store expressed milk in a cooler or refrigerator for immediate use or freeze breast milk for use at a later time ■ Feed both breast milk and infant formula. Breastfeeding is the best option, but breast milk in a bottle is better than not giving breast milk
<p>Does Not Want to Follow a Diet</p>	<ul style="list-style-type: none"> ■ No special diet is necessary. Nutrition while breastfeeding is similar to nutrition in pregnancy. Even if the mother eats junk food, her breast milk is better than formula. ■ A healthy diet is important for the mother's health and postpartum weight loss ■ Some mothers fear they must stop eating their favorite food or spices but that is not needed. Most babies like the different flavors of mother's diet and it may help them accept a greater food variety later in life. ■ Refer to the handout, <i>Nutrition and Breastfeeding-Common Questions and Answers</i> for answers to specific questions the woman may ask

Breastfeeding Concerns	Suggested Responses/Tips
	<i>To correct misinformation, all members of the health care team need to share consistent and accurate breastfeeding information.</i>
Wants Other Family or Partner to Feed the Baby So They Are Involved	<p>Fathers and family are an important part of the baby's life. They can:</p> <ul style="list-style-type: none"> ■ Tell stories or read to the child to help the baby's development ■ Hold the baby and play games, such peek-a-boo and pat-a-cake ■ Feed expressed breast milk in a bottle and feed other foods once the baby is 6 months of age
Lack of Role Models Who Support Breastfeeding	<ul style="list-style-type: none"> ■ Ask the woman what she is hearing about breastfeeding from those closest to her. Help her identify any misinformation or challenges. ■ Help her name role models who have successfully breastfed and are in similar circumstances (e.g., returned to work or school) ■ Talk to her about professional, friend, and family support after delivery ■ Help her list those she will call for help and encouragement ■ Encourage the woman to discuss breastfeeding with her partner, her mother, family and friends, and others important to her ■ Encourage her to attend a mother's support group at WIC, La Leche League, or others. She can invite her support team to go with her
Doesn't Want to Be Solely Responsible for Feeding the Baby or Fears Loss of Freedom	<ul style="list-style-type: none"> ■ Many mothers like the fact that their baby knows it is mom who feeds them, even if others share in the care of the baby. ■ Breastfeeding can help her feel more "free" because she will not have to deal with formula and cleaning bottles ■ Assure the woman breastfeeding gets faster and less frequent and the mother will have more time between feedings ■ Acknowledge that many times mothers may feel pressured to "get away" from the baby. Not all mothers want or need to "get away" for a break. It is normal to not want to leave your baby. ■ If mothers do desire time away from their baby they can ask friends for help with childcare and household chores. If she needs a day off, she can express her breast milk and have someone else feed her baby.

Breastfeeding Concerns	Suggested Responses/Tips
	<i>To correct misinformation, all members of the health care team need to share consistent and accurate breastfeeding information.</i>
Is Not Confident in Her Ability to Breastfeed	<ul style="list-style-type: none"> ■ Encourage the woman that most women can successfully breastfeed their babies and that you are here to help her. Validate her concerns and fears and tell her many women are not sure they can breastfeed and with practice she will become more confident. ■ Ask the woman how she feels about her ability to breastfeed her baby and help her plan and prepare for breastfeeding. Use <i>My Breastfeeding Resources</i> to discuss available resources. ■ Ask the woman if she would like the help of a breastfeeding peer mentor (if available in your area); provide referrals to breastfeeding classes and consultation ■ Let the health care provider know if she lacks breastfeeding confidence ■ Help the woman prepare to breastfeed. She can talk to her doctor about pre-existing medical conditions and medications she takes. She can share her plans to breastfeed with her employer, school, and doctor. ■ Help her complete a birth plan to share with her health care provider and delivery hospital that includes her wish to breastfeed ■ She can talk to friends and family members about her decision to breastfeed. She can get support from case managers, peer counselors, WIC, or mothers in support groups like La Leche League. ■ Let her know that breastfeeding might be hard at first but that she has support to meet and overcome any challenges. Review <i>A Guide to Breastfeeding</i> and discuss <i>My Action Plan for Breastfeeding</i>.

Reference

U.S. Department of Health and Human Services

The Surgeon General's Call to Action to Support Breastfeeding
Washington, DC. U.S. Department of Health and Human Services, Office of the Surgeon General; 2011. This publication is available at:
www.surgeongeneral.gov

U.S. Department of Health and Human Services

Your Guide to Breastfeeding, Washington, DC. U.S. Department of Health and Human Services' Office on Women's Health, 2011. This publication is available at: www.womenshealth.gov/publications/our-publications/breastfeeding-guide/

	Milk	The Infant	The Mother
Birth	<p>There is milk in the breast by 28 weeks of pregnancy. Some women leak milk prior to delivery, but most do not. The first milk, colostrum, is yellowish in color and gives infants early protection against disease. Colostrum is the perfect first food for all newborns. Do not discard it. If the baby is not able to breastfeed, hand express colostrum to a small clean spoon and feed it to the baby by spoon or syringe.</p>	<p>The infant will be awake and alert in the first hour. This is the best time to start learning how to breastfeed. The infant's stomach at birthⁱ can hold only about as much as what fits in a marble. It is a "getting to know you" time when baby adapts to the world and looks for mother's face, hears her voice and adjusts to the new environment. Place baby on the mother's chest to warm up and hear familiar sounds. This releases normal seeking behavior leading to the first breastfeeding.ⁱⁱ</p>	<p>Mother is tired after birth but ready to touch and talk to her baby. This is the perfect time to make her comfortable as she recovers and help her cuddle with and warm her baby skin-to-skin. This is important bonding time. When baby shows "ready to eat" behaviors (cues) the mother can breastfeed often, giving mother and baby many opportunities to learn new breastfeeding skills.</p>
First 12 to 24 hours	<p>The infant will drink 1 teaspoon of colostrum at each feeding. Women may not see the milk, but it has what the infant needs and in the right amount. Baby shows cues when ready to eat: licking the lips, reaching to the mother or breast, sucking hands or fingers.</p> <p>The baby's stool reflects the changes in breast milk. Stools starts out dark, almost black, and become lighter.</p> <p>If baby cannot be brought to mother to breastfeed, hand expression with pumping should be taught so that baby can be given mothers' milk as soon as the baby can feed</p>	<p>It is normal for infants to sleep heavily shortly after birth. Some infants may be too tired to latch on well at first. Expect frequent feedings. Babies have strong instincts to suck and feed every one to two hours and sleep after feedings. Some infants, especially if they are not full-term, will be tired and the mother may have to wake them up to breastfeed if they sleep more than three hours. Mothers should ask the hospital staff not to give her baby any formula, water, or pacifiers unless needed for medical reasons, because at this age, babies usually breastfeed due to sucking needs rather than hunger. If pacifiers are used to soothe babies, they may skip breastfeedings and not stimulate needed milk production.</p>	<p>Mother needs quiet time to rest during the short times between feedings and time to bond with her baby. Mothers may want to limit visitors. Nipples may be tender, but should not hurt. If breastfeeding hurts, she should ask for breastfeeding help. A semi-reclined position, with the baby on top of the women helps the infant latch on to the breast. Women with a C-section may need extra help positioning baby for feeding, but they can breastfeed even if they are taking medication for pain. If there is concern, consult the baby's health care provider.</p>

	Milk	The Infant	The Mother
Days 2 to 5	<p>The milk now has more water, so it will look bluish-white, but may still have a yellowish appearance for about two weeks. The milk the woman makes is just right for her baby.</p> <p>Many mothers do not leak milk. This is not a sign of how much milk mother makes.</p> <p>By day three the stool should be lighter (more yellow) in color.</p>	<p>The infant will feed often, 10 or more times in 24 hours. The more a baby breastfeeds, the more milk a mother makes.ⁱⁱⁱ The infant's stomach is slowly growing to the size of baby's fist. All infants do not eat on a schedule or know day from night. It is normal for breastfeeding infants to feed every one to two hours for a while, followed by a longer sleep. Feedings will probably take about 30 minutes. It is best not to remove the baby from the first breast until they let go. Some babies take only one side at a feeding. If they nurse on one side only, start on the other side at the next feeding. After delivery, it is normal for an infant to lose some weight. By about 10 days to 2 weeks of age the baby should be back to birth weight. The baby should be seen by the health care provider at least once by two days after discharge.</p>	<p>Between days two to four the mother's breasts will begin to feel full and may leak. Insert pads inside the bra to absorb milk. She usually makes more milk than her baby needs. Frequent breastfeeding can help reduce swollen and hard breasts (engorgement). Between feedings, ice packs can reduce swelling, which goes away in one to two days. If breastfeeding becomes difficult, the mother should call for assistance. Day or night, mothers need to rest when baby sleeps. Family and friends should help her and allow her time to rest and recover.</p> <p>If she has pain in her nipples or worries about her milk supply, she can contact WIC, her health care provider, a lactation consultant, the delivery hospital, or other breastfeeding resources.</p>

	Milk	The Infant	The Mother
Day 6 to 4 weeks	<p>Milk transitions from colostrum to transitional milk to mature milk. Changes will usually not be noticed by either mother or baby, but these changes perfectly meet the baby's needs at this time.</p> <p>Setting aside six diapers every morning reassures her that her baby has taken enough milk if she has used them all up in 24 hours. At 6 to 8 weeks, the baby may not have as many dirty diapers; this is normal. He/She will still have at least 5 wet diapers per day. (see WIC handout https://www.cdph.ca.gov/Programs/CFH/DWICSN/CDPH%20Document%20Library/Families/FeedingMyBaby/Guide-to-Breastfeeding.pdf).</p> <p>By day six the stool should be soft and thicker yellow looking or have a "cottage cheese" like look.</p>	<p>It is normal for all infants to have irregular feeding and sleeping schedules. Breastfeeding babies feed frequently to meet their growth needs. Frequent feedings increase the mother's milk supply. The baby is learning to feed more efficiently and the mother's milk production is adjusting to the needs of the baby. Setting a feeding schedule or limiting feedings can decrease baby's growth and reduce mother's milk supply. Teach mothers to respond to their baby's cues and to enjoy their baby's communication skills. See <i>Resources</i> for baby cues. Reinforce that frequent, irregular feeding patterns are normal. Mothers need help anticipating and preparing for her baby's frequent feeding needs during this time. Mothers need to know that as breastfeeding infants grow they will breastfeed fewer times per day and night.</p>	<p>The mother may feel down one moment and frustrated the next. This is normal and often called "baby blues". She should expect to feel better in about two weeks. She should reach out for help and accept it. Family and friends can bring food for her, and help with the housework, but let the mother and baby learn how to be with each other rather than taking the baby away.</p> <p>The mother's body will adjust to making the right amount of milk. If she is worried, she should call WIC and CPSP for help.</p>

	Milk	The Infant	The Mother
First 4 to 6 weeks	Most mothers never see their milk. If she expresses her milk, she may see that it looks bluish-white at the beginning of a feeding and creamy white towards the end. Milk may change color and flavor after the mother eats certain foods. This is normal and helps the baby get used to the family's diet.	The infant is more efficient at breastfeeding and may take less time on each breast. The infant has a larger stomach capacity and is able to take more milk. Feedings may be farther apart. At around 10 days and 6 weeks, infants will breastfeed more frequently (called "growth spurts"). Breastfeeding is not just for food – it also meets many of baby's needs, such as security, warmth, and closeness. This is normal and will not lead to a "spoiled" baby.	The mother's breasts make the milk her baby needs, but not a lot more, so her breasts will be less hard unless she has delayed a feeding. Leaking usually slows down. She should not worry, as her milk will be there for her baby. Women can eat a variety of foods and still make good milk. To help her recover, she should eat a variety of foods when hungry, drink fluids when thirsty and rest whenever she can. If the mother is returning to work or school, she should be referred to WIC or other local resources for pumps and information about Lactation Accommodation laws.

Sources of Information for the Health Care Provider:

- American Academy of Pediatrics: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Breastfeeding/Pages/Benefits-of-Breastfeeding.aspx>
- American Academy of Family Physicians: www.aafp.org/about/policies/all/breastfeeding-support.html
- Academy of Breastfeeding Medicine: policies listed on: www.bfmed.org/Resources/Protocols.aspx

Sources of Information for the Mother:

- California Department of Public Health: www.cdph.ca.gov/breastfeeding
- Office of Women's Health, U.S. Department of Health and Human Services: www.womenshealth.gov/breastfeeding/
- La Leche League: www.lalecheleague.org

ⁱ Stomach Capacity References:

www.cdph.ca.gov/programs/breastfeeding/Documents/MO-StomachCapacityReferences.doc

ⁱⁱ Colson SD, Meek J, Hawdon JM. (2008). Optimal positions triggering primitive neonatal reflexes stimulating breastfeeding. *Early Human Development*, Volume 84, Issue 7, Pages 441–449.

ⁱⁱⁱ Pang W & Hartmann PE. Initiation of Human Lactation: Secretory Differentiation and Secretory Activation. *Journal of Mammary Gland Biology and Neoplasia*. Volume 12, Number 4, Pages 211-221. DOI: 10.1007/s10911-007-9054-4



My Action Plan for Breastfeeding

Name: _____

Check the box for each step you are doing now to prepare for breastfeeding. Check the boxes for the steps you plan to take. Write down other ways you plan to prepare for breastfeeding.

Things that I can do to get ready for breastfeeding

- Learn more about breastfeeding by asking questions, attending classes, and reading. Ask my local WIC agency, medical provider, or clinic staff for more information and help.
- Attend a breastfeeding support group at WIC or La Leche League to talk to moms who have breastfeeding experience.
- Talk to my family, husband/partner, friends, and my work or school about my plans to breastfeed my baby.
- Fill out a birth plan and give it to my doctor. Ask your case manager for a copy of *My Birth Plan*.
- Ask that my baby stay in my room after I give birth.
- Start breastfeeding in the first hour after delivery.
- Avoid pacifier use for the first month.
- Complete and save *My Breastfeeding Resources*.
- If I have trouble breastfeeding, I will ask for help instead of giving my baby formula.
- Give my baby only breast milk for the first six months and try to breastfeed for at least a whole year. If I need to be away from my baby, I can pump breast milk.
- Other ideas to help me breastfeed my baby:

Am Doing	Steps I Will Take
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Signature: _____

Date: _____

Mi plan de acción para dar pecho



Nombre: _____

Marque la casilla para cada paso que está realizando ahora para prepararse para dar pecho. Marque las casillas de los pasos que piensa tomar. Escriba otras maneras que piensa prepararse para dar pecho.

Cosas que pienso hacer para prepararme para dar pecho

- Aprender más sobre la lactancia al hacer preguntas, asistir a clases y leer. Pedir más información y ayuda en la agencia de WIC de mi zona, a mi proveedor de atención médica o al personal de la clínica.
- Asistir a reuniones de un grupo de apoyo de lactancia en WIC o en la Liga de La Leche, para hablar con mamás con experiencia dando pecho.
- Hablar con mi familia, esposo/pareja, amigos y mi trabajo o escuela sobre mis planes para darle pecho a mi bebé.
- Llenar un plan de parto y dárselo a mi médico.
- Pedir que mi bebé se quede en la habitación después de nacer.
- Empezar a dar pecho en la primera hora después del parto.
- Evitar el uso de chupones durante el primer mes de vida.
- Llenar y guardar "Mis recursos para dar pecho".
- Si tengo problemas para dar pecho, llamaré para obtener ayuda en lugar de darle fórmula a mi bebé.
- Darle solo leche materna a mi bebé durante los primeros seis meses de vida e intentar darle pecho durante por lo menos un año entero. Si tengo que separarme de mi bebé, puedo sacarme leche.
- Otras ideas para ayudarme a darle pecho a mi bebé:

Estoy haciendo	Pasos que tomaré
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Firma: _____

Fecha: _____

My Breastfeeding Resources

	Situation	Specialist	How to Contact	Contact Information (e.g. phone number)
Professional Breastfeeding Help	When you need help breastfeeding, have problems with latching on, feel pain, have questions about drug safety, etc.	WIC lactation consultant	Call local WIC agency 1-888-WICWORKS or 1-888-942-9675 https://m.wic.ca.gov/	
Medical/ Nutrition Help	If your baby is ill or if you have medical or health concerns for you or your baby. If you have questions or concerns about your diet, weight, or food intake. For emergency situations	Other lactation consultant (hospital, private) Primary health care provider (doctor or clinic) for mother or baby Registered Dietitian	Nearby certified consultants can be found here: http://www.ilca.org/why-ibclc/falc Call health care provider. Call local WIC agency For the closest WIC clinic call: 1-888-942-9675	
Community Breastfeeding Support	When you would like breastfeeding support or to talk about breastfeeding and taking care of babies with professionals and experienced mothers.	Emergency Room La Leche League groups WIC agency: WIC peer counseling is offered in some counties Other local support groups	Call 911 For local La Leche League www.llli.org/Web/California.html Call local WIC agency 1-888-942-9675 Find support groups in your county: www.californiabreastfeeding.org	
Milk Bank	To donate or get breast milk (this is a Medi-Cal benefit that requires a doctor's prescription).	Mother's Milk Bank of California	English and Spanish Hours: M-F 9am-6pm EST 1-800-994-9662 TDD for the hearing-impaired: 1-888-220-5446 24-hour toll-free helpline 1-877-4-LALECHE (1-877-452-5324)	
Breastfeeding Supplies/ Pumps	Breast pumps for qualified WIC participants. To purchase and/or rent a breast pump.	Local WIC agency Hospital Rental Private Rental Local Breastfeeding Coalition	http://www.mothersmilk.org/ 1-408-998-4550 MothersMilkBank@hhs.co.santa-clara.ca.us https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/HowCanIGetWIC.aspx http://californiabreastfeeding.org/	
Other Resources	Websites for more breastfeeding information, tips, and handouts.	California Department of Public Health Women, Infant, and Children (WIC) Office on Women's Health	www.cdph.ca.gov/breastfeeding https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Families/FeedingMyFamily/FeedingMyBaby.aspx www.womenshealth.gov/breastfeeding/	

Mis recursos para dar pecho

	Situación	Especialista	Cómo ponerse en contacto	Información de contacto (por ejemplo, número de teléfono)
Ayuda Profesional Para Dar Pecho	Cuando necesita ayuda para dar pecho, tiene problemas para prender el bebé al pecho, siente dolor, tiene preguntas sobre los medicamentos que puede tomar, etc.	Asesora de lactancia de WIC	Llame a la agencia de WIC de su zona 1-888-WICWDRKS o 1-888-942-9675 https://www.cdph.ca.gov/programs/wicworks/Pages/AboutWICandHowtoApply.aspx	
		Otra asesora de lactancia (hospital, privada)	Puede encontrar consultor de lactancia certificadas aquí: http://www.ilica.org/why-ibclc/false	
Ayuda Médica/ de Nutrición	Si su bebé está enfermo o tiene preocupaciones médicas o de su salud o la de su bebé. Si tiene preguntas o preocupaciones sobre su dieta, peso o lo que come.	Proveedor primario de atención de la salud (médico o clínica) para la mamá o el bebé	Llame al proveedor de atención de la salud. Llame a la agencia de WIC de su zona Para conocer la clínica de WIC que tiene más cerca, llame al: 1-888-942-9675	
		Dietista licenciada	Llame al 911 Para grupos de la Liga de La Leche en su zona www.lilli.org/Web/California.html	
Ayuda en la Comunidad para dar Pecho	Cuando quiere respaldo para dar pecho o quiere hablar sobre la lactancia y el cuidado de bebés con profesionales y madres experimentadas.	Sala de emergencia	Llame al 911	
		Grupos de la Liga de La Leche	Para grupos de la Liga de La Leche en su zona www.lilli.org/Web/California.html	
		Agencia de WIC. Algunos condados ofrecen consejería de pares de WIC	Llame a la agencia de WIC de su zona 1-888-942-9675	
		Otros grupos de apoyo locales	Encuentre grupos de apoyo en su condado: www.californiabreastfeeding.org	
		Línea de asistencia nacional sin cargo sobre la lactancia	Inglés y español Horarios: de lunes a viernes, de 9 de la mañana a 6 de la tarde, Hora del Este 1-800-994-9662 TDD para las personas con disminuciones auditivas: 1-888-220-5446	
Banco de Leche	Para donar y obtener leche materna (este es un beneficio de Medi-Cal que requiere una receta médica).	La Liga de La Leche	Línea de asistencia sin cargo las 24 horas 1-877-4-LALECHE (1-877-452-5324)	
Suministros para dar Pecho/Bombas Sacaleches	Para donar y obtener leche materna (este es un beneficio de Medi-Cal que requiere una receta médica). Para comprar y/o alquilar un sacaleches.	Banco de leche materna de California	http://www.mothersmilk.org/ 1-408-998-4550 MothersMilkBank@hhs.cosanta-clara.ca.us	
		Agencia WIC de su zona	https://www.cdph.ca.gov/Programs/CEH/DWICSN/Pages/HowCanIGetWIC.aspx	
Otros Recursos	Sitios web para más información, consejos y folletos sobre dar pecho.	Alquiler del hospital	http://californiabreastfeeding.org/	
		Alquiler privado	www.cdph.ca.gov/breastfeeding	
		Coalición local de lactancia	http://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/FamiliesFeedingMyFamilyFeedingMyBaby.aspx	
		Departamento de Salud Pública de California	www.cdph.ca.gov/breastfeeding	
		Mujeres, Bebés y Niños (WIC)	http://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/FamiliesFeedingMyFamilyFeedingMyBaby.aspx	
		Oficina para la salud de la mujer	www.womenshealth.gov/breastfeeding	

Breastfeeding Checklist for My Baby and Me

This checklist will help you know things are going well for you and your 4 day to 4 week old baby. If you have any concerns, call the baby's doctor and a lactation expert.

Check that breastfeeding is going well for you and for your baby.

My baby is over 4 days old and:

- Breastfeeds at least 10 times or more in 24 hours.
- Makes swallowing sounds during most of the feeding.
- Makes at least **3 dirty** at least the size of a quarter **and 4 wet diapers** in 24 hours.
- Has dirty diapers that are lighter in color and not so dark and thick.
- Only breastfeeds and does not take formula or other liquids.

I delivered more than 4 days ago and:

- I enjoy breastfeeding my baby.
- Latching baby on to feed is getting easier.
- I feel 100% comfortable when breastfeeding. If I am having pain, it is getting less each day.
- My breasts were larger and heavier after delivery.
- My breasts feel softer after I breastfeed.
- I believe that breastfeeding is going well.

Check if you and your baby need help with breastfeeding. If you check any of these boxes, contact your baby's doctor or a lactation expert and/or WIC to get help quickly.

My baby is over 4 days old and:

- Sleeps more than 5 hours at a time
- Does not wake up to breastfeed at least 10 times every 24 hours.
- Does not make swallowing sounds during the most of the feeding.
- Wet diapers are not heavy and have a pink color.
- Does not make at least **3 dirty and 4 wet diapers** in 24 hours.
- The dirty diapers are dark and thick.
- Breastfeeds and drinks formula and other liquids.
- Has yellow colored skin and eyes.

I delivered more than 4 days ago and:

- My breasts did not get larger and heavier after delivery.
- Latching baby on is difficult.
- My breasts do not feel softer after I breastfeed.
- I worry I don't have enough milk.
- I can't tell when my baby is hungry and when my baby is full.
- After my baby latches on and I count to 10, my nipples still hurt.
- I change sanitary pads every hour because I bleed so much.
- I do not think breastfeeding is going well.

Baby's Doctor _____

Phone _____

My Doctor _____

Phone _____

Lactation Expert _____

Phone _____

WIC's Phone _____

Baby's Birth Date _____ Baby's Birth Weight _____ Baby's Discharge Weight _____

Lista de verificación de lactancia para mí y mi bebé

Esta lista de verificación le ayudará a saber que las cosas le van bien a usted y a su bebé entre los 4 días y las 4 semanas de edad. Si tiene preocupaciones, llame al médico del bebé y a un experto en lactancia.

Verifique que la lactancia sea buena para usted y su bebé.

Mi bebé tiene más de 4 días de edad y:

- Toma pecho por lo menos 10 veces o más en 24 horas.
- Hace sonidos de tragar durante la mayoría de la mamada.
- Ensucia 3 pañales por lo menos con excremento de por lo menos el tamaño de una moneda de 25 centavos de dólar y moja 4 pañales por lo menos en 24 horas.
- Tiene pañales sucios de color más claro, y ya no son tan oscuros y espesos.
- Solo toma pecho y no toma fórmula ni otros líquidos.

Di a luz hace más de 4 días y:

- Disfruto de darle pecho a mi bebé.
- Cada vez es más fácil prender el bebé al pecho.
- Me siento totalmente cómoda al darle pecho a mi bebé. Si tengo dolor, se va reduciendo con el pasar de los días.
- Mis senos están más grandes y pesados después de l parto.
- Mis senos están más blandos después de dar pecho.
- Creo que la lactancia está yendo bien.

Sepa si usted o su bebé necesitan ayuda con la lactancia. Si marca alguna de estas casillas, póngase en contacto con el médico del bebé o con un experto en lactancia y/o con WIC para obtener ayuda rápidamente

Mi bebé tiene más de 4 días de edad y:

- Duerme más de 5 horas a la vez.
- No se despierta para tomar pecho por lo menos 10 veces cada 24 horas.
- No hace sonidos de tragar durante la mayoría de la mamada.
- Los pañales mojados no son pesados y tienen un color rosado.
- No ensucia por lo menos 4 pañales en 24 horas.
- Los pañales sucios son oscuros y espesos.
- Toma pecho y fórmula y otros líquidos.
- Tiene la piel y los ojos de color amarillento.

Di a luz hace más de 4 días y:

- Mis senos no aumentaron de tamaño y peso después del parto.
- Es difícil prender el bebé al pecho.
- Mis senos no están más blandos después de dar pecho.
- Estoy preocupada porque no tengo suficiente leche.
- No me doy cuenta cuándo mi bebé tiene hambre y cuándo está lleno.
- Después de prender al bebé y contar hasta 10, todavía me duelen los pezones.
- Cambio de toallita sanitaria cada hora porque sangro tanto.
- No creo que la lactancia esté yendo bien.

Médico del bebé _____

N° de teléfono _____

Mi médico _____

N° de teléfono _____

Experto en lactancia _____

N° de teléfono _____

N° de teléfono de WIC _____

Fecha de nacimiento del bebé _____ Peso del bebé al nacer _____ Peso del bebé al ser dado de alta _____

California MyPlate for Moms



Make half your plate vegetables and fruits, about one quarter grains and one quarter protein. Choose foods that are high in fiber and low in sugar, solid fats and salt (sodium). For most women, these are the average food amounts for one day.

Vegetables

Eat more vegetables.

Use fresh, frozen or low-sodium canned vegetables. Avoid French fries.

Daily Amount

- 3 or more of these choices:
- 2 cups raw leafy vegetables
- 1 cup raw vegetables or juice
- 1 cup cooked vegetables



Protein

Choose healthy protein.

Eat vegetable protein daily. Avoid bacon, hot dogs and bologna.

Daily Amount

- 6-7 of these choices:
- 1 ounce fish, poultry or lean meat
- 1 egg
- ½ ounce nuts
- ¼ cup cooked dry beans, lentils or peas
- ¼ cup tofu
- 1 tablespoon nut butter



Grains

Eat mostly whole grains

like brown rice. Limit bread, noodles and rice that are white.

Daily Amount

- 6 of these choices in the 1st trimester,
- 8 in the 2nd/3rd trimester and while breastfeeding:
- 1 slice whole wheat bread or ½ bagel
- 1 small (6-inch), whole wheat tortilla
- 1 cup cereal
- ½ cup cooked pasta, rice or cereal



Fruits

Add color with fruit.

Make most choices fruit, not juice.

Daily Amount

- 2 of these choices:
- 1 cup fresh fruit
- 1 cup unsweetened frozen or canned fruit
- ½ - ¾ cup juice
- ½ cup dried fruit



Dairy

Enjoy calcium-rich foods.

Choose pasteurized nonfat or lowfat milk, yogurt and cheese.

Daily Amount

- 3 of these choices for women or
- 4 of these choices for teens:
- 1 cup milk
- 1 cup soy milk with calcium
- 1 cup of plain yogurt
- 1½ ounces cheese



Choose Healthy Fats & Oils

- Use plant oils like canola, safflower and olive oil for cooking.
- Read food labels to avoid saturated and trans fats (hydrogenated fats).
- Avoid solid fats such as lard and butter.
- Eat cooked fish at two meals each week.
- Limit oils to 6 teaspoons each day.

Choose Healthy Beverages

- Drink water, nonfat or lowfat milk instead of soda, fruit drinks and juice.
- Limit caffeine drinks like coffee and tea. Avoid energy drinks.
- Do not drink alcohol when you are pregnant or may become pregnant.
- Alcohol passes through breast milk. If breastfeeding, talk with your healthcare provider about alcohol use.

California My Nutrition Plan for Moms

These tips can help you to eat well and have a healthy weight during and after your pregnancy. Fill in your weight goals and check off which tips you are willing to try.

Pregnancy: My recommended weight gain in pregnancy is _____ pounds. My current weight gain is _____ pounds.

After Pregnancy: A healthy weight range for me is _____ pounds. My goal is to weigh _____ pounds.

Vegetables

Each day I will:

- Try to eat at least 3 choices of fresh, frozen or low-sodium canned vegetables.
- Flavor vegetables with herbs and spices instead of fat or salt.
- Eat many dark green and orange vegetables.

Protein

Each day I will:

- Try to eat 6-7 choices.
- Grill, broil or bake meat instead of fry.
- Eat beans, nuts, tofu, seeds and nut butter.
- Eat lean meat (15% fat or less).
- Take skin off poultry.
- Eat 12 oz. of fish per week.
- Limit bacon, hot dogs and bologna.

Grains

Each day I will:

- Try to eat 6-8 choices.
- Choose whole grains at least half of the time.
- Eat W/C-approved cereals.

Fruits

Each day I will:

- Try to eat 2 choices.
- Eat a variety of fresh, frozen or canned fruits.
- Choose fresh, frozen and canned fruits without added sugars.
- Limit fruit juice to ½ - ¾ cup juice each day.

Dairy

Each day I will:

- Try to eat 3 choices.
- Choose pasteurized nonfat or lowfat (1%) milk and cheeses.
- Eat plain yogurt. For sweetness, add fruit.
- Choose soy products, with calcium, like tofu.

Fats & Oils

I will:

- Use 6 teaspoons of plant oils like canola, safflower and olive oil daily.
- Bake, broil, steam, or microwave instead of frying.

Extras (Solid Fats, Sugars and Salt)

I will:

- Choose foods low in fat, sugar and salt.
- Read nutrition labels to limit fat, sugar and salt (sodium).
- Choose fruits, vegetables, unsalted nuts and seeds for snacks.

Beverages

I will:

- Drink water, nonfat or lowfat milk instead of sugary drinks.
- Limit caffeine drinks like coffee and tea. Avoid energy drinks.

My Other Ideas

- Make a daily food plan. Go to www.choosemyplate.gov/SuperTracker/createprofile.aspx.

MiPlato para Mamás

Haga que la mitad de su plato contenga vegetales y frutas, alrededor de un cuarto del plato granos y el otro cuarto alimentos con proteína. Elija alimentos ricos en fibras y de bajo contenido de azúcar, grasas sólidas y sal (sodio). Estas cantidades de alimentos son para el consumo diario de una mujer de tamaño promedio. Usted puede necesitar más o menos de las cantidades sugeridas.



Vegetales

Coma más vegetales.
Coma vegetales frescos, congelados o vegetales enlatados bajos en sodio. Evite comer las papas fritas.

Cantidad Diaria

- 3 o más de estas opciones:
- 2 tazas de vegetales de hoja cruda
- 1 taza de vegetales crudos o jugo
- 1 taza de vegetales cocidas



Proteína

Elija proteínas saludables.
Coma proteínas vegetales a diario. Evite el tocino, las salchichas y la mortadela.

Cantidad Diaria

- 6-7 de estas opciones:
- 1 onza de pescado, pollo o carne magra
- 1 huevo
- ½ onza de nueces
- ¼ de taza de frijol, lenteja o chícharo seco cocido
- ¼ de taza de tofu
- 1 cucharada de crema de cacahuete



Frutas

Agregue color con frutas.
Escoja frutas enteras en lugar de jugos de frutas.

Cantidad Diaria

- 2 de estas opciones:
- 1 taza de fruta fresca
- 1 taza de fruta congelada o enlatada sin azúcar
- ½ - ¾ taza de jugo
- ½ taza de fruta seca



Granos

Coma mayormente granos integrales como arroz integral. Limite su consumo de pan, fideos y arroz que no sean integrales.

Cantidad Diaria

- 6 de estas opciones en el 1er trimestre
- 8 en el 2o o 3er trimestre y mientras esté amamantando:
- 1 rebanada de pan integral o ½ bagel
- 1 tortilla pequeña de trigo integral (6-pulgadas)
- 1 taza de cereal
- ½ taza de fideos, arroz o cereal cocidos



Lácteos

Coma alimentos ricos en calcio.
Elija leche, yogur y queso pasteurizados descremados o bajos en grasa.

Cantidad Diaria

- 3 de estas opciones para las mujeres
- 4 de estas opciones para los adolescentes:
- 1 taza de leche
- 1 taza de leche de soya enriquecida con calcio
- 1 taza de yogur natural
- 1½ onza de queso



Elija Grasas y Aceites Saludables

- Use aceites vegetales para cocinar como el aceite de alazor (safflower), canola y oliva.
- Lea las etiquetas de los alimentos para evitar consumir grasas saturadas y trans (grasas hidrogenadas).
- Evite las grasas sólidas como la manteca y la mantequilla.
- Coma pescado cocido en dos de sus comidas cada semana.
- Limite su consumo de aceites a 6 cucharaditas por día.

Elija Bebidas Saludables

- Beba agua, leche descremada o baja en grasa en lugar de refrescos, bebidas de frutas y jugo.
- Limite su consumo de bebidas con cafeína como el café o el té. Evite las bebidas energizantes.
- No beba alcohol si está embarazada o pudiera estar embarazada.
- El alcohol pasa al bebé a través de la leche materna. Si está amamantando, hable con su médico acerca del consumo de alcohol.

California Mi Plan Nutricional para Mamás

Estas sugerencias pueden ayudarla a comer bien y a mantener un peso saludable durante y después del embarazo.

Llene los espacios en blanco con el peso que le gustaría llegar a tener y marque las opciones que está dispuesta a probar.

Embarazo: Me recomendaron subir _____ libras durante mi embarazo. Hasta la fecha, he subido _____ libras.

Después del embarazo: Un peso saludable para mi es _____ libras. Mi meta es pesar _____ libras.

Vegetales

Cada día trataré de:

- Comer al menos 3 porciones de vegetales frescos, congelados o enlatados bajos en sodio.
- Condimentar las vegetales con hierbas y especias en lugar de grasas o sal.
- Comer mucha verdura de color verde oscuro y anaranjado.

Proteína

Cada día trataré de:

- Comer 6 a 7 de porciones.
- Asar u hornear carnes en lugar de freírlas.
- Comer frijoles, nueces, semillas, tofu o crema de cacahuete.
- Comer carne magra (con el 15% de grasa, o menos).
- Quitarle la piel al pollo.
- Comer 12 onzas de pescado por semana.
- Limitar mi consumo de tocino, salchichas y mortadela.

Granos

Cada día trataré de:

- Comer 6 a 8 porciones.
- Elegir granos integrales al menos la mitad del tiempo.
- Comer cereales aprobados por el programa de WIC.

Frutas

Cada día trataré de:

- Comer 2 porciones.
- Comer una variedad de frutas frescas, congeladas o enlatadas.
- Elegir frutas frescas, congeladas y enlatadas sin azúcares añadidos.
- Limitar el consumo de jugos de frutas a $\frac{1}{2}$ - $\frac{3}{4}$ de taza por día.

Lácteos

Cada día trataré de:

- Comer 3 porciones.
- Elegir leche y quesos pasteurizados descremados o bajos en grasa (1%).
- Comer yogur natural (para endulzarlo, le pondré fruta).
- Elegir productos de soya enriquecidos con calcio, como el tofu.

Grasas y Aceites

Usaré 6 cucharaditas diarias de aceite vegetal como el aceite de alazor (safflower), canola y oliva.

- Cocinaré los alimentos al horno, asados, al vapor o en el microondas, en lugar de freírlos.

Extras (Grasas Sólidas, Azúcares y Sal)

- Elegiré alimentos bajos en grasas, azúcares y sal.
- Leeré las etiquetas con la información nutricional para poder limitar mi consumo de grasas, azúcares y sal (sodio).
- Para mis bocadillos, elegiré frutas, vegetales, nueces y semillas sin sal.

Bebidas

Beberé agua, leche descremada o baja en grasa en lugar de bebidas azucaradas.

- Limitaré mi consumo de bebidas con cafeína como el café y el té. Evitaré las bebidas energizantes.

Mis Otras Ideas

- Hacer un plan diario alimenticio. Visite esta página: www.choosemyplate.gov/SuperTracker/createprofile.aspx.
- _____



Nutrition & Breastfeeding Common Questions and Answers

STEPS TO TAKE

Q: Will I have to change my diet while breastfeeding?

A: Breastfeeding does not require a special diet or different foods. All women need to eat a healthy diet of a variety of fruits and vegetables, lean protein, low fat dairy and whole grains every day. The extra calories and nutrients you need are easy to get when you eat a healthy diet and you eat when you are hungry and stop when you are full. You can make a food plan just for you at: www.choosemyplate.gov/supertracker-tools/daily-food-plans/moms.html

Q: Can I go on a diet to lose weight while breastfeeding?

A: It is not a good idea for breastfeeding women to lose weight quickly. Rapid changes in weight can affect the amount of milk you make. You will lose weight gradually as you make milk for your growing baby. It is best to make slow changes.

To lose weight safely and slowly limits extra fats and sugars and exercise most days. Skipping meals is not healthy for anyone and can reduce your baby's milk. The more often and longer you breastfeed the easier it is to lose weight.

Q: Can I eat "junk food" while breastfeeding?

A: Eating "junk food," such as sodas, French fries, sweets and chips will not hurt your baby. Breast milk from mothers who eat "junk food" is better for babies than formula.

Eat healthy foods for yourself. You will lose extra weight faster and you will feel less tired

and get sick less often. To make healthier food choices, find out how much fat and sugar is in the foods that you eat. Get quick nutrition information at this web site: www.choosemyplate.gov/SuperTracker/foodapedia.aspx

Q: How much water do I need to drink?

A: Many mothers find they get thirsty when they are breastfeeding, so have a glass of water nearby when you sit down to breastfeed. Let your thirst be your guide. Mothers who drink too much water can lower their milk supply.

Q: Do I need to drink milk or eat dairy foods to breastfeed?

A: You do not need to drink milk or eat dairy foods to breastfeed. You do need foods that are high in calcium and Vitamin D in your diet while you are breastfeeding and all through your life. Dairy foods have a lot of calcium and so do many green leafy vegetables, calcium fortified soy products and canned sardines and salmon. If you do not eat calcium rich foods, ask your doctor about a calcium supplement.

Q: Can I have caffeine when I'm breastfeeding?

A: Drinking no more than two to three 8-ounce cups of coffee early in the day should not affect your baby. If your baby isn't sleeping well or is fussy, cut back on caffeine in coffee, tea, soft drinks, and chocolate. Caffeine can keep you awake, too. Most coffee cups and coffee drinks are larger than 8-ounces (1 cup). Avoid energy drinks.



Q: Is drinking alcohol a good idea when breastfeeding?

A: Alcohol passes into breastmilk. An occasional glass of beer, wine, or other alcoholic beverage is not harmful to most nursing babies. But if you drink more frequently or in large amounts, it can be harmful for you and your baby.

If you do drink alcohol, stop after one drink, and wait at least 3 hours before breastfeeding your baby. One drink of alcohol is 1 beer, 1 ½ ounces alcohol, or 5 ounces wine. If you have one drink and your baby cannot wait 3 hours to feed, feed a bottle of warmed-up breastmilk from the freezer.

If you are not using birth control, do not drink alcohol. It can harm your next baby, even before you know you are pregnant.

Q: Can vegetarians or vegans breastfeed?

A: Yes. You need protein, not animal products and meat to make breastmilk. Vegetarian and vegan women need to be sure to eat foods rich in vitamin B12, vitamin D, and calcium. Sometimes vegetarians need to take a vitamin, so talk to your doctor about taking one that meets your needs.

Q: Does my baby need Vitamin D if I breastfeed?

A: Yes. Breastfed babies should begin taking 400 IU of Vitamin D soon after birth. Talk to your baby's doctor about Vitamin D for your baby as soon as possible. Most breastfed babies do not need any other vitamins.

Q: Do I need vitamins?

A: Everyone who might get pregnant should take 400 mcg of folic acid each day by eating a cereal with 400 mcg or taking a folic acid vitamin. If you think you need other vitamins, talk to your doctor or to WIC staff. Even if you take a vitamin, try to eat different colors and textures of fresh and healthy foods each day.

Q: Can I exercise while breastfeeding my child?

A: Yes. Exercising is part of being healthy. Exercise will not hurt your milk. Remember for your health and safety, start exercising gradually once your doctor says it's OK!

P: ¿Tendré que cambiar la dieta mientras doy pecho?

R: Dar pecho no requiere una dieta especial o comidas diferentes. Todas las mujeres tienen que comer una dieta saludable con una variedad de frutas y verduras, proteínas magras, productos lácteos bajos en grasa y granos integrales todos los días. Las calorías y nutrientes adicionales que necesita son fáciles de obtener cuando come una dieta saludable, come cuando tiene hambre y deja de comer cuando está llena. Puede hacer un plan de comidas personalizado en: www.choosemyplate.gov/supertracker-tools/daily-food-plans/moms.html

P: ¿Puedo hacer dieta para bajar de peso cuando doy pecho?

R: Bajar de peso rápidamente no es buena idea para las mujeres que dan pecho. Los cambios repentinos de peso pueden afectar la cantidad de leche que produce. Perderá peso gradualmente a medida que produzca leche para su bebé. Es mejor hacer cambios lentos. Para perder peso sin peligro y lentamente, limite las grasas y azúcares adicionales y haga ejercicios físicos la mayoría de los días. No es saludable para nadie omitir las comidas, y puede reducir la cantidad de leche que toma su bebé. Si da pecho con más frecuencia y por más tiempo, será más fácil perder peso.

P: ¿Puedo comer comida “chatarra” cuando doy pecho?

R: La comida “chatarra”, como por ejemplo los refrescos carbonatados, las papas fritas, las golosinas y las papitas de bolsa, no dañará a su bebé. La leche materna de mamás que comen comida “chatarra” sigue siendo mejor para los bebés que la leche de fórmula.

Coma alimentos saludables para usted. Perderá el peso de más que tiene más rápidamente y se sentirá menos cansada y se enfermará con menos frecuencia. Para elegir comidas más saludables, averigüe cuánta grasa y azúcar tienen los alimentos que come. Puede obtener información de nutrición rápidamente en este sitio web: www.choosemyplate.gov/SuperTracker/foodapedia.aspx

P: ¿Cuánta agua necesito tomar?

R: Muchas madres descubren que tienen sed cuando dan pecho, así que le conviene tener un vaso de agua cerca cuando se siente a dar pecho. Déjese guiar por su sed. Las mamás que toman demasiada agua pueden bajar su producción de leche.

P: ¿Necesito tomar leche o comer productos lácteos para dar pecho?

R: No tiene que tomar leche o comer productos lácteos para dar pecho. Sí necesita comer alimentos con alto contenido de calcio y vitamina D cuando da pecho, y durante toda la vida. Los productos lácteos tienen mucho calcio, así como muchas verduras de hoja verde, los productos de soja fortificados con calcio, y las sardinas y el salmón enlatados. Si no come alimentos ricos en calcio, pregúntele a su médico sobre los suplementos de calcio.

P: ¿Puedo tomar cafeína cuando doy pecho?

R: Si no toma más de dos a tres tazas de 8 onzas de café por la mañana, su bebé no debería sentir ningún efecto. Si su bebé no duerme bien o está molesto, reduzca la cantidad de cafeína que ingiere en el café, té, refrescos carbonatados y chocolate. La cafeína también puede dejarla despierta a usted. La mayoría de las porciones de café y bebidas de café que compra tienen más que 8 onzas (1 taza). Evite las bebidas energizantes.

P: ¿Es buena idea tomar alcohol cuando doy pecho?

R: El alcohol se pasa a la leche materna. Un vaso de cerveza, vino u otra bebida alcohólica de vez en cuando no causará daño a la mayoría de los bebés que toman pecho. Pero si toma con más frecuencia o en grandes cantidades puede ser dañino para usted y para su bebé.

Si toma alcohol, tome solo una bebida alcohólica y espere por lo menos 3 horas antes de darle pecho a su bebé. Una bebida alcohólica es 1 cerveza, 1 ½ onzas de alcohol o 5 onzas de vino. Si toma una bebida alcohólica y su bebé no puede esperar 3 horas para comer, caliéntele un biberón de leche materna congelada.

Si no está usando métodos de control de natalidad, no tome alcohol. Puede dañar a su próximo bebé aun antes de que sepa que está embarazada.

P: ¿Las vegetarianas y ovo-lácteo vegetarianas pueden dar pecho?

R: Sí. Necesita proteínas para producir leche materna, pero no necesariamente productos

animales y carnes. Las mujeres vegetarianas y ovo-lácteo vegetarianas deben comer alimentos ricos en vitamina B12, vitamina D y calcio. A veces las vegetarianas necesitan tomar una vitamina; puede hablar con su médico para encontrar una vitamina que cumpla con sus necesidades.

P: ¿Mi bebé necesita tomar vitamina D si doy pecho?

R: Sí. Los bebés que toman pecho deben empezar a tomar 400 IU de vitamina D a poco tiempo de nacer. Hable con el médico de su bebé sobre la vitamina D lo antes posible. La mayoría de los bebés que toman pecho no necesitan tomar otras vitaminas.

P: ¿Yo necesito vitaminas?

R: Todas las mujeres que pueden llegar a quedar embarazadas deben tomar 400 mcg de ácido fólico todos los días, ya sea comiendo cereales con 400 mcg o tomando una vitamina de ácido fólico. Si piensa que necesita otras vitaminas, hable con su médico o con el personal de WIC. Aunque tome una vitamina, trate de comer comidas saludables y frescas con diferentes colores y texturas todos los días.

P: ¿Puedo hacer ejercicios físicos cuando le doy pecho a mi hijo?

R: Sí. El ejercicio físico es parte de ser saludable. No dañará su producción de leche. No se olvide, para su salud y seguridad: ¡empiece a ejercitarse de a poco una vez que su médico le dé permiso!

My Birth Plan

(For a normal, full-term delivery)

Name: _____

My plan is to:

- Have my labor start and stop without drugs, unless medically required
- Have my chosen support people stay with me
- Drink clear liquids and eat light foods during early labor
- Move, change positions, take a shower, have a massage and walk, as much as possible during labor
- Have a Heparin Lock versus a continuous drip IV for quick access in case of an emergency
- Hold my baby skin to skin immediately after birth
- Have my baby's tests performed while in contact with me so my baby is not taken from me until after he/she has breastfed
- Have 24 hour rooming in
- Receive help and education to breastfeed successfully
- Have my baby brought to me if for some reason he/she is not in my room and is giving hunger cues, such as sucking hands or making sucking sounds, moving the head towards a person or, in very sleepy babies, eye movements under the eyelids before he/she is crying
- Get an appointment for a health checkup for my baby upon discharge and be given the names of helpers, in case I need help with breastfeeding
- Be given instruction on the use of an electric breast pump if my baby is unable to breastfeed or is separated from me due to a medical condition within 6 hours after delivery

I do not want:

- My bag of waters broken, or to have an episiotomy or other surgery done unless medically necessary
- My baby given a pacifier, bottles, water or formula without my consent and the medical order of his/her doctor

Signature of the patient

Date signed

Copies for MD, hospital, clinic and patient

Mi plan de parto

(Para el parto de un bebé a nacido tiempo completo y saludable)

Nombre: _____

Mi plan es:

- Que mi trabajo de parto empiece y termine sin medicamentos, a menos que sea una necesidad médica. Tener conmigo a las personas de apoyo que escoja.
- Tomar líquidos claros y comer comidas livianas durante las primeras etapas del trabajo de parto.
- Moverme, cambiar de posición, bañarme en regadera, hacerme masajes y caminar todo lo que pueda durante el trabajo de parto.
- Tener una cánula intravenosa en lugar de goteo continuo intravenoso para acceso rápido en caso de emergencia.
- Tener a mi bebé en contacto con mi piel inmediatamente después del nacimiento.
- Que le realicen las pruebas al bebé mientras sigue en contacto conmigo, para que no se lleven a mi bebé hasta después de tomar pecho.
- Tener al bebé en mi habitación las 24 horas.
- Recibir ayuda y educación para dar pecho exitosamente.
- Que me traigan al bebé si por algún motivo no está en mi habitación y da señales de tener hambre, como por ejemplo chuparse las manos o hacer sonidos de succión, mover la cabeza hacia una persona, o en bebés con mucho sueño, movimientos de los ojos debajo de los párpados, antes de que lllore.
- Tener una cita para una revisión de salud para mi bebé al ser dados de alta y conocer los nombres de ayudantes, en caso de que necesite ayuda para dar pecho.
- Recibir instrucciones sobre cómo usar una bomba sacaleches eléctrica si mi bebé no puede tomar pecho o si está separado de mí debido a una afección médica en las primeras 6 horas después del parto.

No deseo:

- Que me rompan la fuente, me realicen una episiotomía u otra cirugía a menos que sea médicamente necesario.
- Que le den un chupón, biberón, agua o fórmula a mi bebé sin mi consentimiento y la orden de su médico.

(Firma de la paciente)

(Fecha)

Copias para el médico, el hospital y la paciente

STEPS TO TAKE

PSYCHOSOCIAL



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(Client Handouts are indicated in bold)

These Steps to Take Guidelines are to be used with your office protocols, which are your facilities' procedures for providers (health ed, nutrition, psychosocial) services and related case coordination.

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The goal of CPSP psychosocial services is to help the client understand and deal effectively with the biological, emotional, and social stresses of pregnancy with the overall aim to improve health outcomes for her and her baby. The psychosocial process assists the woman by providing crisis intervention, community resources, transportation needs, or any psychosocial resource she may need.

The following psychosocial guidelines provide information about several important psychosocial conditions. The guidelines are intended to provide the CPSP practitioner with the tools needed to discuss these topics with clients and make appropriate referrals. *Complex or high-risk conditions require the expertise of a mental health professional.*

Assessment

The initial assessment will help you identify social, emotional, and economic issues and needs that affect the woman and her pregnancy. From the assessment you can help her develop an Individualized Care Plan to deal with these problems. You will also help her identify her own strengths so she can trust her ability to find and carry out solutions.



See the CPSP Provider Handbook for a description of required psychosocial assessment components, components of basic psychosocial care, complex psychosocial conditions warranting specialized care, and required CPSP psychosocial personnel.

Assessment Guidelines

Complete an initial psychosocial assessment on every client within four weeks of entry into care.

If the client declines the assessment, document the refusal in the chart. Offer reassessments at least once every trimester and at the postpartum visit

High-risk clients may need more intervention and may be seen more frequently.

For high-risk clients, see information on the following page.

SeeK help from your supervisor in any case where you think someone has been harmed or is in danger of being harmed. If a supervisor is not immediately available, consult with the health care provider responsible for the client's care.

Get help before the client leaves the office. You don't have to be sure that the situation is dangerous.

When in doubt, check it out.

Some dangerous situations are:

- Someone may be thinking of hurting or killing themselves
- Someone may be thinking of hurting or killing someone else
- Someone may be a victim of physical or sexual assault
- Someone may be pregnant as a result of rape, date rape, or birth control sabotage
- Someone may have a mental problem that makes them unable to care for themselves or puts them in danger
- A child may be a victim of abuse or neglect
- An elder or dependent adult may be a victim of abuse or neglect

Each site will have different ways of handling these situations. Be sure there are written procedures on how your site deals with high-risk cases. All staff should be trained on how to follow the procedures before the possible crisis.

In this section you will find guidelines with suggestions for how to deal with the following high-risk situations:

- *emotional or mental health concerns*
- *depression*
- *child abuse and neglect*
- *spousal/intimate partner abuse*
- *perinatal substance use/abuse*

How early a woman is first seen during the pregnancy will determine her options:

- Before 16 weeks—all options are available
- Between 16 and 24 weeks—abortion needs specialized counseling for the complex psychological and medical aspects involved
- After 24 weeks—abortion is generally not an option. The client needs to consider parenting the child or placing the child for adoption
- Adoption is an option to be considered for a woman of any age, not just a teen

Refer to a health care provider immediately if client needs additional counseling about her choices or wants a TAB.

Steps to Take

Explore Choices

The client may want help to identify what makes her pregnancy unwanted. Reasons may include her:

- Financial situation
- Career, job, or educational plans
- Relationship to the baby’s father or her partner
- Reproductive coercion (putting pressure on a woman to get pregnant against her wishes, which may or may not include birth control sabotage)
- Lack of a support system
- Other family issues (such as other small children at home or disapproval of extended family)
- Age (perceived as either too young or too old)
- Medical problems (either known or feared)
- Substance abuse
- Psychiatric problems
- Lack of emotional preparedness for parenting

Outline the options for her stage of pregnancy and then explore how each could fit into her situation.

Discuss practical and emotional resources that might affect her choice, such as teenage parenting programs, public assistance, prenatal diagnosis of birth defects, and single parent support groups.

Discuss how each option fits with her personal and cultural values and her spiritual/religious beliefs. Find out if there is someone she trusts who can give emotional support during this time.

Background

If the pregnancy is unplanned or unwanted, the client may have many mixed feelings. Her decision to attend this appointment does not mean she has decided to follow through with her pregnancy. If she indicates she is unsure about her pregnancy, she may be struggling with her options. You can help a woman in this situation by outlining all the options available to her. The main options are:

- Having a therapeutic abortion (TAB)
- Placing the child for adoption
- Raising the child

For Teens Under 18 Years

A minor, age 12 or older can receive pregnancy-related care (including abortion) without her parents’ permission, as long as she seems capable of giving an informed consent. This will be determined by the health care provider (doctor or midwife).

A pregnant minor is eligible for a special kind of Medi-Cal called “sensitive services” or “minor consent services.”

Medi-Cal may not contact the parents and the parents’ income is not considered in determining eligibility; only the teen’s own income is counted. Parents are not responsible for payment if the minor seeks and receives services on her own, under this type of Medi-Cal.

Keeping the Baby

Some clients become more attached to the baby later in the pregnancy. Refer her to resources to improve her ability to parent. See the *Parenting Stress Guidelines* and *Financial Concerns Guidelines* sections.

If the client continues to consider the child “unwanted,” help her consider life with the child. She may agree it would be hard to parent an unwanted child. A therapist or counselor can help her explore her feelings in more depth before the baby is born. She may reconsider the option of adoption.

Abortion

If after considering her options, the client wishes to terminate the pregnancy, have the health care provider refer her to the most appropriate medical resource. Encourage counseling before and after the procedure to help manage emotions, provide information about the procedure, and help her understand and cope with her feelings. Counseling will also provide education on preventing future unplanned pregnancy.

If you work in a setting that does not support the woman’s choice to have an abortion, follow your internal policies for such cases.

Adoption

There may be a great deal of pressure on the woman—from her partner, family members, friends, or institutions—to either keep the child or place the child for adoption. Encourage her to make a decision that she believes is truly in her best interest and that of her unborn child. She must live with the decision for the rest of her life.

Give special attention to adolescents, those who have developmental disabilities, those with psychiatric problems, and undocumented women. Women in these groups may be more vulnerable to pressure. Their decision-making skills may be lacking.

There may be sexual abuse involved including forced sex or reproductive coercion (putting pressure on a woman to get pregnant against her wishes, which may or may not include birth control sabotage).

In most cases, the client should discuss her plans with the baby’s father, who is usually required by law to sign papers consenting to the adoption. If he wants custody, he has preference over any potential adoptive parents.

There are a variety of adoption placement arrangements, depending on the wishes of the birth parents and adoptive parents.

Open Adoption

All parties know the identity of the other. They may never meet, meet once, or have ongoing contact. There may be a continuing relationship between the birth parents and child following adoptive placement.

Closed Adoption (confidential adoptions)

Once the most common form of adoption, these are still an option. Birth parents and adoptive parents do not know each others’ identities. Personal and medical history can be exchanged through the agency. Ongoing pictures and letters can also be exchanged through the agency as the child grows.

Agency Adoptions

Agencies are licensed and regulated by the state. They provide the best protection for the birth mother, who is their client, and her child. Families are carefully screened and receive extensive education and counseling regarding the adoption process. Most agencies provide an opportunity for the expectant mother to choose and perhaps meet and interview the potential adoptive family. Many agencies offer financial assistance. All provide counseling.

Inform the woman that she does not have to be sure of her decision before contacting an adoption agency. She can receive special counseling to sort out her feelings without any charge or requirement to place her child for adoption at birth.

Independent (Private) Adoption

Independent (private) adoptions focus more on the needs of the adoptive couple, who are often paying for the services of the attorney or other adoption facilitator. While many satisfactory adoptions happen through the private route, caution your client there is a greater chance that her needs may not be addressed.

If she has already chosen to work with a private, non-licensed resource, honor her decision. You can refer her to an additional legal resource to be sure her legal rights are protected. See the *Legal/Advocacy Guidelines* section. Encourage her to request counseling from a neutral individual—someone who is not employed by the adoptive family or the adoption attorney.

Informal Adoption

Informal adoption takes place when a family member or close associate raises the child. Because this arrangement does not go through the courts, the client's parental rights are not terminated. She keeps her legal rights to care for the child. This is a serious decision that needs careful consideration of the short and long-term effects for the woman and her child. Encourage her to seek counseling during pregnancy to sort out feelings and explore this option. Refer her for legal advice so that she understands the legal consequences of having an informal arrangement for the care of her child.

Adoption — Other Considerations

The State Department of Social Services must approve all adoptions, whether private or agency. The State Department of Social Services will interview both the birth parents and adoptive parents. The adoption is not final until granted by a judge in a court of law.

Native American clients: Federal rules apply when placing Native American babies for adoption. Call a local Native American community agency, the adoption division of your county's social services department, or a legal resource for more information.

You must act as an advocate for your pregnant client, not for a person or couple wanting to adopt or an attorney. Help the client explore her feelings about the pregnancy. Refer her to appropriate adoption resources. When her decision is made, be sure her choices are honored and her plan is carried out.

Follow Up

Continue to support her choice. Inquire about the results of any referrals made at previous visits. Assess the need for additional resources.

Be sure she receives a referral for family planning services so she can avoid an unwanted pregnancy in the future.

Referrals

- Medical resources for pregnancy termination
- Individual counseling
- Adoption resources
- Parenting resources (See *Parenting Stress Guidelines* section)

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Uncertain About Pregnancy?

Women often have mixed feeling when they are faced with an unplanned pregnancy.

Any decision you make—keeping the baby, having an abortion, or planning an adoption—will come with changes in your life.

If you are involved with the baby's father, it may be helpful to talk with him about your feelings regarding your options. He may also have strong feelings about the pregnancy.

You will actually be making two decisions if it is early in the pregnancy:

- Do I want to continue the pregnancy?
- Do I want to parent a child?

Ask Yourself These Questions

- Am I able to give a child what he/she needs—emotionally and financially?
- Will I have to count on my parents or family for help? Are they willing and able to do so? Will they pressure me to do what they want?
- Can I raise a child and meet my own needs: Finishing school? Supporting myself? Starting a career?
- Am I ready to become a parent on my own? Will the baby's father be there for me now or in the future?
- What kind of help can my husband/baby's father give me? Financial? Emotional? Will he help me care for the baby?
- Am I too young or too old to have the responsibility of a baby?
- Do I have problems, like drinking or using drugs, which will keep me from being the kind of parent my baby needs?
- Will my religious or cultural beliefs influence what choice I make?

Las mujeres a menudo sienten una mezcla de emociones cuando tienen un embarazo no planificado. *Cualquier decisión que tome - quedarse con el bebé, tener un aborto o planear una adopción - será difícil y resultará en grandes cambios en su vida.*

Si está de novia con el padre del bebé, quizás le ayude hablar con él de lo que piensa sobre las distintas opciones. Él también puede tener sentimientos fuertes sobre el embarazo.

En realidad estará tomando dos decisiones, si es suficientemente temprano en el embarazo:

- ¿Quiero continuar con el embarazo?
- ¿Quiero ser la mamá de un niño?

Hágase estas preguntas

- ¿Puedo darle a un niño lo que necesita, tanto emocional como económicamente?
- ¿Tendré que depender de mis padres o de mi familia para que me ayuden? ¿Estarán dispuestos a ayudarme y pueden hacerlo? ¿Me pondrán presión para hacer lo que quieren ellos?
- ¿Puedo criar a un niño y atender al mismo tiempo mis propias necesidades? ¿Terminar la escuela? ¿Mantenerme? ¿Empezar una carrera?
- ¿Estoy preparada para ser una madre soltera? ¿El padre del bebé estará presente para ayudarme ahora o en el futuro?
- ¿Qué tipo de ayuda me puede dar mi esposo/el padre del bebé? ¿Ayuda económica? ¿Ayuda emocional? ¿Me ayudará a cuidar al bebé?
- ¿Soy demasiado joven o demasiado vieja para asumir la responsabilidad de tener un bebé?
- ¿Tengo problemas, como el uso de alcohol o drogas, que impiden que sea el tipo de madre que necesita mi bebé?
- ¿Mis creencias religiosas o culturales influirán en la elección que tome?



You are pregnant and unsure what you want to do. If it is still early in the pregnancy, you have three choices: keep the baby, have an abortion, or plan an adoption. It is important to talk with a counselor about your choice.

Keeping the baby is:

- Accepting at least 18 years of responsibility for a child
- Giving up your freedom in order to meet your child's needs
- Changing your social life, your sleep patterns, and your daily schedule
- Having patience and love to deal with the 24-hour-a-day needs of your baby
- Adjusting both your education and career goals with your baby in mind

Abortion is:

- Ending the pregnancy
- Having an outpatient surgical procedure, done early in the pregnancy
- Going through both physical and emotional changes after the procedure
- A decision that you may feel both relieved and sad about

Adoption is:

- A loving but difficult choice that means giving birth without parenting
- Choosing between two types of adoption

Open adoption means:

- Choosing the family, meeting them, and maybe spending time with them
- Perhaps having the family help you with medical care and other needs
- Continuing contact with them after the baby is born if you desire

Closed/private adoption means:

- Not meeting the family who adopts the baby
- Perhaps having the family help you with medical care and other needs
- Not having ongoing contact with them or the baby

Está embarazada y no está segura qué quiere hacer. Si su embarazo es reciente, tiene tres opciones: quedarse con el bebé, tener un aborto, o planear una adopción. Es importante hablar con una consejera sobre su elección.

Quedarse con el bebé significa:

- Aceptar la responsabilidad por el niño durante por lo menos 18 años.
- Poner a un lado su independencia, para poder cumplir con las necesidades de su hijo.
- Cambiar su vida social, sus hábitos de sueño y su vida cotidiana.
- Tener la paciencia y el amor necesarios para lidiar con las necesidades de su bebé las 24 horas al día.
- Modificar sus metas educativas y de carrera con su bebé en mente.

Un aborto significa:

- Dar por terminado el embarazo.
- Hacer intervención quirúrgica como paciente externa al principio del embarazo.
- Pasar por cambios físicos y emocionales después de la intervención.
- Una decisión que le puede producir sentimientos de alivio y tristeza a la vez.

La adopción significa:

- Una opción compasiva pero difícil, que significa dar a luz sin criar al bebé.
- Escoger entre dos tipos de adopción.

La adopción abierta significa:

- Escoger a la familia, conocerlos y posiblemente pasar tiempo con ellos.
- Posiblemente recibir ayuda de la familia con su atención médica y otras necesidades.
- Seguir en contacto con la familia después de que nazca el bebé, si lo desea.

La adopción cerrada o privada significa:

- No conocer a la familia que adopta al bebé.
- Posiblemente recibir ayuda de la familia con su atención médica y otras necesidades.
- No tener más contacto con la familia ni con el bebé.

Background



A woman may experience a perinatal loss at any stage of her pregnancy. Common terms for such loss are:

- **Miscarriage;** fetal death before 20 weeks gestation
- **Stillbirth;** after 20 weeks
- **Neonatal death or newborn death;** the death of an infant after birth
- **Abortion;** another kind of loss, especially if the procedure is done because a fetus has genetic or other severe abnormalities

Sometimes a pregnancy will progress normally but a loss will occur at labor and delivery. This can happen at preterm births or at the end of a full-term pregnancy.

Each person experiences perinatal loss in a unique way. Although the situations and reactions differ, many of the issues surrounding different kinds of loss are similar.

Families from different cultures will have different attitudes toward the death of an infant, an autopsy, preferences for burial, and normal expressions of grief. If you are not familiar with a client's beliefs, customs, or rituals, let her know. Ask if she feels comfortable sharing them with you.

Refer immediately to the health care provider if the woman is severely depressed and/or has made statements about hurting herself.

Steps to Take

When the loss is suspected during the pregnancy, help the client find a support person to accompany her for the tests to check on the fetus.

If the diagnosis is confirmed and the fetus is dead, the woman and her partner may need a period of privacy to express shock and disappointment. You can help in the following ways:

- Remain available to offer support when the woman and her family are ready
- Be prepared for anger and hostility, a common reaction for parents who need to identify a cause for their tragedy
- Give factual information about causes
- Acknowledge their feelings of fear and anxiety and allow them to express negative feelings
- Encourage additional support from family, friends, or someone from their religious or spiritual community
- When the family is ready, help them prepare for the many decisions that need to be made

Assist the family in preparation for the upcoming labor and delivery. This may include:

- What to take to the hospital
- Arranging for care of other children
- Childbirth preparation and techniques

Outline possible options for contact with the baby following delivery. For example:

- Seeing the baby
- Holding, bathing, or dressing the baby
- Naming the baby
- Taking pictures
- Saving mementos such as foot and hand prints or a lock of hair
- Planning a funeral or memorial

At first, parents may say they don't want any contact with the dead baby, but this is often the first step in acknowledging their loss. You may say something like: Many parents find it helpful to say goodbye to their baby.

Contact social service staff at the delivery hospital to alert them to the family's need for services during the mother's hospitalization. Ask if the woman can be moved from the maternity unit following delivery, to avoid contact with other mothers and their newborns. Following her discharge, re-contact the hospital to coordinate any follow-up plans.

Follow Up

Try to schedule the postpartum visit so the grieving family will not be in contact with pregnant women and newborns. Inform clinic staff, both health care and clerical, of the perinatal loss so they can express sympathy or at least not ask about the baby.

Some staff often feel uncomfortable with the grieving family. Be aware of your own feelings and urges to avoid the family. Nonverbal body language and simple expressions of concern are usually much appreciated.

Assessment and Ongoing Help

Allow the family to describe their experiences at the hospital and after discharge. Retelling the story may help them feel it really happened.

Evaluate symptoms of grief:

- Lack of appetite
- Inability to return to normal activities (such as taking care of other children, working, socializing with others, etc.)
- Irritability and anger
- Difficulty concentrating
- Sleep disturbances (not being able to sleep, sleeping too much, having nightmares)
- Apathy (not caring about anything)
- Fatigue (tiredness)
- Unable to think about much else besides images of the baby or hearing the baby cry
- Flashbacks
- Crying

These symptoms are common in the early stages of grief. Assess clients who appear severely depressed or not able to function as usual for suicide potential. Refer for counseling. See the *Depression Guidelines* section for further information.

Evaluate the client's social support system. Assess for conflict between the woman and her partner and the reaction from family members and friends. The mother and father may handle the loss quite differently. The woman may be focused on the loss of her baby, while her partner may be more concerned with her health and emotional wellbeing.

Family and friends may be supportive during the early weeks of the loss, but may then urge the mother to put the loss behind her and get on with her life.

Refer the client to a support group for parents who have suffered a similar loss.

If the family has other children, find out the children's attitude toward the pregnancy and understanding of the death. Then, in most cases, the following points can be made:

- No one is to blame for the baby's death
- No one intentionally harmed the baby
- No one else in the family is in danger of dying from the baby's illness

Siblings sometimes feel jealous during their mother's pregnancy and even wish the baby would die. Such children need to understand that their wishes did not cause the baby's death.

Help the family understand the medical causes of the baby's death, if known. Help them ask appropriate questions of the medical staff regarding the autopsy and other diagnostic tests.

Determine the parents' level of understanding of the explanations given. Many parents will blame themselves for the death. Sometimes, the mother may be blamed by her family and friends for causing the loss of the baby.

They may also blame the medical staff. If they have concerns about the kind of care that they received, encourage them to discuss it first with the health care provider. Provide them with a legal referral if they need advocacy.

Help the family discuss future pregnancies. The medical staff will advise when it is okay to attempt another pregnancy. Parents may have strong negative or positive feelings about future pregnancies.

Often families find it helpful to wait until the intense period of mourning is completed, usually about a year. The next pregnancy may be especially stressful and best attempted when the couple feels emotionally strong.

Reassure the parents that the pain will eventually lessen, though the loss will always be a part of them. The pain may reappear at different times, but will eventually lessen. Anniversaries of the baby's birth and death often bring back feelings of grief.

Ongoing support during the year following the loss can greatly help the family. Schedule additional psychosocial visits or continue contact by phone if needed. Encourage the family to use bereavement services in the community.

Explain that if the parents' feelings of grief and social functioning are not greatly improved by three months following the baby's death, they should seek counseling.

Complicated Situations

Teens or developmentally delayed women who have lost a baby may need special attention. They may not have the support of a partner and may get the message from family, friends, and professionals directly or indirectly that "it is for the best." Acknowledge the client's loss and give her permission to grieve like any other woman who has had such a loss. She may also be unfamiliar with the biology of her pregnancy and may need extra help in interpreting medical explanations for the death.

Substance abusers who may actually have contributed to the loss through their drug use have special issues. Some friends, family, and medical professionals may treat them harshly. These women may feel guilty. Encourage the woman to forgive herself. She cannot change the past, but she can change the future by accepting a referral for substance abuse treatment. Refer her to counseling or someone from the religious community, if appropriate. See the *Perinatal Substance Use/Abuse Guidelines* section.

The grief of a **battered woman** may be complicated by anger at the abusive partner and her guilt for not protecting the child. Acknowledge that she can't change the past, but she can change the future. She may be ready to take steps to leave the abusive situation. See the *Spousal/Intimate Partner Abuse Guidelines* section.

If the pregnancy was **unplanned and unwanted**, the loss may be seen as a relief by some women. Such women may have conflicting feelings about the loss and experience both positive and negative feelings. Help her explore both.

If the perinatal loss was the result of an **abortion** because of fetal abnormalities, the grief may be complicated by guilt over the decision and feelings of shame for having produced an imperfect child. Ask a genetics counselor if there is a special grief support group or counseling for such women and their families.

Referrals

- Perinatal loss support group or other bereavement services (Call the delivery hospital social worker for a referral)
- HAND: Help After Neonatal Death (www.handonline.org)
- Individual or couple's outpatient counseling
- Psychiatric evaluation
- Hospice grief counseling programs (some have fetal/infant loss groups)
- Suicide Prevention Hotline
- The family's minister, priest, rabbi, or spiritual advisor



You've lost your pregnancy or your baby has died. You may be feeling sad, angry, helpless or numb. You may be thinking:

- *Why me?*
- *Why did it happen?*
- *What did I do to cause it?*
- *It's not fair!*

You may have physical as well as emotional pain. **Some of the emotional pain may always be with you, as will the memory of your baby.**

Having Another Baby

After losing a baby, there may be a strong desire to become pregnant again, or your partner may try to ease his grief by pressuring you to have another baby right away. A new baby will not replace the baby you lost. Doctors recommend waiting at least 18 months between pregnancies. This gives your body time to recover fully and be ready to have another baby. Ask your health care provider since he or she knows you best. In the meantime, use a reliable method of birth control, get plenty of rest, and eat well.

Grief Process

You will go through a grieving process because of the loss. There will be many emotional ups and downs. It is necessary to grieve so you can move on to feeling better. These are feelings you may experience at different times:

Shock and Denial: *This can't be happening to me.* You may have trouble believing you lost your baby.

Anger: *Why me?* You may be angry with the doctor, your family, your partner, or everyone. You may resent other people who have a baby.

Sadness and Depression: *What's the use? It's not fair that my baby died. My dreams are gone. Life is meaningless.* If you are severely depressed and are having suicidal thoughts, it is important to seek help immediately by telling your medical providers or by calling 911.

Acceptance: *I can go on. I can't change it. I will accept it.* You may start to have energy. You can have a good time without feeling guilty.

Perdió su embarazo o murió su bebé.
Puede sentirse abrumada, desamparada o insensibilizada. Puede estar pensando:

- *¿Por qué a mí?*
- *¿Por qué ocurrió?*
- *¿Qué hice para causarlo?*
- *¡Es injusto!*

Puede sentir frustración, enojo y amargura.
Puede tener dolor, tanto físico como emocional. **Puede ser que siempre lleve consigo algo del dolor emocional, así como la memoria de su bebé.**

Tener otro bebé

Después de perder a un bebé, hay un fuerte deseo de volver a quedar embarazada. Su pareja puede intentar aliviar la pena poniéndole presión para tener a otro bebé de inmediato. Un bebé nuevo no reemplazará al bebé que perdió. Los médicos en general recomiendan esperar por lo menos 18 meses entre embarazos. Esto le da tiempo al cuerpo para recuperarse del todo y estar listo para tener otro bebé. Háblelo con su proveedor de atención de la salud. Mientras tanto, use un método de control de natalidad confiable, descanse mucho y coma bien.

Proceso de duelo

Pasará por un proceso de duelo porque perdió no solo a su bebé sino también a una parte de sí misma. Tendrá muchos altibajos emocionales. Necesita pasar por el proceso de duelo para salir adelante y sentirse mejor. Estos son unos sentimientos que puede tener en distintos momentos:

Conmoción y negación: *Esto no me puede estar pasando.* Le puede resultar difícil creer que perdió a su bebé.

Ira: *¿Por qué a mí?* Puede estar enojada con el médico, con su familia, con su pareja o con todo el mundo. Puede sentir resentimiento hacia otras personas que tienen un bebé.

Tristeza y depresión: *¿Para qué sirve? Es injusto que haya muerto mi bebé. Mis sueños se esfumaron. La vida no tiene sentido.* Si está muy deprimida y tiene pensamientos suicidas, es importante decírselo a sus proveedores de atención de la salud.

Aceptación: *Puedo seguir adelante. No lo puedo cambiar. Lo aceptaré.* Puede empezar a tener energía. Puede pasarla bien sin sentirse culpable.



Ways to Remember Your Baby

For some women, it is important to create a permanent memory of their loss baby. If a client chooses to do so, here are some suggestions.

Ways to Remember your Baby

- Start a memory box, and put into it, any of the baby's belongings, such as a rattle, blanket, or ultrasound picture. Include items from the hospital such as photos, a lock of hair, or footprint.
- Plant a rosebush or tree in memory of the baby
- Have a plaque engraved with the baby's name and birth date
- Write a letter to your baby
- Buy a porcelain or ceramic angel in memory of your baby
- Order a charm with the baby's birth date to wear on a chain
- Recognize the anniversary of your loss with a special yearly ceremony

Ways to Help Yourself

- Be gentle and kind to yourself
- Consider counseling or a support group
- Talk to a friend who cares about you
- Remember that crying and sadness are a part of the grieving process
- Don't make any big decisions right now because it is okay to wait a while
- Focus on getting through one day at a time
- Talk to your health care provider, pastor, priest, rabbi, or spiritual advisor about your loss



Maneras de recordar a su bebé

- Haga una caja de memorias, y coloque en ella cualquiera de las pertenencias del bebé, como por ejemplo un sonaja, una cobijita o imagen de ultrasonido. Incluya objetos del hospital, como las fotos, un mechón de pelo o la huella del pie.
- Plante un rosal o árbol en memoria del bebé.
- Mande a hacer una placa grabada con el nombre y fecha de nacimiento del bebé.
- Escríbale una carta a su bebé.
- Compre un ángel de porcelana o cerámica en memoria de su bebé.
- Compre un dije grabado con la fecha de nacimiento del bebé para usar con una cadena.
- Conmemore el aniversario de su pérdida con una ceremonia anual especial.

Maneras de ayudarse a sí misma

- Sea compasiva y paciente con sí misma.
- Considere la posibilidad de asistir a consejería o un grupo de apoyo.
- Hable con una amiga que la quiere.
- Recuerde que el llanto y la tristeza son parte de perder a un ser querido.
- No tome decisiones importantes ahora; está bien esperar un poco.
- Concéntrese en superar día con día.
- Hable sobre su pérdida con su proveedor de atención de la salud, pastor, cura, rabino o asesor espiritual.

Background

A birth defect is a physical or mental abnormality present from the time of birth. It can be a major problem such as missing portions of the brain or a relatively minor one, such as an extra finger. The defect may not interfere with the normal life of the individual, can greatly affect his or her life, or even lead to death. Some birth defects can be corrected while others have no effective treatment.

Types of Abnormalities

Structure: the way the body is made. A body part may be missing, misshapen, or duplicated. Examples are open spine (spina bifida), water on the brain (hydrocephalus), clubfoot, cleft lip or palate, extra fingers or toes, and dwarfism.

Function: the way one or more parts of the body work. It may be related to a chemical deficiency. Examples are color blindness, muscular dystrophy, and some mental defects.

Metabolism: the way the body changes certain chemicals into others. For example, a child with galactosemia is unable to produce a substance needed to break down milk sugar. Other examples include PKU (phenyl-ketouria) and Tay-Sachs disease.

Blood: problems with being able to carry out its normal duties due to a reduced or missing blood component. Examples include sickle cell anemia, hemophilia, and thalassemia.

When defects commonly occur together, they are called a syndrome. For example, Down syndrome and fetal alcohol syndrome are both conditions in which there is mental retardation together with typical structural defects.

Refer to a supervisor immediately if you suspect that a baby has a birth defect.

Causes of Birth Defects

Birth defects have several causes:

- Genetic
- Environmental
- A Combination of Both

Genetic Birth Defects

A genetic birth defect is present from the time of conception. It can be caused by a mistake during the development of the sperm or egg that forms the fetus. The birth defect may never have occurred in the family in the past. An example of this would be Down syndrome. Or the birth defect can be inherited from either the father or the mother. The trait will have occurred before in the family and may be from either parent or both. The parent who passed the trait to the child inherited it from his or her parent or parents. Color blindness and hemophilia are examples of birth defects inherited from either the mother or the father.

Environmental Birth Defects

An environmental defect is one that occurred sometime during the pregnancy or delivery because of some influence from outside the baby's body. Generally the effect is greater earlier in the pregnancy when the growth of the fetus is very rapid and the major body parts and systems are taking shape. This can happen as a result of the mother getting sick, taking harmful drugs, or eating poorly.

For example, rubella (German measles) early in pregnancy can cause deafness, heart defects, eye problems, and nervous system damage in the baby depending on when the mother becomes ill during the pregnancy. Sexually transmitted diseases such as syphilis, gonorrhea, or herpes can cause severe

mental or physical damage to the baby. Alcohol, tobacco, some prescription drugs, and “street drugs” can damage the developing fetus. Poor maternal nutrition can cause fetal malnutrition and poor mental and physical development in the baby.

Birth Defects Caused by Genetic and Environmental Factors

Most birth defects are thought to be caused by a combination of genetic and environmental factors. How strongly a child may be affected by an environmental cause, for example, may depend on his or her genetic background. Many normal babies may be born to mothers who took a certain drug during the pregnancy. Possibly these children inherited a greater resistance to the drug than did children who were born with negative effects.

Each year as many as 250,000 babies are born with birth defects in the United States. The most common birth defects result from **being born prematurely**.

These babies have immature organs unready to function outside the mother’s womb. **Malformations** of the heart are the second most common.

Some birth defects are more common in **certain populations**, such as sickle cell anemia in the African American community. California has a Birth Defects Monitoring Project, which keeps track of patterns of birth defects within the state.

Cultural Views of Birth Defects

Different cultures have their own beliefs about what causes certain birth defects. A defect may be seen as a parent’s punishment by God for previous sins or the work of an evil spirit or other supernatural powers. To the client, these views are as believable as the medical explanation.

Language to Describe Birth Defects

A variety of words can describe children with birth defects. Some are *disabled, handicapped, retarded, delayed, impaired, disordered, challenged, exceptional,*

or special. The general public uses certain words; medical or legal professionals use others. Some words used in the past such as *crippled* are no longer used. The client may have her own words to describe the disability.

Today we are urged to use language that shows respect for the person’s strength and individuality, such as *a person with a disability* rather than a disabled person. **This acknowledges that the individual is a person first and someone with a disability second.**

Treatment of Birth Defects

Few birth defects can be completely corrected. However, available treatments can slow, stop, or partially reverse harmful effects. These include:

- **Corrective surgery** for structural defects such as cleft lip and palate, clubfoot, and various heart malformations
- **Chemical treatment** by drugs, hormones, or vitamin and dietary supplements or restrictions; for example insulin for diabetes and protein substitute for PKU
- **Prostheses** such as hearing aids and mechanical hands
- **Transplants** such as corneas, kidneys, and bone
- **Rehabilitative training** to deal with mental, physical, and sensory handicaps

Prevention of Birth Defects

Some birth defects can be prevented. Encourage the woman to keep all her prenatal care appointments, follow nutrition guides, and avoid harmful substances such as alcohol, tobacco, and other drugs.

More Information on Birth Defects

Contact your local **March of Dimes** to receive client education materials on birth defects.

What to Look For

Prenatal Diagnosis

If the client has had a previous child with a mental or physical problem, the health care provider may suggest **genetic counseling**. A genetics counselor will ask questions about the health of each parent's family. The counselor will try to determine if the birth defect is the result of genetic or environmental factors and give an idea of how likely the same problem will occur in other children. The counselor helps parents make informed decisions and shares community resources.

Genetics counseling is available through **Prenatal Diagnostic Centers (PDCs)** located throughout California. The Genetic Disease branch of the California Department of Health Care Services approves these centers. Depending on her insurance, prior approval may be required. Call 1-916-445-4171 for more information.

Tests that can identify possible problems include:

Amniocentesis: A hollow needle is inserted into the pregnant woman's uterus to draw out some fluid surrounding the fetus. The test is usually done between 15 and 24 weeks of pregnancy. Cells from the fluid, or the fluid itself, are analyzed. Analysis can detect genetic and metabolic disorders.

Chorionic villus sampling (CVS): Cells from the developing placenta are obtained early in pregnancy, usually between 10 and 12 weeks. Analysis can detect genetic and metabolic disorders.

Blood tests: Blood tests of the mother or fetus, such as the Expanded AFP blood test is usually done between 15 and 20 weeks.

Sonograms: The mother's abdomen is scanned with high frequency sound waves to determine fetal position, head size, and rate of fetal growth and development. With a sonogram the physician may suspect or confirm a birth defect, such as missing limbs and malformed internal organs.

Women with no previous history of babies with birth defects are also offered some of these tests. The tests are optional and each woman should be counseled as to the advantages and disadvantages of taking these tests. See the "First Steps" introductory chapter *Decision Making Guidelines* section.

Suspected Problems

If a birth defect is suspected, further tests may confirm the diagnosis, but often the infant's full condition cannot be known until after birth. The period of waiting is often difficult. Her reactions may include shock, disbelief, anger, sadness, and guilt. She may wonder what she might have done to cause the problem. Family and friends may also blame her. Until the diagnosis is confirmed, she and her family will have to cope with the anxiety of facing the unknown.

Confirmed Problems

Early in the pregnancy the mother may have the same basic decisions as in an unwanted pregnancy: abortion, raising the child, or making an adoption plan for the child. Later in the pregnancy, abortion is not an option. The family will have the two remaining options.

Termination Due to Birth Defects

A genetic counselor can help clients considering therapeutic abortion to understand the diagnosis of the fetus and choose among available options. This is an opportunity to evaluate their personal and religious values and to learn more about services for the child should they decide to continue the pregnancy. See *Unwanted Pregnancy and Perinatal Loss Guidelines*.

Voluntary Placement of Child in the Child Welfare System

Some families will decide they cannot care for a child with birth defects. They may need temporary or long-term relief from the care of the child by voluntarily placing the child outside the home, in a state-licensed residence or in a foster home. Parents might also choose to place the child for adoption with another family. These decisions cannot be made until after the birth of the child, but can be explored prenatally. After delivery, their options can be evaluated with a local child welfare agency.

Raising the Child

Over the last 20 years there has been increased interest in helping people with disabilities participate more fully in community life. Far more children with birth defects are being raised in their own families instead of being placed in institutions. Many community-based services are now available to help the family meet the child's special needs.

Postpartum Diagnosis

A great many birth defects will not be discovered until after the baby is born. Some birth defects may be quite obvious at the time of delivery, such as club foot or Down syndrome. Some birth defects will not be discovered until the baby grows or when the child enters school, such as a baby whose mother took drugs during her pregnancy.

Steps to Take

When there is suspicion of a birth defect:

- Help the client find a support person to accompany her to the tests that have been suggested to check on the fetus
- Help the family understand what is suspected about the baby's condition. Help them ask appropriate questions of the medical staff. Determine the parents' level of understanding of the explanations they are given.
- Acknowledge their feelings of fear, anxiety, and grief
- Remain available to offer support
- Assess the strengths within the family. Encourage contact with supportive family members, friends, or someone from their religious or spiritual community.
- Talk to the family about a referral to a social worker or other mental health professional

Follow Up

When the birth defect is confirmed:

- Remain available to offer support when the family is ready
- Be prepared for a range of emotions--anger, sadness, fear, confusion
- Allow them to express their feelings
- Assess for feelings of depression. See the Depression Guidelines section for suggestions.
- When the family is ready, help them prepare for the decisions that need to be made by prioritizing what needs to be done first and what can wait until later.

- Help the family prepare for the birth of the baby. Encourage them, if possible, to tour the hospital and meet the staff. It might be helpful to visit the Newborn Intensive Care Unit and get used to the policies and equipment. Be sure the family has a referral for specialized pediatric care.
- Ask if they want to talk to parents of a child with a similar condition. A network of family resource centers can be found by contacting your community's Early Intervention Program. See Referrals below.
- Contact social service staff at the delivery hospital to alert them to the family's need for services during the mother and baby's hospitalization. Following discharge, call the hospital to coordinate follow-up plans.

Postpartum Diagnosis

- Some birth defects are not known until after the birth of the baby. Hopefully you've been told of the baby's condition before you see the mother for her postpartum visit, and if so, you can be better prepared to deal with the family's psychosocial concerns.
- Refer to *Perinatal Loss Guidelines* which have suggestions on dealing with grief. Although the baby may be alive, some families experience a birth defect as a significant loss
- Assess for feelings of postpartum depression, which may be increased by having a child with birth defects. Refer to the Depression Guidelines section.
- Find out how the rest of the family, including children, is reacting to the baby
- Encourage the parents to take advantage of any early intervention programs in their community to help the child reach his or her full potential
- Discuss respite care for those families who desire a break from caring for - the baby. The early intervention program may help them find a

babysitter who is willing and able to care for a child with special needs.

- Try to point out the baby's positive features or strengths instead of focusing only on his or her defects

Referrals

Genetics Counseling

A genetics counselor can assist the family during their current crisis and help the family make decisions about future pregnancies.

Regional Centers

Every part of California is served by a Regional Center, a private, nonprofit agency funded by the state to provide services to people with developmental disabilities from birth throughout his or her lifetime.

The Center serves people who:

- Are developmentally delayed
- Have cerebral palsy
- Have epilepsy
- Are autistic
- Have similar disabilities

The Regional Center's staff of doctors, nurses, social workers, psychologists, and other specialists help determine the problem, provide referrals for infant development programs, residential facilities, respite care for caregivers, and may help pay for some services.

Early Intervention Programs

In California there is a statewide program of comprehensive services for infants and young children under 3 years who are:

- Handicapped
- Experiencing delay in reaching developmental milestones or at risk of developing handicapping conditions

Early intervention services help lessen the impact of the disability. They may include family training, special instruction/education, occupational or physical therapy, psychological services, case management services, medical screenings, assessments, and other related services based on the needs of the child and the family. Call your county health department to locate the early intervention programs in your area.

Support Groups for Families with Special Needs

Some communities have groups that meet regularly to explore feelings, share problems and concerns, and learn more about how best to care for their children. Some groups deal with a single problem such as parents of blind children. Others include families with children who have a range of conditions such as parents of children with genetic disorders. Some are designed for siblings of children with birth defects.

California Children's Services (CCS)

Serves children under the age of 21 who have:

- A handicap requiring orthopedic treatment or plastic surgery
- Heart disease
- Epilepsy
- Cystic fibrosis
- Vision problems that require surgery
- Hearing problems
- HIV infection
- Blood diseases

CCS can provide:

- Diagnosis of the problem
- Help in finding appropriate health care
- Help with financial planning
- Fund some or all of the medical care

Supplemental Security Income (SSI)

See the *Financial Concerns Guidelines* section.

Disabilities Rights Advocates

Numerous local, state, and federal laws affect people with disabilities. Many of them were designed to protect rights and guarantee services. If the family wants to know more about their legal rights, refer them to a legal resource that can help them. You may be able to find one that specializes in the rights of the disabled. See the *Legal/Advocacy Guidelines* section.

Services for Parents in General

- Parenting classes/support groups
- Single parent groups
- Family support centers
- Respite care (short term, occasional child care)
- Parental stress line (sometimes called a "hotline" or "warmline")
- Family or marriage counseling
- Public health nursing
- Child abuse prevention programs
- Parent aide home visiting programs
- In-home family preservation programs
- Other programs in your community that help parents under stress
- Perinatal loss support groups

Complicated Situations

If the mother uses drugs or alcohol her child will be at higher risk for birth defects. See *Perinatal Substance Use/Abuse Guidelines* for additional suggestions.

The client whose child has birth defects may be at higher risk for depression. See the *Depression Guidelines* section for additional suggestions.

Parents of a child with birth defects may experience more stress. See the *Parenting Stress and Child Abuse and Neglect Guidelines* section for more information.

Background

The CPSP client will often have many financial concerns. Although you may not be able to solve all of her financial problems, you may be able to help in some areas. This may relieve some of her stress. You may also help her gain skills that she can use after the baby is born to get help for herself and her family.

Check with the resources in your county to find out eligibility requirements, application procedures, and what the client needs to bring to her first appointment.

Rules and regulations for public benefits programs constantly change. Legislation may greatly change what programs are available to the CPSP client and her family. Try to keep up with current changes that affect your clients. When in doubt, seek advice from a welfare rights advocate. Refer to the *Legal/Advocacy Guidelines* section.

An excellent source is *The Peoples' Guide to Welfare, Health and Other Services in Los Angeles County*. This guide has information about many statewide programs such as CalWORKs, SSI, WIC, CalFresh benefits, etc., and is accurate and up-to-date. The Guide is available in both English and Spanish, can be viewed and downloaded at https://d3n8a8pro7vhmx.cloudfront.net/hungeractionla/pages/28/attachments/original/1423592735/2015_English_Peoples_Guide.pdf or can be ordered for a small fee.

Nonprofit community agencies that help low income people may also change. Be sure to keep your referral lists up-to-date.

A client may have many different financial concerns. This guideline will address: **cash assistance, housing, utilities, food, clothing, and baby supplies**. It will also cover the two main kinds of financial concerns: **emergency and non-emergency**.

Refer to supervisor immediately if you're unable to find emergency shelter or food for a client.

Steps to Take

When a client tells you she has financial concerns, ask questions that will give you a better idea of the situation. *Is this an emergency? Does she have a place to sleep tonight? Is there food in the house? Does she have diapers?*

Refer her to the appropriate community resource to help her with her immediate problem. Emergency resources are often hard to locate. Sometimes great patience and repeated efforts are necessary to find help for the family.

Referrals for Cash Assistance

CalWORKs (California Work Opportunity and Responsibility to Kids)

CalWORKs is a welfare program that gives temporary cash aid and services to eligible families with children under 19 years old. County welfare departments operate the program locally. It replaces the former AFDC (Aid to Families with Dependent Children) program.

Qualifying for Cash Aid

Children, and the adult relatives who care for them, may be eligible to get cash aid. Both single parent and two-parent families may qualify if there is a child with a deprivation (the death of a parent, incapacity of a parent, absent parent, or unemployed or under-employed parent).

Applicants for cash aid must meet income limits. Some sources of the family's income are counted, such as wages, and others are not counted such as SSI/SSP payments, tax refunds, and most student loans and grants.

The family must also meet limits on property and other resources. Again, some property is counted such as cash on hand, savings, and stocks and bonds.

Some property is not counted such as a home if lived in by the family, or personal items such as furniture, appliances, and tools needed for work.

A pregnant woman with no other children on CalWORKs can start receiving cash aid in the third month prior to the month of the anticipated birth. She will get a grant for one person and a small amount for the unborn child called a “special need payment.” If she has other children on CalWORKs, she can get the special need payment from the date of the pregnancy verification until the baby is born. She can get Medi-Cal immediately.

Pregnant teens with no other children can get cash aid, from the date of the application with proof of pregnancy. However, they must participate in the Welfare-to-Work Teen Parent Program to earn a high school diploma or the equivalent unless they are exempt. Refer the client to the local Welfare-to-Work Teen Parent program.

If she has never been married, she must live with her own parent, a guardian or another adult relative, or in an adult-supervised arrangement in order to qualify. If living with her parent(s), their resources and income would be considered in determining eligibility for the teen but not the unborn child. There are a few exceptions to this rule.

If the pregnant woman is undocumented or receives SSI and has no other children on CalWORKs, she must wait until the child is born to get benefits for the baby.

The rules and regulations are complicated and often change. Trained staff will determine if the family qualifies.

Time Limits for Cash Aid

Adults can only get CalWORKs cash aid for four years (48 months) in a lifetime. Any month the adult gets cash aid counts against the 48-month time limit, even if the person is entitled to only a few dollars a

month. The client will need to decide if it is worth “using up” a month of eligibility to get a small amount of cash. The person may be able to get Medi-Cal, CalFresh benefits, and childcare money even if not getting cash aid. The limit does not apply to children. If an adult has exceeded the 48-month lifetime limit, children will continue to receive cash aid.

There are a few exemptions to the 48-month limit. Any month does not count in which the client does not receive a check, is physically or mentally disabled, suffering from the effects of current or past domestic violence, caring for a sick family member, or is a pregnant or parenting teen excused from Cal-Learn.

Diversion Payments

Instead of monthly CalWORKs cash aid, the family may receive a lump sum of money for a major expense that will help the person get or keep a job. For example, the payment may be used for car repairs or insurance, work tools or clothing, rent or utilities, license fees, or childcare expenses.

To get the payment, the family must:

- Be eligible for CalWORKs
- Have a job or immediate job opportunity
- Have an unexpected, one-time need

The family receiving the diversion payment may also get Medi-Cal, CalFresh (Food Stamps) benefits, and supportive services such as childcare.

Not Eligible for Cash Aid

Some clients who may meet the basic CalWORKs eligibility requirements may not be eligible in the following situations:

- If she has been convicted of welfare fraud or was found to have committed fraud by an administrative court, the period of disqualification may last from six months to a lifetime, depending on the seriousness of the fraud

- If she was convicted in state or federal court after December 31, 1997, for a drug felony committed on or after August 22, 1996, she will never receive CalWORKs cash aid or supportive services (such as childcare) for herself. Her children can still qualify for cash aid.
- If a child is under 16 and is not attending school regularly without good cause, the parents' portion of the cash aid will be cut off. A child over 16 not attending school without good cause will have cash aid cut off, but the parents' cash aid will not be cut off.
- If a child under 6 years does not have proof of immunizations, cash aid to the adults will be cut off. There are exceptions if you can prove that you have "good cause." Examples include: providing a sworn statement that immunizations are against your religious beliefs or that the parent lacks access to obtain immunizations.
- If the adult does not participate in the Welfare-to-Work programs and does not have a legal exemption, his or her cash aid will be cut. The children's cash aid will not be cut.

Amount of Cash Aid

CalWORKs payments may be issued in the form of a plastic debit-like card called the Electronic Benefits Transfer (EBT) card and a private PIN (personal identification number).

The amount of a family's monthly assistance payment, called the "Maximum Aid Payment," depends on a number of factors including:

- The number of people who are eligible
- The special needs of any of those family members
- The income of the family

Maximum Family Grant (MFG) or Family Cap Rule

Even though larger families generally get more cash aid, they will not get more money for children born

while the family is getting CalWORKs unless the family meets one of the several exemptions.

Other Services

In addition to cash aid, the CalWORKs family is eligible for a variety of programs:

- **Medi-Cal:** for each eligible family member. When the family is no longer eligible for CalWORKs, they may receive "transitional" Medi-Cal for varying lengths of time.
- **CalFresh (food stamp) benefits:** in most cases, emergency CalFresh benefits are available within three days of the application. Transitional CalFresh benefits are available for five months after leaving CalWORKs.
- **Immediate need payment:** a cash advance at the time of application or before the application is approved for money to buy diapers, medicine, transportation, utilities, food, etc. The \$200 (or prorated grant amount) immediate need payment can be given to the family the next working day if the family has an eviction notice and resources less than \$100.
- **Homeless assistance:** cash for temporary shelter and to help with move-in costs for permanent housing if the applicant is homeless. See *Homeless Assistance in Emergency Housing Guidelines*.
- **Non-recurring special needs:** if the family has less than \$100, they may qualify for cash to replace clothing and household items lost because of fire, disaster, theft, or other event beyond their control, or to pay for shelter if the family does not qualify for the Homeless Assistance Program. This money does not need to be repaid.
- **Special needs:** extra money may be added each month to the grant if an eligible family member has special needs such as higher food costs because of a medically necessary diet or pregnancy.

- **Welfare-to-Work supportive services:** such as job training, educational assistance, childcare, help finding work, job-related transportation, housing relocation, mental health, and substance abuse or spousal/intimate partner violence counseling.

Steps in Applying for Aid

Fill out the application form as completely as possible.

Have an Interview with the Eligibility Worker

It is helpful to bring as many of the following documents as possible:

- Identification with current name and address
- Social Security number or card for all family members
- Proof of income such as pay stubs or copy of your most recent tax return
- Proof of relationship to any children for which you are applying
- Proof of county residence
- Proof of citizenship or acceptable immigration status such as birth certificate, naturalization papers, or green card
- Proof of housing situation such as rent receipts, lease agreement, etc.
- Auto payment papers and registration if the family owns a car
- Letters from a doctor if anyone in the household is pregnant, has a disability, special medical need, or special diet
- Any documents having to do with marriage, divorce, or child support

Get Fingerprinted

All adults 18 years and older and teen parents must be fingerprinted in order to apply for and receive CalWORKs. If the client refuses, she will not be eligible for cash aid, but her children can receive aid.

Have Children under the Age of 6 Immunized

The client must submit proof that all children under age 6 are up-to-date on their immunizations at the time of application and at the annual redetermination. Certain exceptions apply such as if immunization is against the parents' religious or other beliefs.

Keep School-age Children in School

The parents' cash aid will be cut off if a child under 16 is not attending school regularly without good cause. Children 16 and over will have their own cash aid cut off if not attending school or Welfare-to-Work activities without good cause.

Have a Home Visit

Some counties require a home visit for all CalWORKs applicants. If the client does not agree, the application will be denied. See section on *Emergency Housing, Homeless Assistance Guidelines*.

Receiving Aid

Benefits may be given in the form an EBT (Electronic Benefits Transfer) card to use at banks, ATMs, and participating stores. Using the EBT card at non-participating banks and ATMs may result in extra fees deducted from the card.

Continuing to Get Aid

The client must do the following to continue to receive aid:

Send in the Quarterly Report Form: QR-7

Once the application is approved, the woman will need to complete and return the quarterly eligibility form called the "QR-7." This form updates changes in income, property, or the number of people living in the household. Some things need to be reported within 10 days: address changes, certain criminal activities, parole or probation violations, and income going over the limit to receive aid. Encourage her to send in the QR-7 on time or her benefits will be discontinued.

Participate in Welfare-to-Work Plan Activities

All CalWORKs recipients must be working, looking for work, going to job training, or going to school.

There is a long list of exemptions to this requirement such as illness, severe family problems, lack of transportation or childcare, mental illness, substance abuse, domestic violence, and many others.

Cooperate with Child Support Collection

Unless excused, parents participating in CalWORKs must cooperate with the Child Support Agency to collect child support from any absent parent. There are some exceptions to this rule, for example if the client can show that attempting to collect support payments will put her children in danger. The county keeps most of the child support it collects, up to the amount of the family's cash aid. The family gets the CalWORKs grant plus an extra \$50 per month if the other parent pays on time. Questions will be asked about the identity of the father, where he lives and works, his Social Security number, etc. The county, using a national network, will try to find the father so he can share in the cost of supporting the child. If the client does not cooperate with the Child Support Agency, the family's grant may be cut.

Resources

California Department of Social Services

<http://www.cdss.ca.gov/>

California Immigrant Welfare Collaborative

1-916-448-6762 / www.caimmigrant.org

SSI (Supplemental Security Income), State Supplementary Payment (SSI/SSP) Program, and Cash Assistance Program for Immigrants (CAPI)

The SSI Program is a federally funded program which provides income support to low-income citizens and some categories of lawfully admitted non-citizens who are either elderly (65 years and older) or disabled. There are limits on the amount of financial assets and

personal property the person can have and still get benefits. The person should apply at their local Social Security Administration (SSA) office. Locations of SSA offices can be found in the telephone directory under "United States Government." The agency's toll-free number is 1-800-772-1213.

The SSP Program is a state program, which adds money to the federal payment. Eligibility for both programs is determined by the SSA using federal criteria. If you qualify for SSI, you qualify for SSP automatically. The single payment received at the beginning of each month includes both the federal and state payment.

The Cash Assistance Program for Immigrants (CAPI) is a state-funded program that pays cash benefits to some non-citizens who are not eligible for the federal SSI program.

For an adult to be considered disabled, the person must be determined unable to do any substantial, gainful activity because of a mental or physical impairment that can be expected to last for a continuous period of at least 12 months or that will result in death. In order to meet eligibility based on a disability, the applicant may submit proof from a doctor or other medical person accepted by the SSA, or SSA can request the proof from the individual's doctor with the individual's permission. SSA then reviews this information to determine if the person qualifies.

Drug and alcohol dependency is no longer considered a disability that qualifies for SSI benefits. If a client has another disabling condition and happens to be a drug or alcohol addict, the person is still eligible for SSA if the other source of disability meets the agency's requirements. If the person has become disabled because of the addiction, such as liver disease, the person may still be eligible because of that other disability. The basic test is: *Would the person still be disabled if he or she stopped using drugs or alcohol?* If the answer is no, the person will probably not be eligible.

For children under age 18, “disabled” means there is medical evidence of a physical or mental impairment that limits the child’s ability to function and the impairment is expected to last for a continuous period of at least 12 months.

A person cannot receive both CalWORKs and SSI. Usually the payment from SSI will be higher, and the client may want to contact a welfare rights advocate before making the decision of which government program meets their needs best. See the *Legal/Advocacy Guidelines* section.

A person on SSI automatically receives Medi-Cal benefits without a share of cost. A separate Medi-Cal application is not necessary.

Resources

The Social Security Administration has an excellent website with information in many languages: Call 1-800-772-1213 or visit www.ssa.gov.

The publications section has an electronic fact sheet on SSI in California.

General Assistance (GA) or General Relief (GR)

The county funds this financial assistance program for people who have almost no money and are not eligible for other programs such as CalWORKs or SSI. Eligibility, benefits, and procedures vary greatly from county to county. If unemployed but determined by the county to be able to work, the recipient may need to look for work or participate in a county “workfare” project to “work off” (without pay) the GA or GR grant. A person receiving GA or GR automatically receives CalFresh (Food Stamps) benefits. GA/GR is not available for persons convicted in state or federal court after December 31, 1997, for a drug felony committed on or after August 22, 1996.

State Disability Insurance (SDI) during pregnancy

The disability period for a normal pregnancy is up to four weeks before the expected delivery date and up

to six weeks after the actual delivery date. The period may be extended if there are complications in the pregnancy or delivery such as a C-section.

How to make a claim:

Obtain a claim form from any Employment Development Department (EDD) office by telephone, letter, or in person. It is helpful to order disability forms in bulk and offer them to clients. Both the client and health care provider must complete the form and mail it to the EDD office. The client will receive a weekly check in the mail based on the client’s earnings. It can take up to three weeks to receive payment after the form is mailed to EDD.

Earned Income Tax Credit (EITC)

EITC is a special benefit for low and moderate income working people. Unlike other public benefits programs, the United States Internal Revenue Service (IRS) administers this tax credit program. It provides cash payment (in the form of a check) even if the person does not owe any taxes. The working person must file a federal income tax return. The family may be eligible for free help in filling out the required tax forms through the VITA (Volunteer Income Tax Assistance) Program. To locate the nearest VITA site, call 1-800-906-9887.

The IRS website has information in English and Spanish

www.irs.gov

Housing

Emergency Housing

CalWORKs Clients

Clients who are receiving CalWORKs, or are eligible, may receive money for temporary shelter if they are homeless. “Homeless” is defined as having no regular, permanent place to live for any reason. They may receive \$65 to \$125 a day depending on family size for a maximum of 16 days. The money is in addition to

the family's usual cash grant and does not need to be repaid. The family may receive this homeless assistance only once in a lifetime, with a few exceptions such as domestic violence, a fire or other disaster, or physical or mental illness (not including drug addiction or alcoholism). The client should contact her caseworker if already receiving CalWORKs. If the client is not receiving CalWORKs, she should apply, letting the intake worker know she has an emergency.

If a client has received an eviction notice because she is not able to pay the rent, CalWORKs may pay up to two months back rent that is overdue.

Homeless Shelters

Intake requirements vary. Find out if the shelter:

- Accepts pregnant women
- Has restrictions on number of weeks gestation
- Needs proof of pregnancy
- Accepts children
- Has age or gender restrictions
- Allows partners or spouses
- Requires an interview or appointment
- Accepts clients on a drop-in basis
- Has a limited length of stay and what their hours of operation are daily

Also find out what services are offered, such as meals, showers, laundry facilities, childcare, clothing, or medical or social work services. Some have job counseling, placement, and bilingual staff.

Complicated Situations

Teens

Many resources such as homeless shelters may only serve people 18 years and older. Locate a facility designed to serve youth and inquire if they will accept a pregnant teen; youth shelters are unlikely to

accept teens with children. Call your county's child welfare agency to see if there is a group home or a foster home for the teen mother and her child.

Refer to legal resource if the teen wishes to be legally emancipated. Refer to the *Teen Pregnancy and Parenting Guidelines* section for additional information.

People Who Abuse Substances

A client who is actively abusing substances may not be eligible for homeless shelters that have clean and sober policies. The client who wants help with substance abuse may need to go through detoxification first or enroll in a residential substance abuse treatment program. See the *Perinatal Substance Use/Abuse Guidelines* section.

Non-emergency Housing

CalWORKs Clients

Families on CalWORKs may be eligible for payments to assist them in securing permanent housing. The rent cannot be more than 80% of the maximum aid payment of the household (monthly check). The payment is for security deposits and last month's rent, but does not include first month's rent. In the Modified Payment Program, the rent check can be paid directly to the landlord each month by the county welfare agency.

Subsidized Housing

Call the local Housing Authority to be put on a waiting list for public housing. If the client is homeless, she should be given top priority. If she does not want to live in a housing project, she can ask for a Section 8 voucher or certificate that will allow her to look for private housing on her own. The housing must meet a number of requirements.

Nonprofit Housing Organization

The local Housing or Community Development Department may refer the client to a nonprofit

organization that owns houses or apartments reserved for renting to people with lower incomes.

Rental Housing

The client will usually need to locate her own rental housing. Encourage her to let all her friends and family know she needs housing and her requirements. Consider advertising on bulletin boards located in churches, hair salons, laundromats, small grocery stores, and her children's schools.

Shared Housing

In areas where housing is very expensive, it is often necessary to share housing. Look for roommate referral agencies (either free or a low cost), single parent support agencies, or childcare referral agencies.

Utilities: Gas and Electric, Phone, and Water Bills

Emergency Utilities

Local utility companies can refer to local agencies where there is help for people with overdue bills and who are being threatened with disconnection.

Call the State Department of Community Services and Development, LIHEAP (Low Income Home Energy Assistance Program) at 1-866-675-6623 for referrals to local agencies that can help clients with overdue bills such as electricity bills.

If the family is receiving CalWORKs, they may be eligible for "immediate need" money to pay overdue bills and avoid having their utilities being shut off.

Non-emergency Utilities

The Low Income Home Energy Assistance Program (LIHEAP) also provides financial assistance to eligible households to help pay the costs of heating and/or cooling dwellings as well as free weatherization services to improve energy efficiency.

Resources

To find a local agency that participates in LIHEAP call 1-866-675-6623 or check the Department of Community Services and Development website: www.csd.ca.gov/Home.aspx

Food

Emergency Food Resources

Each community has different food resources for families with emergency needs. They are often run by volunteers and rely on donations, so call first to see if help is available. Check on emergency food box/bank programs and soup kitchen programs. Ask about assistance for pregnant women or food choices to suit specific ethnic groups. Dining halls and soup kitchens that serve free meals on a regular basis are often located in churches. Find out the meal schedule and what other services may be offered.

Non-emergency Food Resources

WIC

Refer all CPSP clients to WIC. This federally financed program provides free food vouchers to be used in local stores to purchase nutritious foods such as milk, cheese, eggs, juice, cereals, beans, peanut butter, infant formula, and cereals. Breastfeeding counseling and nutrition assistance is also available to help clients make healthy food choices.

The program is designed for:

- Pregnant women
- Mothers up to 12 months postpartum if breastfeeding (six months if not breastfeeding)
- Women whose pregnancies ended in spontaneous (SAB) or therapeutic abortion (TAB)
- Infants and children under the age of 5

The average value of the vouchers is about \$50 per month. Social Security numbers and proof of immigration status are not required. Some WIC offices participate in the Farmers' Market Nutrition Program (FMNP) which provides additional coupons to WIC participants that they can use to purchase fresh, unprepared fruits and vegetables at participating farmers' markets.

Resources

The Women, Infants, and Children Program (WIC)

1-888-WIC-WORKS (1-888-942-9675)

www.wicworks.ca.gov

CalFresh Benefits (formerly known as the Food Stamps Program)

CalFresh benefits are government coupons issued monthly that can be used like money to buy food at many local grocery stores and farmers' markets. Some counties have replaced the paper coupons with a plastic Electronic Benefit Transfer (EBT) card that allows a recipient to authorize transfer of their government benefits from a federal account to a retailer account to pay for products received. They can't be used to purchase hot foods to be eaten immediately or nonfood items such as soap or diapers. CalWORKS recipients are automatically eligible for CalFresh benefits. Applicants must meet income and other requirements. They must be a U.S. citizen or eligible noncitizen (usually someone with residency documents). See the *Legal/Advocacy Guidelines* section for additional guidance.

Apply at the county welfare office. A client can get emergency CalFresh benefits within one day if they are eligible. An interview is required to review the application and necessary papers such as identification, proof of income, rent and utility receipts, etc. will be necessary for documentation purposes. All adults (including any adult applying for CalFresh benefits for children only) must be

fingerprinted. Upon receiving CalFresh benefits, the client will have to fill out and return a QR-7 quarterly report form every three months. On this form she will indicate any changes from the previous quarter in household members, income, expenses, etc. There is an annual recertification to continue receiving CalFresh benefits.

Ineligibility for CalFresh benefits

A person will not be eligible for CalFresh benefits if:

- Convicted of some drug-related felonies committed after August 22, 1996, including possession with intent to sell, selling, manufacturing, or distributing drugs. As of January 1, 2005, recovering addicts convicted of the lesser crime of felony drug possession may receive benefits. The person must first serve out their sentence and complete a drug program or self-certify that he or she is sober.
- Convicted of selling CalFresh benefits over \$500
- A worker on strike (and his/her family) unless he or she met the income requirements one day before the strike
- A fulltime student unless enrolled in CalWORKS and working at least 20 hours a week with few other exceptions
- Receives SSI; the state adds money to the federal SSI payment instead of providing CalFresh benefits

California Department of Social Services, CalFresh Program (formerly known as the Food Stamp Program)

Further information and application forms in several languages are available at: <http://www.cdss.ca.gov/food-nutrition/calfresh>

California Food Assistance Program (CFAP)

CFAP is a state-funded food stamp program for legal permanent noncitizens residing in the United States and determined ineligible for federal food stamp

benefits solely due to their immigration status.

www.sccgov.org/ssa/foods/fschap31.pdf

Emergency Food Assistance Program (EFAP)

EFAP is a program of the United States Department of Agriculture (USDA), which provides non-perishable canned fruits and vegetables, frozen meat, and fresh products to be distributed to hungry families. In California EFAP is administered by the California Department of Social Services and distributed through a network of emergency food providers, such as food banks, food closets, and soup kitchens to low income Californians. To find the authorized EFAP food distribution agency serving your community call 1-916-229-3344 or visit: <http://www.cdss.ca.gov/inforesources/EFAP>

California Department of Social Services Emergency Food Assistance Program

<http://www.cdss.ca.gov/inforesources/EFAP>

Go to: California Association of Food Banks, where you can locate a food bank in your community: www.cafoodbanks.org or 1-510-272-4435

Child Nutrition Programs

Generally, public or nonprofit private schools, elementary and secondary schools, and public or nonprofit private residential childcare institutions may participate in the school lunch program. Children may be eligible for free or reduced-price meals. Apply at the school office. A child is automatically eligible if the family is receiving CalWORKs or CalFresh. Some programs require families to state the total family income, and sometimes require verification. Families will also have to list names and Social Security numbers of all household members. If a family member does not have a Social Security number, list "none." He or she is not required to apply for a Social Security number or to give a reason why the person doesn't have one. Undocumented children are eligible for assistance.

Certified Farmers' Markets

In many counties, families can buy fresh products at lower prices directly from farmers and growers at farmers' markets. CalFresh (Food Stamps) and WIC Farmers' Market coupons are usually accepted.

Other Food Resources

Many communities have additional food resources, like food-buying cooperatives where members can purchase food at reduced prices or through community gardens.

Clothing and Baby Supplies

Emergency and Non-emergency Resources

Resources for free clothing and baby supplies vary widely in communities. Check churches and religious charities such as Salvation Army, Catholic Charities, St. Vincent de Paul, Jewish Family and Children's Services, and Goodwill. Some pro-life groups help pregnant women in need through crisis pregnancy centers. Parental stress lines or family resource agencies may have referrals for clothing and baby supplies. The client may need a referral letter from you in order to receive assistance. Also check: *Does she need an appointment or can she drop in? What languages are spoken? Are there any income guidelines? Are there other services offered? Are there waiting lists to obtain certain items such as baby equipment and furniture?*

Follow Up

Review the client's financial concerns. *Are they better? Worse? Did she follow through on any referrals? Were they helpful? Does she want to try another resource?*

If she was denied benefits, try to determine if she was unjustly denied. Sometimes **informal action** will resolve the problem. Talk to the worker or supervisor.

Help the client explain her situation and see if they can come to an agreement.

Sometimes **formal action** is necessary. If she was seeking help from a government agency, she probably received a “notice of action” which describes the formal complaint procedure. Usually there are time limits in which to file a complaint. Refer her to a welfare rights advocate for her situation. See the *Legal/Advocacy Guidelines* section.

Special Financial Considerations for Undocumented Immigrants

In most cases, undocumented people are not eligible for many public benefits such as CalWORKs, SSI (Supplemental Security Income), Healthy Families, or CalFresh (Food Stamps). However everyone, regardless of immigration status, is eligible for:

- WIC
- Pregnancy-only Medi-Cal
- Sensitive services or minor consent Medi-Cal (under 21 years)
- Emergency Medi-Cal
- Health care from some county and community clinics
- Free or reduced-price school breakfast, lunch, and summer food programs
- CHDP (Child Health and Disability Prevention Program)
- Immunizations for children
- CCS (California Children’s Services) for children under 22 who have serious medical or disabling conditions
- Services of the Regional Centers for California residents with developmental disabilities
- Elementary and secondary public education
- Services from most nonprofit community organizations such as churches

- Help from most shelters such as domestic violence or homeless shelters
- Food from food pantries/banks and soup kitchens

A child born in the United States is a U.S. citizen and may be eligible for many kinds of help that are not available to the undocumented parent.

Resources

The California Immigrant Policy Center

For up-to-date information on the current laws on immigrants’ rights to public benefits and free brochures in several languages, call 1-916-448-6762 or visit <https://www.caimmigrant.org/>

Check with local immigration advocates for the latest laws that affect different categories of immigrants.

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Background

Many times during the assessment, a client will describe a problem that may indicate a need for legal advice or advocacy. Do not give legal advice. Instead, help the client by getting more details about her situation and making an appropriate referral. The referral agency will help the woman decide if she has a legal case and, if so, what actions she should take. It may be difficult to find the appropriate resource, especially one that will serve the client at a price she can afford. Be sure to ask each resource that you contact if they know of others who may be able to help as well.

Legal Rights of Working Pregnant Women

It is illegal for employers to discriminate against an employee who is pregnant. There are many complex federal and state laws that protect her rights. She should contact the California Department of Fair Employment and Housing (FEHA) for information on her rights under the current laws. Look in the “State Government Offices” section of your phone book.

FEHA rules apply to employers who have five or more employees. In general, an employee:

- May be allowed to take up to four months unpaid leave
- Must be given the same or similar job when she returns to work
- May be transferred to less strenuous or hazardous positions, provided it is medically indicated and the transfer does not require the employer to either create a new job or to fire another employee

The California Family Rights Act requires employers of 50 or more employees to allow employees who have been working at least one year to take up to a total of four months leave following the birth of a child. The law does not require that the leave be paid.

Steps to Take

After getting more details about the client’s situation, **suggest that she contact a legal services program.** See the *Making Successful Referrals* in the “First Steps” chapter. Help her find a program that handles her kind of problem. Some agencies help with a wide range of issues; others provide assistance with only specific problems. They will advise her of her rights and may represent her. She may qualify for free (sometimes called pro bono by the legal community) or low-fee services.

Encourage the woman to document her case, writing down dates, places, times, and possible witnesses to her difficulties. She can create a “paper trail” by making her complaints in writing.

Advise her to use any grievance procedures and appeals, if available. Remind her to meet any filing requirements and deadlines.

Follow Up

Check with the client at her next visit to see if she followed through on the referral to legal or advocacy services. *If not, why not? If yes, did the referral help her situation? Does she want additional referrals? Can you help her through other methods to solve the original problem?*

Referrals

- **Yellow Pages** listings under legal help. Nonprofit legal resources in your community may go by the name of Legal Aid Society, Legal Services Foundation, Neighborhood Legal Assistance Foundation, and Rural Legal Assistance.
- **Legal referral service** operated by the local bar association (an association of lawyers) that makes referrals to private attorneys that see clients free of charge or for a fee. Some will provide a free or low-cost initial consultation.

- **Ethnic-specific legal services** such as Indian Legal Services or Chinese for Affirmative Action. There are also organizations that specialize in certain types of legal problems such as those for the disabled, minors, etc.
- **Law schools** may provide legal services to low-income people
- **Internet search engines** like Google or Bing. Search for “low cost legal services” in your county.
- **Community boards** may have free, informal conflict resolution services to solve problems between neighbors, family members, friends, housemates, organizations, landlords and tenants, merchants and consumers, and employees and employers. Trained community volunteers assist the people in reaching their own agreement. Although not legally binding, it is often a good way to avoid the lengthy, expensive legal system.

Consider Making a Referral for Legal Advice for the Following:

Housing

- Evictions
- Disputes with the landlord
- Housing discrimination
- Illegal rent increases
- Unsafe housing, need for repairs
- Lack of heating, water, weather protection, garbage collection
- Rodents and other pests

Immigration

- Deportation
- Legal residency
- Citizenship
- Sponsorship of relatives who want to emigrate
- Rights to public benefits
- Refugee or political asylum

Public Benefits

- Being denied benefits
- Having benefits decreased
- Having benefits discontinued
 - ◆ CalWORKs, SSI, GA or GR
 - ◆ Medi-Cal
 - ◆ Unemployment benefits
 - ◆ Disability benefits

Employment/Labor

- Discrimination on the basis of sex, race, ethnic group, sexual orientation, or disability (including pregnancy)
- Sexual harassment
- Firing
- Layoff
- Family care leave
- Unfair labor practices
- Pay inequity
- Domestic workers
- Affirmative action
- Unsafe working conditions
- Pensions

Family

- Child custody, support, and visitation
- Paternity
- Court dependency for abused, neglected children
- Termination of parental rights
- Adoption
- Legal guardianship for children
- Legal emancipation for minors 14 years or older
- Grandparents' rights
- Separation
- Divorce
- Conservatorship
- Wills
- Probate
- Name changes
- Intimate partner abuse
- Restraining orders

Civil and Criminal Prosecution

- Small claims court
- Arrest
- Incarceration
- Parole
- Probation
- Victim of crime
- Witness to crime
- Lawsuits
- Personal injury
- Negligence/professional malpractice

Financial/Consumer

- Bankruptcy
- Debts
- Credit
- Product liability
- Real estate
- Insurance
- Business

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Background

New immigrants to this country have special concerns. **Learn as much as you can about their immigration experience.** See *Cross Cultural Communication Guidelines* in the "First Steps" chapter.

General Concerns

New immigrants are likely to have many emotional concerns such as:

- Feeling homesick and missing loved ones left behind
- Regretting their decision to come to the U.S.
- Inability to return home
- Experiencing culture shock and confusion with unfamiliar customs, values, and ways of life
- Feeling conflict and tension between younger and older generations in the family
- Being isolated with limited social support systems
- Experiencing constant fear of deportation

Post-traumatic Stress Disorder (PTSD)

Some immigrants will have experienced significant emotional trauma in their homeland or during their migration process. Some come from war-torn countries where they have suffered or witnessed many horrors. Women are sometimes sexually assaulted during the process of migration. These experiences may lead to a mental condition called **post-traumatic stress disorder (PTSD)**.

A person with PTSD may **re-experience the trauma** through painful daydreams (flashbacks) or nightmares. Each episode may last from several minutes to several days. **Anxiety, depression, fear, distress, irritability, detachment, and numbing of the emotions also commonly occur with this disorder.** It can be treated through individual or group counseling, self-help support groups, and/or drug therapy. See the Emotional/Mental Health Concerns Guidelines sections for additional assistance.

Refer to a supervisor immediately if the client has severe anxiety or depression or has a deportation order.

Financial Concerns

New immigrants often have many financial concerns. Family members' ability to find work depends on their job skills, whether or not they have legal authorization to work, and their ability to communicate in English. Undocumented persons will often have difficulty securing steady or fair paying jobs.

If the family needs financial assistance, immigration status determines which government benefits they may receive. These benefits are sometimes called "public" benefits. Children born in the U.S. are citizens and are eligible for the full range of government benefits. Legal permanent residents (LPRs) can receive most, but not all, public benefits. In most cases, undocumented people are not eligible for government help. However, they may be able to receive help from private agencies such as churches. See the *Financial Concerns Guidelines* section for further guidance.

Immigration Status

An immigrant is someone who enters another country with the intention to live there temporarily or permanently. Students and tourists are considered non-immigrants. The federal government's United States Citizenship and Immigration Services (USCIS), formerly known as Immigration and Naturalization Services (INS), recognizes many categories of immigrants.

The rules and regulations are complex and change from time to time as the result of new laws. Refer to the USCIS website for up-to-date Information: www.uscis.gov/portal/site/uscis

Some major current categories are listed below:

Lawful Permanent Residents (LPRs)

- Are often called “green card” holders
- Have permission to live and work permanently in U.S.
- Can travel outside the U.S. and return as long as they do not abandon their U.S. residence
- Can lose LPR status if absent from the U.S. for an extended period of time without requesting a re-entry permit, or commits certain deportable crimes
- Are considered conditional for two years if they receive their legal status through marriage to a U.S. citizen; the couple must jointly file a petition to remove the conditional status, or the immigrant spouse must qualify for a waiver to keep his or her LPR status; see *Special Immigration Concerns* for more on these waivers
- Can apply for U.S. citizenship after living in the U.S. for five years (three years if married to a U.S. citizen); such citizens are called “naturalized” and have most of the rights of U.S. born citizens
- May be eligible for some federal and state public benefits
- May be “commuter aliens” who live in Mexico or Canada, but work in the U.S.

Refugees

- Are given permission to enter and reside in the U.S. because they are unable or unwilling to return to their home country due to persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. Women from countries where there are coercive population control programs (such as forced therapeutic abortion or sterilization) may qualify for refugee status.
- Are issued a refugee travel document to travel abroad
- Are issued an employment authorization card

- Receive resettlement services aimed at economic self-sufficiency, including CalWORKs and Medi-Cal
- Are not affected by the “deeming of sponsor income” rule; see section on *Special Immigration Concerns*, “Sponsor Income” in this section
- May apply for LPR status after one year

Asylees (those requesting asylum)

- Are already in this country and can apply for asylum or withholding of deportation if they satisfy the requirements for refugee status (see previous category). Women or girls who have a well-founded fear of being forced to submit to female genital mutilation in their home country may qualify for asylum.
- Are eligible for most of the same benefits as refugees once the status is granted
- Requests must be filed within one year of entry into the U.S.

Temporary Protected Status (TPS)

- Is a status granted to people already living in the U.S. who are from certain designated countries (or parts of countries) where unsafe conditions such as war or natural disaster would make it a hardship for them to return
- Authorizes a stay for a specific period of time and does not lead to permanent resident status
- May receive permission to work
- Does not allow for eligibility for most public benefits
- In the past, people from Burundi, Somalia, Liberia, El Salvador, and Honduras, (check the USCIS website for currently accepted countries), have qualified for temporary protected status

Undocumented Immigrants

- May have entered the country legally, as a non-immigrant (student or tourist), and overstayed the term of their visa

- May have entered the country illegally without inspection at the border by USCIS
- Are not permitted to work in the U.S.; individuals and businesses are legally forbidden to hire someone without the necessary work authorization papers
- Can be deported if their status becomes known to USCIS
- May be eligible for temporary or permanent lawful status by qualifying for asylum, TPS, or suspension of deportation
- May have to return to their country of citizenship and apply from their country for legal entry into the U.S.; the wait may be several years depending on the yearly visa allotment for their group
- Are ineligible for most public benefits; however they may be able to apply on behalf of any children born in the U.S. who are therefore citizens; see the *Financial Concerns Guidelines* in this section
- How long they have lived in the U.S.
- The number of quarters they have worked and paid into Social Security
- If their sponsor signed an Affidavit of Support Form I-864 accepting legal responsibility for financially supporting the sponsored immigrant; see section on “Sponsor Income” for more information.

In most cases, undocumented people are not eligible for many public benefits such as CalWORKs, SSI (Supplemental Security Income), Healthy Families, or CalFresh (Food Stamps).

Everyone, regardless of immigration status is eligible for:

Public Benefits

If the family needs financial assistance, there are many factors that determine which government benefits they may receive. These benefits are sometimes called “public” benefits.

A child born in the U.S. is a citizen and is eligible for the full range of government benefits. If undocumented parents are applying for benefits for a citizen child or other eligible child, they do not have to tell the agency that they are undocumented. They may simply tell the worker that they are not eligible for the program and are seeking assistance for the citizen child only.

Eligibility for legally admitted immigrants may depend on:

- Their immigration classification
- Whether they entered this country before or after August 22, 1996
- WIC
- Pregnancy-only Medi-Cal
- Sensitive services or minor consent Medi-Cal (under 21 years)
- Emergency Medi-Cal
- Health care from some county and community clinics
- Free or reduced-price school breakfast, lunch, and summer food programs
- CHDP (Child Health and Disability Prevention Program)
- Immunizations for children
- CCS (California Children’s Services) for children under 22 who have serious medical or disabling conditions
- Services of the Regional Centers for California residents with developmental disabilities
- Public education
- Services from most nonprofit community organizations such as churches
- Help from most shelters such as domestic violence or homeless shelters

- Food from food pantries/banks
- ADAP (AIDS Drugs Assistance Program) provides pharmacy benefits for persons who are HIV positive and under-insured or without insurance: <https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx>

Sponsorship

Immigrants who come to this country under the family preference system need a sponsor.

A sponsor must:

- Be a citizen or legal permanent resident (LPR)
- Be 18 years or older
- Sign an affidavit of support accepting legal responsibility for financially supporting the immigrant
- Show that they earn enough to support a household that includes the immigrant, family members joining the immigrant, and the sponsor's family, at 125% of the federal poverty level

Affidavit of Support

An affidavit of support is a contract signed by the sponsor to show that the immigrant applying for LPR status is not likely to become dependent on the government, or a "public charge." The sponsor must accept legal responsibility for financially supporting the family member until the relative becomes a U.S. citizen or can be credited with 40 quarters of work (usually 10 years). There are two major types of affidavits:

- The "traditional" Affidavit of Support (Form I-134), which is the main form used before December 19, 1997. This affidavit of support is not an enforceable document.
- The "enforceable" Affidavit of Support (Form I-864) went into use on December 19, 1997. It is a binding contract by the sponsor for support of the immigrant, and for repayment of certain benefits received by the immigrant such as

CalWORKs, SSI, CalFresh (Food Stamps) (unless the sponsor is also receiving CalFresh (Food Stamps) and is part of the same household as the immigrant), and non-emergency Medi-Cal.

Sponsor Income

Sponsors who sign "enforceable" affidavits must show that they earn enough to support a household that includes the immigrant, family members joining the immigrant, and the sponsor's family, at 125% of the federal poverty level. Sponsors who can't meet these requirements may find a joint sponsor who also must sign an affidavit of support, promising to support the immigrant. A joint sponsor must meet all the same requirements as the sponsoring relative, except the joint sponsor does not need to be related to the immigrant.

Sponsored Immigrants and Public Benefits Deeming

The income and resources of the immigrant's sponsor are considered, or "deemed", available to the sponsored immigrant when he or she applies for certain public benefits. Deeming rules usually make the immigrant ineligible for benefits because adding the sponsor's income and resources usually makes (deems) the immigrant "over-income."

Sponsored immigrants can get some other benefits without counting their sponsor's income or the sponsor having to pay back the government. These include emergency or pregnancy-related Medi-Cal, immunizations, testing and treatment of communicable diseases, short-term emergency cash aid, school breakfast and lunch programs, Head Start, student financial aid, and a few other programs. Other exceptions to the deeming rules include domestic violence survivors or immigrants who would go hungry or homeless without assistance. Additional exceptions may be available, depending on the program.

Public Charge Issue

“Public charge” is a term used by USCIS to classify persons who have become dependent on public assistance programs. It can deny legal permanent resident status or the right to sponsor a relative. Only some forms of public assistance will be counted when deciding if the person is a public charge, namely cash assistance programs such as CalWORKs, SSI, and General Assistance (GA) or General Relief (GR). Other forms of public assistance such as CalFresh (Food Stamps), WIC, school lunch, vocational training, rent subsidies, and Medi-Cal are not usually counted.

Conditional LPR (due to marriage to a U.S. citizen)

Generally, the citizen and alien spouse need to file a joint petition to have the conditional status removed after two years. Then the alien can become an unconditional legal permanent resident. Under certain circumstances, an alien spouse may receive a waiver and be able to receive unconditional LPR status without the cooperation of her citizen spouse. (i.e., proving she is a battered spouse.) For more details, refer the client to an immigration attorney; see the *Legal/Advocacy Guidelines* section for further assistance.

Steps to Take

Immigration Status

Assure the client that her medical record is confidential and will not be seen by officials of the USCIS. You will be asking her questions about her immigration status in order to better determine her eligibility for appropriate services. You or other staff will not report her and her family to USCIS if she is here without legal papers. If she has concerns about her immigration status or eligibility for public benefits, do not try to provide legal advice. Refer her to an immigration advocate or agency where her questions can be answered.

Immigration Experience

Gently ask questions about her reasons for leaving her native country. Questions may include:

- *Did she want to come to the U.S.?*
- *Did she come because of a spouse, parent, or other person?*
- *Did she experience trauma such as war or extreme poverty in her homeland?*

Ask about her experience of traveling to the U.S.

- *Was it easy or hard?*
- *Did she experience emotional or physical hardship during the journey?*
- *How long did it take for her to get here?*
- *How did she cross the border: on foot, by plane, or other vehicle?*
- *Did she stay in a refugee camp? If so, what was it like?*

Cultural Adjustment

Ask what she expected before she came to the U.S.

- *What's been positive and negative so far?*
- *Does she plan on staying here?*
- *What has been the cultural adjustment of other family members?*
- *Has this caused problems for the client's family?*

You can help provide orientation to American culture and customs. Ask if she is homesick.

- *What does she miss about her homeland?*

Find out what loved ones she left behind such as children, parents, grandparents, spouse, or partner.

- *Does she hope to be reunited with them?*
- *What are her plans?*
- *Provide an opportunity for her to express her sad feeling.*

Knowledge of English

Determine her knowledge of English. If she has a limited ability to communicate in English, find out her willingness to learn more. Provide her with referrals to ESL (English as a Second Language) classes, if she wishes.

Social and Community Support

Find out more about her social support systems.

- *Does she have family and friends living nearby?*
- *Has she found a community of friends or acquaintances from her country of origin?*
- *Has she found a place of worship to practice her religion and a store that sells familiar foods?*
- *Does she know of a radio station, television station, or newspaper in her native language?*

You can make suggestions on expanding her social network.

Follow Up

- Provide an opportunity for her to discuss her feelings of cultural adjustment and homesickness
- Provide support and encouragement
- Assess for depression and post traumatic stress disorder
- Provide further referrals to community resources
- Continue to provide orientation to American culture

Referrals

- Churches, temples, synagogues, mosques, or other places of worship
- Charitable and religious organizations
- Community self-help organizations focusing on immigrants
- Cultural organizations

- Local news media in her native language
- ESL (English as a Second Language) classes (contact your local community college or adult school)
- Immigration advocates and attorneys

Resources

The United States Citizenship and Immigration Services (USCIS)

Formerly known as Immigration Naturalization Services (INS), the USCIS has an excellent website that provides information and forms in many languages: www.uscis.gov.

U.S. Department of State, Bureau of Consular Affairs

Visa Services

Information on immigrant visas: www.travel.state.gov

The National Immigration Law Center (NILC)

A national support center with two offices in California which is an excellent resource for information on the latest immigration laws, which offers many free brochures in several languages.

National Headquarters in:

Los Angeles 1-213-639-3900

Oakland 1-510-663-8282

www.nilc.org

The California Immigrant Welfare Collaborative

Up-to-date information on the current laws on immigrants' rights to public benefits and free brochures in several languages.

1-916-448-6762 or 1-510-451-4882

www.caimmigrant.org

Background

Parenting is one of the world's most important jobs. Like all important work, there is stress from time to time. Parents can feel overwhelmed and even dissatisfied with caring for their children. You can help a pregnant woman prepare for the demanding task of caring for her newborn, which may also decrease the stress a pregnant woman may experience about parenting.

Parents who experience a lot of stress may take it out on their children. As a health practitioner, you are required by state law to report suspected child abuse or neglect to the authorities. See the *Child Abuse and Neglect Guidelines* section.

Every culture has its own child rearing values. There are differences among cultures in what parents expect of a child at a certain age and attitudes toward child development. What may be considered positive child rearing in one culture may be frowned upon in another. Discipline practices may vary as well. Some cultures may rarely discipline unless real danger exists; others may approve of corporal (physical) punishment; others may use indirect methods such as shame.

What to Look For

For the Pregnant Woman

All women expecting a child face a period of adjustment. Even with a planned and wanted pregnancy, caring for a dependent and needy newborn can be a tremendous strain.

Experienced parents may also experience difficulties. Many factors determine how much stress a woman will face. Although it is impossible to predict how a client will do once her baby is born, you may be able to guess which ones may experience a lot of stress. These may include clients who:

Inform your supervisor immediately if you suspect that a child has been harmed or is in danger of being harmed.

- Are teens, especially young teens
- Have a history of intimate partner abuse
- Have emotional concerns such as marital stress or other family problems
- Were abused or neglected as a child
- Lack social support, such as some single parents or new immigrants
- Have severe financial concerns, such as homelessness
- Are expecting a child with problems, such as birth defects
- Are substance abusers
- Have a physical illness or disability
- Have a mental illness or disability
- Are developmentally delayed
- Have a baby who is premature

For guidance on how to help a client with some of these stresses, see the "Table of Contents" for the Psychosocial section in this manual.

For the Pregnant Woman with Other Children

A client may tell you of parenting stress during the interview. For example, she may say:

- The kids are driving her crazy
- She can't take it any more
- She's afraid of losing control
- The child is no good
- She can't handle the child

You may also observe parenting stress in your office. For example, the client may:

- Use harsh discipline such as hitting or threatening to hit the child
- Yelling or swearing at the child
- Not respond to the child's needs or requests for comfort or help such as:
 - ◆ Letting a newborn cry without attempting to comfort him or her (this may be a cultural practice, so ask about her related beliefs)
 - ◆ Not protecting a toddler from harm
 - ◆ Ignoring a preschooler's request for help with a difficult task

Steps to Take

For the First-time Mother

Find out what she thinks parenting will be like. Is she confident or scared? What does she need to learn or do to help her prepare for being a parent? Ask questions like:

- *Do you have any ideas about how you'll handle...?*

Help prepare the pregnant woman, and her partner, if available, by letting them know what to expect, especially in the early weeks and months of the baby's life. Say things like:

- *A lot of new parents find themselves wondering...*
- *Many parents find it useful to...*
- *You may want to try...*
- *Many couples experience...*

For the Pregnant Woman with Other Children

Build on Strengths

Acknowledge that being a parent has its ups and downs, and you know she's trying to do her best. Say something like:

- *It seems to me that you really love your child. You're trying your best to get him to behave.*

Encourage her to discuss her parenting joys as well as difficulties. Say something like:

- *Being a parent is a difficult job. Are there times when it seems worth all the effort? Can you tell me about one?*

Build Upon Parental Strengths Rather than Focusing on Weaknesses

Let her know when you think she's doing a good job. Say something like:

- *It's so nice to see a parent who...*
- *I like the way you...*
- *You seem really good at...*

Help the mother identify positive things about her child. Some behaviors that the mother identifies as bad can be reflected to her as acceptable. For example if the mother is angry at a toddler who is busy pulling open all the drawers in the exam room, you may say:

- *What a curious child! She really wants to find out more about her world. Maybe we can help her explore something else besides the drawers. Here's a toy that she might like to play with.*

Help the Parent Make a Plan for Changing the Child's Behavior Over Time

Say something like:

- *Let's see if we can figure out a better way.*
- *Would you like help in finding a way that works?*

Help her figure out the steps in teaching the child, and make plans for how long it may take and what to do if the plan doesn't work.

Help her identify the child's positive instead of negative behaviors. Help her determine if the child is capable of such behavior at his/her stage of development. For example, is it reasonable to expect an 18 month old to sit quietly for half an hour while the mother watches a video on childbirth? Is it reasonable for a 3 year old to have responsibility for watching the newborn while the mother naps?

Explore what methods she has tried in the past. What was effective and what was ineffective?

Provide information on behavior management techniques for children of different ages. Contact your local Child Abuse Prevention Council for suggestions.

Encourage the woman to focus on positive behavior. Reward good behaviors as much as possible.

Ignore unwanted behavior if it is not harmful to someone or something. An example of this is a toddler temper tantrum. The child should be praised as soon as the inappropriate behavior stops and when the child does something approved of by the parent.

Distraction works well especially with young children. Suggest alternatives. If the child stands on the table, suggest:

- *Come sit next to me, and I will show you some pictures in this book.*

Some behaviors can't be ignored. If a child is hurting himself or others or damaging something, the parent will have to intervene as unemotionally as possible. She can say something like, "I can't let you do this. I will have to help you stop until you can stop yourself." Setting limits is an important parenting skill. It creates structure, ensures safety and develops health boundaries. The parent lets the child know that the behavior is unacceptable. At the same time she should let the child know what is acceptable. For example she

can say, "You may not stand on the table. You may sit next to me in this chair."

Time Out

With time out the child is taught to spend a short time by him or herself away from the rest of the family, perhaps one minute for each year of the child's age. This technique stops the child from getting attention for unacceptable behavior and sets limits on what is acceptable. It also gives the child and parent each a chance to calm down. When the time is up, the parent calmly explains why he or she was sent to the time out space and what behavior she expects in the future.

The goal is for the child to develop self-control, not to act properly due to fear of punishment.

Model Behavior

Set a good example for the parent in handling the child. For example, praise the child for good behavior:

- *Mommy must be really proud of you for making that picture while she's waiting for the doctor. What a good artist you are.*

Put an arm around the fussy child and say:

- *You seem to be having a bad day. I wonder what you're trying to tell us.*

Advise the mother to have patience. A different approach may take time to show results in changing the child's behavior.

Create hope by reminding her that there are ways she can relieve her parenting stress. Tell her that other parents in her situation have found solutions to difficult problems.

Giving Advice

Try to give **nonthreatening, supportive advice** on how to handle the child differently. When giving advice, try not to criticize the parent or make her feel

defensive. Instead of saying *You shouldn't . . . or Stop doing . . .*, try saying:

- *You may get better results if you . . .*
- *Have you tried . . . ?*

Emphasize how the different approach may benefit her as well as the child. Say something like:

- *You'll probably find it easier to . . .*

Encourage Parental Responsiveness

If the mother is not responsive to the child's needs, gently try to get her to empathize with the child. In other words, get her to feel what the child may be feeling. Say something like:

- *I wonder how she feels when . . .*
- *What do you think he feels when . . .*
- *It must be hard for the child to . . .*

Attitudes about Child Raising

Ask how she was raised. Does she want to do the same things her parents did or something different? If her parents were abusive, she may not want to use the same parenting techniques. She might be less likely to abuse her child if she can remember what it felt like to be a helpless, scared child.

Find out what role the child's father or the mother's partner plays in providing care to the children.

- *What role do extended family members play?*
- *What are their ideas about child raising and discipline?*
- *Do they agree or disagree on how the children should be handled?*
- *How does she handle parenting disagreements?*

While you want to respect the family's cultural values, you also may need to inform some families that the discipline techniques they find acceptable may be against the law. Discipline that

is excessive or forceful enough to leave marks or injuries is considered abusive. The use of instruments such as whips, belts, sticks, shoes, and cords also increases the likelihood of serious injury.

The Importance of Social Support

The isolated parent often experiences a lot of parenting stress. Help her see the need for support systems and how to develop them. Discuss the possibility of getting help from her current community, which may include: extended family, friends, neighbors, place of worship, support groups, parenting and childbirth preparation classes, and ESL (English as a Second Language) classes.

Encourage her to find one or two women she can call when she feels angry or frustrated. They can support each other.

Seeking Outside Assistance

Give all parents the number of the parental stress line, if you have one in your community. Most are staffed by trained volunteers and operate 24 hours a day.

If you think the family needs outside assistance, explain the benefits of a referral. See the following referral guidelines.

If the woman is angry with you for suggesting such help, remain calm. Don't take it personally. Share with her success stories of other families in her situation (leaving out names and details to maintain confidentiality). If she refuses help, tell her that you will be happy to give her the referral again if she changes her mind.

If the mother is interested in the referral, you may want to help her call from your office. See *Making Successful Referrals* in the "Introduction."

Doing Something for Herself

Encourage the client to meet her own needs. She may have more energy to deal with her children if

she is able to fulfill some of her own dreams. Clients may need help recognizing the possibility for seeking out their own interests or achieving personal goals. You may acknowledge her central role as caregiver, but also show interest in what brings her pleasure, such as visiting friends, taking a walk, or going shopping on her own.

Follow Up

For the First-time Mother

Continue to help the pregnant woman think about having a newborn in the household. Help her prepare emotionally for the many demands. Help her decide what kinds of preparations she needs to make, such as purchasing basic supplies.

For the Pregnant Woman with Other Children

Continue to observe for signs of parenting stress. Ask

Tip

Your local child abuse prevention council may have guest speakers or brochures on parenting techniques and preventing child abuse. To locate your nearest council or to obtain other information, call Prevent Child Abuse-California.

1-916-244-1900 / <http://core2.thecapcenter.org/pca-ca>

if she's tried any of the suggestions that you made at her last visit. Did they work? Problem solve any difficulties she may be having in following through on the plan to change the child's behavior.

See if she followed up on any of the referrals you suggested. If not, why not? If yes, what has been her experience so far?

Referrals

- Parenting classes/support groups
- Childbirth preparation classes
- Single parent groups
- Family support centers
- Respite care (short term, occasional child care)
- Child care or preschool (especially those with parental involvement programs such as Head Start)
- Parent observation classes (available through some school districts or community colleges)
- Parental stress line (sometimes called a "hotline")
- Parental advice line (sometimes called a "warmline")
- Family counseling
- Child therapy
- Public health nursing
- Parent aide home visiting programs
- In-home family preservation programs
- Other programs in the community that help parents under stress

Call your local parental stress line for additional referrals.

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Background



PSP practitioners who are licensed are mandated (required) to report child abuse and neglect.

Mandated Reporters:

In general, CPSP practitioners are Mandated Reporters:

- Physician
- Certified Nurse Midwife
- Physician Assistant
- Registered Nurse
- Licensed Vocational Nurse
- Licensed mental health staff including LCSW, MFT, psychologist
- An unlicensed marriage and family therapist intern registered under Section 4980.44 of the Business and Professions Code.
- Unlicensed mental health staff, i.e. interns registered with the state
- Any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

Note:

Anyone who suspects abuse may report to the local authority or agency if necessary. (Penal Code §11166(g). It is important that those who don't function in the role of a mandated reporter communicates suspected or alleged abuse to their supervising licensed health practitioner or the CPSP Practitioner's supervising physician.

This practice ensures that the physician or licensed CPSP Practitioner meets his or her reporting duties.

Keep in mind:

- CPSP Practitioners should inform licensed medical and mental health staff of the high-risk situation. The mandated staff member has the responsibility to assure a report has been completed in the

Inform your supervisor immediately if you suspect that a child has been harmed or is in danger of being harmed. It is extremely important for all CPSP offices and clinics to have Policies and Procedures in place on how they will handle Mandated Reporting in their practice.

specific timeframes mandated by California law. CA Penal Code Ss 11165.9 and 11166

- A report must be made if there is a reasonable suspicion that a child is being abused or neglected. You do not need to prove that abuse/neglect occurred or know who did it to make a report. It is up to the authorities to investigate. The law was made to protect the children and get help for their care providers.

Reporting Child Abuse and Neglect

Child abuse and neglect must be reported when a child (defined as anyone who is under 18 years) experiences any of the following:

Physical Abuse

Any act that results in non-accidental physical injury is defined as physical abuse. It is most often the result of severe physical (corporal) punishment. It is considered abusive if discipline is excessive or forceful enough to leave injuries. These may include striking, shaking, pushing, or throwing the child. This definition also includes intentional, deliberate assault such as burning, biting, cutting, poking, twisting limbs, or otherwise torturing a child.

Physical Neglect

The law divides physical neglect into two categories: severe neglect and general neglect.

Severe neglect: endangering the child's health by intentional failure to provide adequate food, clothing, shelter, medical care, or supervision.

General neglect: failure to provide adequate food, clothing, shelter, medical care, or supervision where the child's health has not been endangered. This is reportable only to county welfare, not to law enforcement.

Sexual Abuse

Includes acts over a long period of time or a single incident that involves:

Sexual assault: rape, incest, sodomy, molestation, or other acts

Sexual exploitation: child pornography or promoting prostitution

See the *Teen Pregnancy and Parenting Guidelines* section for information on child abuse reporting laws for consensual sexual intercourse of minors.

Emotional Maltreatment

This includes verbal abuse and emotional deprivation. Such cases are extremely difficult to prove and only the most severe cases involving "willful cruelty or unjustifiable mental suffering" must be reported.

Past Abuse

A Mandated Reporter is required to report all instances of current and past child abuse and neglect as long as the victim is currently younger than 18 years of age. It is up to the child welfare agency whether or not they will investigate the case. When a report has been made, the Mandated Reporter has followed the law by reporting.

If the victim is now an adult and the abuse took place when the victim was younger than 18 years of age, a Mandated Reporter is not required to report the past abuse. However, if there are other children in the home of the abuser and there is a reasonable suspicion that these children may be currently in danger, a Mandated Reporter is required to report this as a possible danger to these children to the local child welfare agency.

Cultural Differences

Be aware of different cultural attitudes toward child raising and discipline. Some immigrant parents may need to be informed that customary discipline legally permitted in their country of origin may be against the laws of this country. Some parents may use severe physical punishment that they received as a child.

Abused Teens

If the teen is younger than 18 years of age and physically or sexually abused by someone in her home, a Mandated Reporter is required to report to the child welfare agency in his/her community. If she is battered by someone outside the home, such as a boyfriend, a Mandated Reporter is usually required to report the assault to law enforcement; they may direct the reporter to report to child welfare, depending on the policies of the specific county. The teen may be placed in a foster home or special teen shelter.

Steps to Take

Reporting Suspected Abuse and Neglect

Consult with your clinical supervisor immediately if you have any suspicions that a child is experiencing abuse or neglect. This should take place before the family leaves the office. It is extremely important for all CPSP offices and clinics to have Policies and Procedures in place on how they will handle Mandated Reporting in their practice. The Perinatal Service Coordinator in your local health jurisdiction will ask to see site specific Protocols, which should reflect this practice.

If you or your supervisor is unclear as to whether the case should be reported to the authorities, one of you should call your local child welfare agency for a "telephone consultation" to discuss the case. Remember to document the results of the phone consultation in the chart, including the date, time, agency and representative with whom you consulted.

If your supervisor will file the report, this will meet the mandate; however, always keep documentation that a report has been made within the time required by law. If your supervisor disagrees with a need for a mandated report and you still reasonably suspect a child is being abused or neglected, a Mandated reporter would still be required by law to report the suspicion of abuse and a non-mandated reporter is not liable for making a report based upon reasonable suspicion (as this is allowable by California law, and best when done in accordance with your practice protocols) through the mandated reporting law requirements. An employer is forbidden by law to stop or punish a Mandated Reporter who makes or intends to make a report as long as the reporter has a reasonable suspicion that a child is being or has been abused or neglected. Source: CA Penal code §11116 (h)-(i)

The Mandated Reporter may want to inform the family that he/she is making a report of child abuse or neglect. This is difficult because the family may be very upset or angry. However, in most cases, it is better to let the family know what is going to be reported and why.

Remind them that in your first meeting you said all discussions would be confidential, with the exceptions as required by law, such as if you suspected someone was being harmed. You need to take steps to protect the child and get help for the care provider(s).

Ask if they want to be present when the call is made to child welfare. This can be helpful in maintaining communication with them in a time of crisis. Tell them you want to help them find a successful resolution for the abuse or neglect investigation.

Making a Report

When reporting, a Mandated Reporter must give his/her name (which will be confidential unless the court orders the report be released to representatives

involved with the case). Non-mandated reporters or those not functioning in the role of a Mandated Reporter may report the suspected abuse at the time this is discovered.

If the situation is very serious and you feel the child is in immediate danger, call your local child abuse reporting line immediately. If there is no immediate danger to the child, a Mandated Reporter is required to report it as soon as possible by phone. Look in the White Pages of the phone book under County Social Services for the reporting phone number. Or you may find the number in the government pages of the phone book, under the county section; look for Department of Social Services or Department of Children and Family Services. In most communities, you will report to county welfare services who will then “cross report” or informs local law enforcement.

Within 36 hours of the phone report, a Mandated Reporter is required to file a written report using the **Suspected Child Abuse Report Form SS8572**. Obtain copies of this reporting form from the county child welfare agency and have them available in your office. The form can also be downloaded from the California Attorney General’s Office: www.caag.state.ca.us/childabuse/pdf/ss_8572.pdf.

Child Welfare is required by law to inform a Mandated Reporter of the results of any action the agency takes. They may not share the details of their findings, but will usually let you know if they will continue to provide services to the family or dismiss the case.

Dealing with a parent suspected of abusing or neglecting a child can be difficult. Discuss the difficulties in a case conference with other members of your health care team, as appropriate. Ask for emotional support, supervision, and training in working with difficult families.

Follow Up

Hopefully, the family will continue to see you after the report is made. Do not take it personally if they choose not to come back for care at your site or refuse to talk to you. You did what the law required or allowed in order to protect the child.

Find out the results of the report. Has a child welfare worker been to visit? What was that experience like? Did the worker make any recommendations or requirements? Is there a way you can help the family follow through on the plan?

Acknowledge that being a parent/care giver is a difficult job.

Build on strengths rather than focusing on weaknesses. See the **Parenting Stress Guidelines** section for additional suggestions.

Referrals

- Parenting classes/support groups
- Single parent groups
- Family support centers
- Respite care (short term, occasional child care)
- Child care or preschool
- Parent observation classes (available through some school districts or community colleges)
- Parental stress line (sometimes called a “hotline”)
- Parental advice line (sometimes called a “warmline”)
- Family counseling
- Child therapy
- Public health nursing
- Parent aide home visiting programs
- In-home family preservation programs
- Additional programs in your community that help parents under stress

- You may want to call your local child abuse council or parental stress line for additional referrals.

Resources

Prevent Child Abuse-California (PCA-CA)

For more information, call 1-916-244-1900.

The National Center for Youth Law

A private, nonprofit law office serving the legal needs of children and their families: See “Minor Consent, Confidentiality and Child Abuse Reporting in California” under “Publications”.

1-510-835-8098 / www.youthlaw.org

What to Look For

There are several ways you may identify that a child is being abused or neglected, according to the previous definitions.

The client may tell you of reportable abuse or neglect during the interview. For example, she may say:

- That she lost control and slapped the child in the face, leaving a black eye, when she was angry at the child for disobeying
- That her boyfriend burned the toddler with his cigarette to punish her for wetting her bed
- That she left the 5 year old alone at home all day unsupervised
- That her uncle is sexually abusing his adolescent daughter
- That she sold her CalFresh (Food Stamps) to buy drugs and the children haven't eaten in two days

You may also observe reportable abuse or neglect in your office. For example, you may see:

- The mother violently shake the newborn when the baby won't stop crying
- A toddler who is continually dirty and not dressed appropriately for the weather
- The child has an injury that doesn't fit the parent's explanation, such as the one-month-old baby pulling the toaster on top of its head

The abuse or neglect may be caused by the child's mother, father, or other caretaker.

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Background

Violence against women is a widespread problem. It is estimated that 1 out of every 12 pregnant women is abused during her pregnancy by her spouse or partner. It can happen in families of all socioeconomic, religious, and ethnic groups.

Intimate partner violence is a pattern of assaultive and coercive behaviors including physical, sexual, and psychological attacks that adults or adolescents use against their intimate partners.

The abuse may take many forms. There may be **physical abuse** such as hitting, slapping, kicking, pushing, shoving, grabbing, biting, attempted strangulation, or assault with an object or weapon. Psychological abuse may also include **emotional and economic abuse**. This can include threats of violence, verbal abuse, social isolation, total control of the family's finances, or other methods of controlling the victim, like birth control sabotage. There may be **sexual abuse** including forced sex, or reproductive coercion (putting pressure on a woman to get pregnant against her wishes). There may also be birth control sabotage.

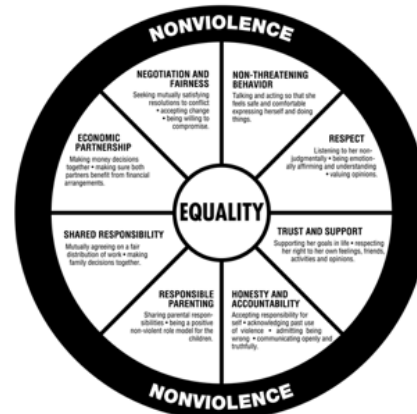
Physical abuse during pregnancy is recognized as a significant health risk for both the mother and baby. If abuse occurs, it frequently begins or escalates during pregnancy. Women have reported direct blows to the pregnant abdomen, injuries to the breasts and genitals, and sexual assault.

Abused women are twice as likely to wait to begin prenatal care until the third trimester. They are at increased risk for **complications of pregnancy** such as poor weight gain, urinary tract and sexually transmitted infections, first or second trimester bleeding, anemia, smoking, and alcohol or other drug use. They are also more likely to deliver an infant with low birth weight and have a higher potential for killing the batterer.

Inform your supervisor immediately if:

- The client has current injuries
- The client is a danger to herself or others
- The client has no option for safe shelter
- The batterer is threatening the client or staff

Domestic Abuse Intervention Programs (<https://www.theduluthmodel.org/>) developed the *Power and Control Wheel* and the *Equality Wheel* which provides a simple framework to understand the range of abuse that constitutes domestic violence and the tenets of a relationship built on equality. More information on the abuse categories can be found at <https://www.theduluthmodel.org/?s=power+and+control+wheel>



Cycle of Violence

Violence is rarely an isolated event. It tends to follow a pattern called “the cycle of violence.” There are usually three phases of the cycle:

- **Increased tension**, anger, blaming, and arguing
- **Abusive incidents**, which may include hitting, slapping, kicking, choking, use of objects or weapons, sexual abuse, verbal threats, or other abuse
- **“Honeymoon” phase**, in which the man may deny the violence, say he was drunk, say he’s sorry, and promise that it will never happen again

The cycle is usually repeated over and over, getting more frequent and severe. The honeymoon phase may get shorter and shorter over time.

Effects on Children

Children who grow up in a household where a parent is abused may suffer physically and emotionally. The effects will vary according to the individual child, but most children living in a family where the parent is abused are also victims of abuse. Children are frequently accidental victims when they attempt to intervene or protect their parent.

Even if the children do not witness the battering, they are affected negatively by being cared for by a depressed or anxious caretaker. If a mother is aware of the effect on her children, she may be more likely to seek help to end the abuse for their sake.

Interviewing the Client

Interview the client alone in a private setting without her partner or children present. If you are using an interpreter, use a staff member, not a family member or friend. Tell the support person you are glad they came to the visit, but it is the federal law (HIPAA) and clinic practice to interview each client alone for part of each visit.

Screen all clients by asking questions about present or past abuse. Approach the topic like any other health risk assessment.

Start with a statement acknowledging that all families have conflict such as:

- *All families have disagreements*
- *All couples fight from time to time*

Inform the client that because of your concerns for your clients’ health, you ask all of them questions about violence in the home. Remind her that her responses will be confidential unless she is being abused and:

- She has current physical injuries, in which case you are mandated (required) to report to local law enforcement; see the *Complicated Situations Guidelines* section for more information.
- She is under the age of 18 and is being abused, in which case you are required to report to your county’s child abuse reporting agency; see the *Complicated Situations Guidelines* section for more information.

Ask general questions about conflict in her home. Some examples are:

- *What are fights like in your house?*
- *What happens when your partner doesn’t get his or her way?*
- *Do you feel safe at home?*

You may need to ask more direct questions such as:

- *Has your partner ever hit, punched, slapped, kicked, or hurt you in any way?*
- *Have there been times during your relationship when you have had physical fights?*

Encourage, but do not insist, that the woman respond to your questions. A woman will choose to share a history of violence when she is ready.

If she denies abuse, but you strongly suspect that it's taking place, let her know that you're available to talk in the future if she wishes.

Steps to Take

If the woman admits to **physical abuse**, get details of current and past occurrences including how badly she was hurt and how often it has happened. Ask about the first, worst, and most recent violent assaults.

Empathize with her and validate her feelings; express support by simple statements such as:

- *You are not alone.*
- *No one deserves to be treated this way.*
- *You are not to blame.*
- *You are not crazy.*
- *What happened to you is against the law.*
- *Help is available.*

Reassure the client she does not deserve to be treated this way, and that you are there for support.

Intimate partner abuse is against the law. This may be new information to immigrant women from some countries where spousal battering is socially accepted and even legal. Offer to listen if she wants to talk. Ask what you can do to help.

Respect the cultural values and beliefs that affect her behavior and decision making. These beliefs may be a source of security. Do not minimize their importance.

Focus on concrete problem solving and emotional support, not on telling her what to do.

If There are Current Injuries

A woman with current physical injuries that you suspect are the result of assault or abuse should be immediately referred to the health care provider who will assess and document the extent of the problem.

Clearly document the client's statements about the current injuries and past abuse using direct quotes from the client, writing: The client states that...

Explain to the client that a report to the police is required by law. Inform her of the likely response by law enforcement. In some counties, the report will be filed but the police will not get involved unless requested by the victim. In other counties, the police will investigate and the district attorney will attempt to prosecute the batterer even if the victim does not want to press charges.

Ask if she wants to be present during the phone call to the police. Inform the police if:

- There are any special concerns regarding how the report should be handled. This may include how the client should be contacted so that her safety is not threatened.
- The client is at a confidential address
- The client has special needs such as need for a translator

The designated staff member must:

- Report to the police (in the city or county where the assault took place) by phone immediately or as soon as you are capable of making the called-in report
- Submit a written report within 48 hours using the Suspicious Injury Report OCJP-92 available on the Governor's Office of Emergency Services website (<http://www.caloes.ca.gov/>) under Law Enforcement and Victim Services Division Publication.
- Document in the medical chart that the verbal and written reports have been made

Help her make a safety plan if there is risk of retaliation by the batterer.

Assessing Her Safety

Before the client leaves the medical setting, assess how safe it is for her and her children to return home. Discuss the possible indicators of escalating danger and increased homicide potential. Watch for:

- An increase in how often or severely she is beaten
- Increasing or new threats of homicide or suicide by the batterer
- A batterer who is severely depressed
- Threats to her children, pets, or extended family members
- Violence by the batterer outside the home
- A weapon, especially a firearm, in the house or available to the batterer
- Drug and alcohol abuse by the batterer (not the cause of violence, but frequently the two behaviors co-exist)
- Watchfulness by the batterer of the woman outside the home
- Obsession by the batterer about the woman, including extreme jealousy or accusations of unfaithfulness
- Forced sexual encounters, reproductive coercion (which may include birth control sabotage)
- Rage by the batterer at the possibility of being left by the woman
- A shortened or absent “honeymoon phase”; the batterer stops saying he is sorry

In general, the woman is the best authority on matters of her own safety and the best predictor of her partner’s behavior. However, she may also benefit from your feedback and objective assessment of the situation.

Make a Safety Plan

If it is not safe for your client to return home, help her explore options for staying with family or friends.

If she is unable to stay with a family member or friend or this is determined to be unsafe, help her contact a **battered woman’s shelter**. If they are full, they can advise on alternatives.

If the woman decides it is safe to return home, encourage her to pack an overnight bag in case she needs to leave quickly in the future. The bag can be hidden or left with a trusted friend/family member. The bag might include:

- Toiletry articles and prescription medications
- An extra set of clothing for herself and the children
- A special toy, book, or blanket for each child
- Extra cash, checkbook, and savings account book
- Important papers such as Social Security cards, CalFresh (Food Stamps), Medi-Cal or clinic cards, SSI or CalWORKs papers, birth certificates, immigration papers, medical records including immunization records for the children, marriage certificate, divorce decree, child custody order, restraining order, income tax returns, school records, diplomas, professional licenses, membership cards, union cards, restraining orders, police reports, rent receipts, copy of lease, utility bills, title to the car, etc.
- Keys to house, car, safety deposit box, etc.
- Personal mementos such as photo albums
- A cell phone or an address book and phone numbers

If she cannot take these things when she leaves, she can ask the police to meet her in the home later and wait for a short time while she gathers her belongings.

Important Considerations for Women with Children

If possible, it is best to **take the children with her when she leaves**, unless their father has been given

custody in a legal proceeding or it is not safe for her to do so. She should get a **restraining order** as soon as possible that can include a temporary custody order, if she does not already have each. This order gives her the right to keep the children; otherwise the father has equal rights to the children.

Advise her to be careful with whom she leaves the children, because the father may try to get them back. Once she has a temporary custody order, she should notify the child's school or day care of the problem so they won't release the children to anyone other than her.

Legal Options

Refer the woman to a legal resource to help her determine if she is able to remain in the home and have her partner receive a "kick out order." Once the partner is out of the home, advise the woman not to let him back in, even if he seems calm and apologetic. Review the cycle of violence and the "honeymoon phase."

You should not provide legal advice; however, you can tell the woman that she has several legal options designed for her protection and she should seek advice on those options, which include:

- Orders of protection such as emergency protective orders and restraining orders
- Pressing criminal or civil charges against the batterer

Recognizing Danger

Remind the woman to **call 911 in case of emergency**. She should tell the police that she is in danger and needs help immediately. She should let them know if she has a court order. If the batterer is arrested and taken to jail, it is most likely he will be released and the woman may be at increased risk. Assist her in making plans to protect herself. She may use the time to quickly gather her personal belongings and find a safe place to stay.

Re-evaluate her situation and be sure to reassess her safety and reinforce her options.

If a client chooses to leave the abusive relationship, it may take multiple attempts. Continue providing support, client education, and referrals to the woman who stays with her batterer.

Try not to be angry or disappointed with a woman who stays with an abusive partner.

She may be doing the best she can to cope with her situation. Women may stay for many reasons. These may include financial, religious, cultural, and many other reasons. In many cases, the woman wants the abuse to stop, not the relationship with her partner. Be honest and explain your concerns for her safety, and let her know that she can always come back to you and you will care about her regardless of her decision.

Referrals

Review with the woman resources appropriate to her situation. This may include referrals to:

- Battered women's shelters
- Legal assistance
- Law enforcement
- Counseling programs for batterers
- Individual counseling or group support for the battered woman and or her children

Couples counseling may benefit the victim and perpetrator.

A counselor who specializes in domestic violence is recommended.

If she refuses referrals, offer her a resource phone number in case she changes her mind. Write the phone number on a clinic appointment card or prescription blank, which is safer than a brochure or resource list. It can be dangerous for her to have written information about intimate partner violence in her possession. Always document in the chart what you have done.

Provide all clients with an opportunity to learn about community resources for battered women.

Have pamphlets and other materials that can be picked up anonymously from the exam room or bathroom where she is usually alone at some point. Information left in the client waiting area is less likely to be picked up by a battered woman, but may be taken by a concerned friend or family member. Materials may be available from local battered women’s shelters or agencies listed in the “Resources” section of this chapter.

Complicated Situations

If the Battered Woman is also a Substance Abuser

Most battered women’s shelters will not accept women who are actively using drugs or alcohol. See the *Perinatal Substance Use/Abuse Guidelines* section.

If the Client is under 18 Years of Age

If the client is younger than 18 years of age and has been physically or sexually abused by someone at home, you are required to report to the local child welfare agency. See the *Child Abuse and Neglect Guidelines* section. If she is battered by someone outside the home, such as the boyfriend, you are usually required to report the assault to law enforcement; they may direct you to report to child welfare, depending on the policies of your county. Some communities have special shelters for teens. Some of these may accept pregnant teens. A few will accept a teen and her child.

If the Client is Developmentally Delayed or Appears Mentally Incompetent

If the client is developmentally delayed or appears mentally incompetent, she should receive an evaluation to determine if a report should be made to Adult Protective Services.

Abused Immigrants

VAWA (Violence Against Women Act)

A federal law called the Violence Against Women Act, or VAWA, may provide help to an abused immigrant. If the client or her child is battered or subjected to extreme cruelty by her spouse and he is a U.S. citizen or a legal permanent resident (has a green card), she may be able to file a “self petition” for a Legal Permanent Resident card without the abuser’s assistance or knowledge. She is eligible to apply even if she is undocumented. An immigration attorney can determine if she qualifies and can help her with her application.

If she and her spouse are both undocumented, she is not eligible to apply for a Legal Permanent Resident card under VAWA. She may go to a domestic violence shelter which will not ask about her immigration status.

If her children are U.S. citizens or lawfully present immigrants, they may be eligible for other benefits such as CalWORKs and CalFresh (Food Stamps), and she can apply on their behalf. See the *Legal/Advocacy and New Immigrant Guidelines* sections for further assistance.

Victims of Trafficking and Violence Protection Act

If the battered immigrant does not qualify for VAWA, she may be eligible for protection under the federal Victims of Trafficking and Violence Protection Act of 2000. This law created two new nonimmigrant visas for noncitizen victims of crimes, the T-visa and the U-visa. Both visas are designed to provide immigration status to noncitizens who are assisting or are willing to assist authorities investigating crimes.

The U-visa is designed for noncitizen victims who have suffered substantial physical or mental abuse from criminal activity and who agree to cooperate with government officials investigating or prosecuting the crime, which may include intimate partner violence.

The abuser does not need to be a U.S. citizen or lawful permanent resident, and the person being abused does not have to have been married to the abuser to be eligible for a U-visa. The federal law gives victims work authorization and California law gives them access to certain public social service, including, but not limited to, refugee cash assistance, Medi-Cal, employment social services, and Healthy Families Program benefits. To receive the benefits, noncitizens would have to be otherwise eligible for the programs and working to meet federal eligibility requirements. After three years, U-visa holders may apply for lawful permanent residence.

To learn more about U-visas visit www.usimmigrationsupport.org/visa-u.html.

The T-visa is for victims of severe forms of trafficking who are assisting in the investigation or prosecution of trafficking, and who would suffer extreme hardship involving unusual and severe harm if they were deported.

California Victim Services

The California Victim Compensation Program (CalVCP) is a statewide program that provides reimbursement for medical-related expenses, outpatient mental health treatment or counseling, wage or income loss, and other services for victims or witnesses to a violent crime such as intimate partner abuse; this includes children who have witnessed domestic violence. Contact the California Victim Compensation Program at 1-800-777-9229. For more information check out: www.vcgcb.ca.gov/victims.

Resources

National Domestic Violence Hotline

Crisis intervention, information about domestic violence, and referrals to local service providers for victims of intimate partner violence.

1-800-799-SAFE (7233) or 1-800-787-3224 (TTY) / www.thehotline.org

Futures Without Violence

Free brochures on intimate partner violence and immigrant women in eight languages; also protocols for clinicians, posters, and other patient education materials.

1-415-678-5500 / www.futureswithoutviolence.org

California Family Health Council Health Information and Education Division

Produces patient education materials available for a small fee; these include "No One Deserves to be Abused" in English and Spanish and the "Everyone has a Right to Live Free from Abuse" wallet card and "Is it Really Love?" in English and Spanish for teens.

1-800-428-5438

<http://www.cfhc.org/learning-exchange>

The National Immigration Law Center (NILC)

A national support center with two offices in California which is an excellent resource for information on the latest immigration laws. Offers many free brochures in several languages. National Headquarters in:

Los Angeles: 1-213-639-3900

Oakland: 1-510-663-8282

www.nilc.org

The California Immigration Welfare Collaborative

Up-to-date information on the current laws on immigrants' rights to public benefits and free brochures in several languages.

Sacramento: 1-916-448-6762

Oakland: 1-510-451-4882

Los Angeles: 1-213-250-0880

www.caimmigrant.org

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Safety When Preparing to Leave

There are laws to protect you from violence and shelters to help you leave your partner. If you have children, they need you to protect them. It takes great courage to leave an abusive man. Even if you think the abuse won't happen again, it is important to plan ahead, and to include where to go and how to get there.

- Call a shelter or hotline for help with making a plan
- Keep the telephone number handy
- Tell someone you trust about the violence
- Hide all important papers (birth certificate, Social Security cards, Medi-Cal cards, etc.). Keep them in one place so you can take them when you leave
- Put aside as much money as you can each week for when you leave
- Leave an extra set of keys with someone you trust, as well as copies of important documents, extra medicines, and clothes
- Have quarters ready for telephone calls and keep your cell phone charged
- Decide what you will take with you. Keep the list short but include one special toy or blanket for each child.
- Determine who would let you stay with them or lend you money for a place to live if necessary
- Review the safety plan yourself and with your children as often as possible in order to plan the safest possible way to leave
- Always remember, leaving a batterer is often the most dangerous time for women experiencing intimate partner violence



Cómo cuidar de su seguridad cuando se prepara para dejar a su pareja

Hay leyes para protegerla contra la violencia, y albergues para ayudarla a dejar a su pareja. Si tiene hijos, necesitan que los proteja. Hace falta mucho valor para dejar a un hombre que la maltrata. Aunque crea que el maltrato no volverá a ocurrir, es importante planear de antemano, incluyendo adónde ir y cómo llegar.

- Llame a un albergue o línea de asistencia para que la ayuden a formular un plan.
- Tenga el número de teléfono a mano.
- Cuénteles a alguien en quien confía sobre la violencia que está sufriendo.
- Esconda todos los documentos importantes (certificado de nacimiento, tarjetas del Seguro Social, tarjetas de Medi-Cal, etc.). Guárdelos en un solo lugar para poder llevárselos cuando se va.
- Ahorre todo el dinero que pueda cada semana para usarlo cuando se vaya.
- Dele una copia de sus llaves a alguien en quien confía, así como copias de documentos importantes, medicamentos adicionales y ropa.
- Tenga a mano monedas de 25 centavos para hacer llamadas telefónicas y tenga su celular cargado.
- Decida qué llevará consigo. Haga una lista corta, pero incluya un juguete o cobija especial para cada hijo.
- Determine con quién se podrá quedar o quién le prestará dinero para albergarse de ser necesario.
- Revise el plan de seguridad, y revíselo con sus hijos, todas las veces que pueda para planificar la manera más segura de irse.
- Recuerde siempre: Irse es, a menudo, el momento más peligroso para una mujer que sufre de violencia a manos de una pareja íntima



Most batterers act in a pattern described as a "cycle of violence."

The cycle has three parts.

Part One

Tension

The abuser is angry and blaming. There is increased tension with lots of arguing. The abuser acts controlling and needs to be in power.

Part Two

Violence

This may be a one time slap, kick, push or punch, or it may be hours of repeated beatings. There may be weapons or objects used to further injure or threaten the woman. Sometimes sexual abuse also happens.

Part Three

Calm

The abuser may deny or minimize the battering. The abuser may promise never to hit again and apologize. The abuser may make promises to change and blame alcohol, drugs, or other people for abusive behaviors.

Most battered women and their children try many things to get the abuser to stop. Usually no matter what is done, the woman is still battered. It is important to know that you are not to blame for the abuser's behavior. You cannot stop the abuser. If there is already battering in your life, it may get worse during pregnancy. Pregnancy is stressful for a couple. If you are pregnant, your baby will need to be safe from violence.

La mayoría de los golpeadores siguen un patrón que se describe como un "ciclo de violencia".

El ciclo tiene 3 partes

Primera parte

Tensión

El golpeador se enoja y asigna culpas. La tensión aumento, hay muchas discusiones. El golpeador es controlante y necesita tener el poder.

Segunda parte

Violencia

Puede ser una sola bofetada, patada, empujón o puñetazo, o pueden ser horas y horas de golpes repetidos. Puede haber armas u objetos que se usan para lesionar o amenazar más a la mujer. A veces también hay maltrato sexual.

Tercera parte

Calma

El golpeador puede negar o minimizar la violencia. El golpeador quizás prometa nunca volver a golpearla, y pedirle perdón. El golpeador puede prometer que va a cambiar y echa la culpa al alcohol, las drogas u otras personas por su conducta violenta.

La mayoría de las mujeres golpeadas y sus hijos intentan muchas cosas para conseguir que el golpeador deje de hacerlo. En general no importa lo que hagan – seguirá golpeando a la mujer. Es importante saber que usted no tiene la culpa de la conducta del golpeador. No puede detener al golpeador. Si ya hay violencia en su vida, ésta puede empeorar durante el embarazo. El embarazo es estresante para una pareja. Si está embarazada, su bebé necesita estar seguro y lejos de la violencia.

Background

During pregnancy, we now know that there are risks associated with any use of alcohol or other drugs. One essential resource is Mother To Baby which provides evidence-based information to mother about medications and other exposures during pregnancy and while breastfeeding. In addition to the most up-to-date fact sheets, MotherToBaby.org has many ways to engage clients: (1) an on-line “Chat Live with An Expert;” (2) a toll free warm line at 866-626-6847; (3) text them at 855-999-3525; and (4) email. These services are also available to health care professionals, and the general public. These guidelines cover the addictive use of the following substances:

Legal substances

Alcohol

Prescription drugs:

- Amphetamines: Ritalin, Aderall, Dexedrine
- Benzodiazepines: Klonopin, Xanax, Valium (also known as Diazepam), Halcion, Rohypnol
- Barbiturates: Pentobarbital, Seconol
- Opiates: Oxycontin, Codeine, Morphine

Illegal substances:

- Opiates: Heroin
- Cocaine
- PCP
- Marijuana
- LSD
- Methamphetamines

Refer to the *Health Education Steps to Take Guidelines* to help the client who uses tobacco, drugs, or alcohol on occasion.

For some people, addiction gets worse over time and can be life-threatening if left untreated. **But it is a**

Refer to your supervisor if you suspect that a client is using any drugs or alcohol during pregnancy.

treatable disease. While addicted people may not be responsible for their disease, they are responsible for their recovery. Many have sought help and currently live productive, clean, and sober lives.

Pregnancy can be a “window of opportunity” when an addicted woman may be highly motivated to accept help for her substance abuse. Non-punitive approaches seem to work the best.

Risks of Perinatal Addiction

Any substance use during pregnancy may cause harm to the pregnancy and the developing baby. Encourage all pregnant women to avoid all drugs and alcohol.

Pregnant women who use substances and their babies are vulnerable to numerous **medical complications** such as:

- Miscarriage
- Preterm labor
- Abruptio placenta
- Intrauterine growth retardation
- Fetal distress
- Intrauterine fetal death
- Birth defects

Whether or not an individual woman will have these problems depends on many factors such as:

- The type of alcohol or other drugs used
- The amount of alcohol or other drugs used
- The frequency of alcohol or other drugs used
- The weeks gestation of the pregnancy
- Individual characteristics of the baby

No one knows why some babies may be more affected by their mothers' substance use than others. Some women will say, "I used and drank with my other kids, and they're fine." That may be true, but this baby may be affected differently than his or her siblings. There is no way of knowing until the baby is born. By that time, the harm is already done.

It is common for addicted women to use more than just alcohol or one drug. If there are medical complications, they may be due to interactions between the different substances she uses, or to lifestyle choices related to nutrition and health and not the substances themselves.

What to Look For

Assessing the Woman's Drug Use

As part of the psychosocial assessment and reassessment, ask all clients about past and current substance use including:

- Type
- Amount
- Frequency
- Date of last use

Some women who use substances will say they use less than they actually do. Some will deny use because they fear disapproval or being reported to child protective services. Therefore, you need to be aware of some of the signs of substance abuse:

- The woman's current status
- Smell of alcohol on her breath
- Slurred speech
- Staggering walk
- Irritability or extreme restlessness
- Inappropriate or strange behavior
- Trouble concentrating
- Suicidal feelings, gestures, or attempts

- Mood swings
- Depression
- Poor nutritional status
- Memory lapses and losses
- Blackouts
- Frequently missed appointments without notice and/or frequently arriving very late (hours) to appointments

The Woman's Other Children

- Previous involvement with Children's Protective Services including foster care or placement with relatives
- Fetal alcohol spectrum disorder
- Learning disabilities or hyperactivity
- Poor school performance or behavior problems

The Woman's History

- Complicated perinatal history including premature birth, growth retardation, or multiple miscarriages
- Many emergency room visits
- Psychiatric treatment or hospitalization
- Depression
- Intimate partner violence
- Partner is a substance abuser
- Client's parent is/was a substance abuser
- Automobile accidents or citation arrests
- Little contact with family or friends isolation

Steps to Take

Provide Education

Discuss the woman's substance use as a health concern, not a moral problem. Some pregnant addicts view themselves as bad mothers and suffer from intense feelings of guilt, shame, and low self-esteem.

Express your concern for the client and her developing baby, and the harm using alcohol and other drugs can cause both.

Provide Referrals

Explain that help is available if she wants to stop substance use. Many other women in her situation are leading alcohol and drug-free lives and can show her how to begin. If possible, refer her to a substance abuse treatment program that is woman-focused and can meet her special needs once the baby is born. County alcohol and drug programs are aware of such programs.

Determine if the client's partner is also a substance user. If so, this may contribute to her stress and make her recovery efforts more difficult. Make appropriate referrals for treatment for the partner so they can support each other in "staying clean." Support the healthy aspects of the woman's life such as coming for prenatal care. Express interest in her priorities. Encourage her to talk about her feelings. Let her know you will support her in her struggle against addiction.

Inform her that Children's Protective Services may evaluate her situation at the time of delivery. They may place the newborn outside the home if they decide that the infant is not safe in her care. Let her know that this may be a good opportunity to begin her recovery process and it may make a difference for her baby.

Act as an Advocate

Offer to act as an advocate with the child welfare system.

Refer her to a public health nurse who can work with her in the home to follow through on the treatment plan.

If she reports intravenous drug use, discuss the risk of exposure to HIV through sharing needles having a sexual partner who uses IV drugs, and risky sexual

practices that can occur while high. Offer a referral for HIV testing. See the Perinatal Health Guidelines, "HIV/STIs" section.

If the client denies alcohol or other drug use after discussing the topics above and you still suspect she is using, discuss the case with your clinical supervisor and the health care provider for coordinated care.

Some addicted people may be very hard to help, and others may not want help at all. Assess what kind of help she desires and focus on meeting that need. Try to find out her most immediate concerns and focus on specific things that can be done.

Prenatal Exposure to Alcohol and Other Drugs

Currently, child welfare agencies will not accept a prenatal report for alcohol or other drug exposure of the fetus. This is not considered child abuse. A postpartum report may be made by the staff at the delivery hospital if the newborn is suspected to be at risk.

Parental alcohol and other drug abuse alone, by law, is not sufficient proof for a report of child abuse and neglect. However, if it is reasonably suspected that the child is being abused or neglected, a report should be made. See the *Child Abuse and Neglect Guidelines* section for further information.

Follow Up

Continue to:

- **Praise** her for continuing her prenatal care
- **Assess** her alcohol and other drug use
- **Educate** her about the health and child welfare consequences of her addiction
- **Refer** her for appropriate treatment
- Offer to **act as an advocate**

Recognize successes no matter how small. Assure her that requesting help is an act of strength and self-respect.

Request a release of information from the client if she is in a substance abuse treatment program. This will enable you to communicate with her counselor and assist in her recovery.

See if she has followed through on any referrals that you made previously such as referrals to public health nursing, substance abuse treatment, and other services.

Inform social services or medical staff at the delivery hospital of the client's history of alcohol and other drug use. This will give the mother and infant appropriate hospital care.

Relapse is a normal part of the recovery process.

This is not a sign of failure for either the client or you. It is rare for a person to quit using substances and never relapse. Encourage her to talk to her substance abuse counselor about ways to prevent future relapse.

For women that are receptive, stress the benefits of her quitting at this stage of the pregnancy.

Stress other things she is doing right, such as getting prenatal care. Every day she does not use alcohol or other drugs helps her developing baby. Remind her of the benefits of a drug-free lifestyle in providing good care to the baby after the birth.

Dealing with Your Feelings

Some of your clients will not quit or cut down their alcohol or other drug use. This may make you feel frustrated, angry, or that you have failed. You have done your job if you have maintained a respectful tone of service, assessed, educated, referred, and offered to act as an advocate. **You are not responsible for the substance user's behavior, only your own.** Talk with your supervisor or co-workers about your feelings. Attend trainings to help you deal with these feelings and to learn more about working with clients who use substances.

Referrals

- Substance abuse treatment: either residential or outpatient counseling
- Self-help groups such as: NA (Narcotics Anonymous), AA (Alcoholics Anonymous), CA (Cocaine Anonymous)
- Public health nursing
- Parenting support
- Respite (short-term, occasional child care)
- Smoking Cessation: 1-800-NO BUTTS
- MothersToBaby.org

Call your county department of alcohol and drugs services to find the most appropriate referral for your client.

Complicated Situations

If the client is a teen under the age of 18 years, it may be hard to find a substance abuse treatment program that will accept minors. Advocate for her with the county's drug treatment agency, stressing the medical urgency of treatment. See the *Teen Pregnancy and Parenting Guidelines* section.

For a client who is homeless or the victim of domestic violence and actively abusing substances, finding a shelter may be more challenging. Help her find a medical detoxification program that accepts pregnant women so she will be able to go to a shelter. See the *Financial Concerns and Spousal/Intimate Partner Abuse Guidelines* sections.

If the client has psychiatric problems that were present before her addiction, she is considered to be "dually diagnosed." Individuals with a dual diagnosis may use substances in an effort to seek relief from their psychiatric symptoms. Once the client quits using substances, the psychiatric symptoms such as depression may be more obvious. Refer for mental health services. See the *Emotional or Mental Health Concerns and Depression Guidelines* sections.



ANY use of alcohol or other drugs during pregnancy may cause harm to you and your baby.

- *No one knows how much alcohol (beer, wine, hard liquor) or drugs (pot, coke, meth, oxy, other pills or drugs) is too much.*
- *Why take a chance with your baby's future?*

- *Now is the time to stop drinking or using. Your baby needs you to say "NO".*
- *What can happen if you continue to use or drink?*

Alcohol Can Cause:

- Miscarriage
- Facial defects
- Small baby
- Heart problems
- Mental retardation
- Hyperactivity
- Slow learners
- Behavior problems
- Fetal Alcohol Spectrum Disorder

Drug Use Can Cause:

- Miscarriage
- Addiction of the baby
- Birth defects
- Hyperactivity
- A small baby
- Behavior problems
- A baby born too early

Many pregnant women worry that if they admit they "use," their baby will be taken from them. This usually does not happen. Entering a treatment program shows you want to change. The program will help you to stop "using" and teach you new ways to take care of yourself and be a clean and sober mother.

Talk to your health care provider or clinic counselor about a treatment program that can help you and your baby. It is never too late to stop. To find the most up-to-date information on medications, alcohol and drug exposure while pregnant or when breastfeeding go to MotherToBaby.org.

Now is the best time to quit!



Su bebé no puede decir que “no”

CUALQUIER uso de alcohol u otras drogas durante el embarazo puede causarle daño a usted y a su bebé.

- *Nadie sabe qué cantidad de alcohol (cerveza, vino, bebidas alcohólicas) o drogas (mota, coca, meta, oxy, otras pastillas o drogas) es demasiado.*
- *¿Para qué arriesgarse con el futuro de su bebé?*
- *Ahora es el momento de dejar de tomar alcohol o usar drogas. Su bebé necesita que usted diga que NO.*
- *¿Qué puede pasar si sigue usando drogas o tomando alcohol?*

El alcohol puede causar:

- Aborto espontáneo
- Defectos faciales
- Bebé pequeño
- Problemas del corazón
- Retraso mental
- Hiperactividad
- Aprendizaje lento
- Problemas de conducta
- Trastorno del espectro alcohólico fetal

El uso de drogas puede causar:

- Aborto espontáneo
- Adicción en el bebé
- Defectos de nacimiento
- Hiperactividad
- Bebé pequeño
- Problemas de conducta
- Nacimiento prematuro

Muchas mujeres embarazadas temen que les quiten a sus bebés si admiten que usan drogas o alcohol. En general esto no ocurre. Si ingresa en un programa de tratamiento, será una señal de que quiere cambiar. El programa la ayudará a dejar de usar drogas o alcohol y le enseñará nuevas maneras de cuidarse y de ser mejor mamá sin las sustancias.

Hable con su proveedor de atención de la salud o consejero de la clínica sobre un programa de tratamiento que los pueda ayudar a usted y a su bebé. Nunca es demasiado tarde para dejar de usar las sustancias. Para acceder a la información más actualizada sobre la exposición a medicamentos, alcohol y drogas durante el embarazo o mientras está dando pecho visite MotherToBaby.org.

¡El mejor momento para dejar de usar las sustancias es ahora!



Drugs and Alcohol, When You Want to STOP Using

- Get all drugs and alcohol out of your house
- Get all items you associate with drugs and all drug paraphernalia out of your house
- Tell people you live with that you cannot have any drugs, alcohol, pipes, bongs, or drug paraphernalia around
- Tell roommates, family members, and the father of the baby to stay away unless they are clean, sober and not using
- If you can't clean up your environment, move
- Avoid people, places, things, and thoughts you connect with using
- Get and use the phone numbers of others who understand
- Use your local recovery resources (AA, NA, CA and other programs)

To find the most up-to-date information on medications, alcohol and drug exposure while pregnant or when breastfeeding go to MotherToBaby.org.



Drogas y alcohol: Qué hacer cuando quiere DEJAR las sustancias

- Saque de su casa todas las drogas y todo el alcohol.
- Saque de su casa todos los elementos que asocie y que estén relacionados con las drogas.
- Dígales a las personas que viven con usted que no pueden tener drogas, alcohol, pipas, pipas de agua u otros accesorios de drogas cerca de usted.
- Dígales a sus compañeros de cuarto, familiares y al padre del bebé que se mantengan alejados a menos que no usen drogas o alcohol.
- Si no puede lograr cambiar el ambiente en que vive, múdese.
- Evite a las personas, los lugares, cosas y pensamientos que usted conecte con el uso de sustancias.
- Consiga y use los teléfonos de personas que entiendan por lo que está pasando.
- Use los recursos de recuperación disponibles en su zona (AA, NA, CA y otros programas).

Para acceder a la información más actualizada sobre la exposición a medicamentos, alcohol y drogas durante el embarazo o mientras está dando pecho, visite MotherToBaby.org.

Prescription medication misuse and overdose is a national epidemic. The misuse of opioid medications has significant consequences for pregnant women and their babies. The prevalence of maternal opioid drug use at the time of delivery in California is approximately very low. Taking opioid medication early in pregnancy can cause birth defects such as neural tube defects, congenital heart defects and gastroschisis. Neonatal abstinence syndrome (NAS) develops in 42 to 94 percent of infants born to narcotic dependent mothers, and often leads to prolonged treatment in a neonatal intensive care unit.

NAS is a term used to describe the constellation of symptoms experienced by newborns withdrawing from substances on which they have become physically dependent while in utero. Exposure of the fetus to opiates, cocaine, amphetamines, or antidepressants may result in NAS. However, the most common causes are maternal opiate use (e.g., heroin, methadone) and misuse of prescription painkillers (e.g., oxycodone). The neonate may be poly-drug exposed to illicit and licit drugs, nicotine, and alcohol. NAS usually manifests between 2-7 days following birth, depending on the amount and type of substances used by the mother during pregnancy.

Symptoms of NAS

Not all exposed babies will withdraw. For those that do, symptoms will vary in severity depending on drug, dosage, and age of the baby at delivery. Symptoms of withdrawal may begin as early as 48-72 hours after birth or as late as 4 weeks of age. Here are some of the most common symptoms of withdrawal for full-term babies:

- Irritability (excessive crying)
- High-pitched crying
- Trembling

- Difficulty sleeping
- Tight muscle tone
- Hyperactive (overactive) reflexes
- Seizures
- Yawning, stuffy nose, and sneezing
- Poor feeding and sucking
- Vomiting
- Diarrhea
- Dehydration
- Sweating
- Fever or unstable temperature

Diagnosis of NAS

An accurate report of the mother's drug exposure is important. Urine and stool samples will be collected from the infant for toxicology screening. An assessment tool, which helps diagnose and grade withdrawal, may be used to evaluate the presence of symptoms.

Refer to the Psychosocial section on Alcohol or Drug Use Steps to Take for guidelines on addressing substance use.

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Background



One in five adults living in the U.S. will have an emotional problem that is severe enough to need treatment. Emotional problems go unnoticed for many reasons. Clients consistently under-report personal distress to their physicians.

Women of every culture, age, income level and race can develop perinatal mood and anxiety disorders. Symptoms can appear any time during pregnancy and the first 12 months after childbirth.

Causes of Emotional Problems

Some emotional problems are related to a specific situation or crisis. Some are the result of chemical imbalances in the brain.

Treatment for Emotional Problems

Treatments that work are available, and range from support groups, peer-to-peer support, counseling from a mental health professional to hospitalization if warranted. It is important to know the resources in your community.

Cultural Considerations

Emotional concerns are viewed in very different ways by different cultures. What may be a problem in one culture may be acceptable in another. The causes and cures will vary according to the cultural beliefs. For example, members of one culture may view emotional problems as a punishment from God while others believe they are caused by bad spirits or other supernatural powers. Culture also influences the type of help, if any, that the client will seek.

Special Considerations for Pregnant Women

Some normal psychological changes can be expected during pregnancy such as:

- More anxiety, especially worries about the baby
- More attention to her own thoughts and feelings
- Greater feeling of being dependent on other people

Refer to a supervisor immediately if you suspect that the client is a danger to herself or others.

- Moods that change more often than before she was pregnant
- Moods that are “higher” or “lower” than before she was pregnant

What to Look For

Ask Questions about Emotional Concerns

If the client tells you of an emotional concern, ask more questions to get a better idea of the problem.

Don't be afraid to ask sensitive questions.

Remember that most clients are willing to answer. In many cases they are relieved to discuss their problems with a helpful, caring person.

Two important and revealing questions, which all practitioners should ask when screening for depression, are:

- Over the past two weeks, have you felt down, depressed or hopeless?
- Over the past two weeks, have you felt little interest or pleasure in doing things?

Your clinic or office should have protocols indicating which screening tools to use, such as the validated screening tools; Edinburgh Postpartum Depression Scale or the Patient Health Questionnaire (PHQ-9), but ultimately, when you have concerns about your patient's emotional state, she should be referred to the practitioner or the Provider in your office who is identified to best handle her needs, and appropriate referrals to local mental health services should be made. The table on the following pages provides you with a list of recommendations from national organizations on screening.

National Clinical Recommendations for Maternal Depression Screening Table

<p>U.S. Preventive Services Task Force (USPSTF)</p>	<p>Recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.</p> <p>The USPSTF acknowledges that there is little evidence regarding the optimal timing for screening or intervals and states that more evidence for all populations is needed to identify ideal screening intervals. The USPSTF notes that a pragmatic approach in the absence of data might include screening all adults who have not been previously screened, and using clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted.</p>
<p>American Congress of Obstetricians and Gynecologist (ACOG), Committee on Obstetric Practice</p>	<p>Recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. Screening should be coupled with appropriate follow-up and treatment when indicated.</p>
<p>Council on Patient Safety in Women's Health Care</p>	<p>Health care providers should (1) obtain from every woman an individual family mental health history (including past and current medications) at intake, with review and update as needed; (2) conduct validated mental health screening during appropriately timed patient encounters to include both during pregnancy and in the postpartum period; and (3) provide appropriately timed awareness education to women and family members or other support persons.</p>

<p>American Academy of Pediatrics (AAP), Bright Futures and Mental Health Task Force</p>	<p>The primary care pediatrician, having a longitudinal relationship with families, has a unique opportunity to identify maternal depression and help prevent untoward developmental and mental health outcomes for the infant and family. Screening can be integrated into the well-child care schedule and included in the prenatal visit. This screening has proven successful in practice in several initiatives and locations and is a best practice for Primary Care Providers caring for infants and their families. Intervention and referral are optimized by collaborative relationships with community resources and/ or by co-located/integrated primary care and mental health practices.</p> <p>The Bright Futures Periodicity table suggest screening should occur by 1 month, and at 2 months, 4 months and 6 months postpartum.</p>
<p>AAP/ACOG Guidelines for Perinatal Care</p>	<p>Prior to delivery, patients should be informed about psychosocial issues that may occur during pregnancy and in the postpartum period. A woman experiencing negative feelings about her pregnancy should receive additional support from the health care team. All patients should be monitored for symptoms of severe postpartum depression and offered culturally appropriate treatment or referral to community resources.</p> <p>Specifically, the psychosocial status of the mother and newborn should be subject to ongoing assessment after hospital discharge. Women with postpartum blues should be monitored for the onset of continuing or worsening symptoms because these women are at high risk for the onset of a more serious condition. The postpartum visit approximately 4-6 weeks after delivery should include a review of symptoms for clinically significant depression to determine if intervention is needed.</p>
<p>Centers for Medicaid and Medicare Services (CMS)</p>	<p>Maternal depression screening during the well-child visit is considered a pediatric best practice and is a simple way to identify mothers who may be suffering from depression and may lead to treatment for the child or referral for mothers to other appropriate treatment.</p>

Steps to Take

Watch the Client for Clues

Is she clean and neat or disheveled? Does she have an angry or tired expression? Does she complain about eating, stomach, or sleeping problems? These can be symptoms of depression or anxiety.

For example, you can say:

You look like you're ready to cry. How are things going for you?

If unable to identify a characteristic, ask:

On an average day what best describes how you feel? Do you feel happy, sad, angry, or depressed?

If she says she is happy, okay, or something similar, no further assessment is needed. A negative answer such as "scared, depressed, or angry," needs further assessment. Go to the appropriate sections: *Helping a Client with Anger* or *Helping a Client with Anxiety, Nervousness or Fears*. If she is depressed, refer to the *Depression Guidelines* section.

High-Risk Situations

The situation is high-risk if you suspect there's an emergency that needs immediate attention. Two main problems require immediate action:

- If the client is a danger to herself
- If she is a danger to another person

If either of these situations is present, inform your clinical supervisor or the health care provider immediately and before the client leaves the office. That person should evaluate the situation and determine the appropriate action.

Danger to Herself

If the client is so depressed that she is considering hurting or killing herself, refer to the *Depression Guidelines* section for more information.

If the client cannot meet her basic needs for food, clothing, and shelter because of **severe mental illness**, she may also be considered a danger to herself. Look for symptoms of:

- **Delusions:** fixed false beliefs, despite confrontation with reason or actual facts. Do not try to convince or argue her out of a delusion. It won't work. Do not tell her what she is saying is crazy or untrue. Try to lead the conversation away from the delusional ideas. If strong feelings accompany the delusions, address the emotions without commenting on the delusions, such as "you seem really frightened."
- **Hallucinations:** experiences (sight, sound, smell, taste, and touch) that are not caused by reality. Hearing voices is the most common kind of hallucination. People with hallucinations may also see things that aren't there, smell things when no odor is present, or feel things, like bugs crawling up and down their arms, when nothing is touching them.
- **Disturbed thinking:** disorganized, illogical, or unrealistic thoughts. Thoughts bounce from one thing to another without seeming connected. Each sentence may be grammatically correct, but the discussion on the whole makes no sense.

Danger to Her Children

When a client is a danger to her children by abusing or neglecting them, steps must be taken to protect them. Refer to the *Child Abuse and Neglect Guidelines* section.

If the family already has a child welfare worker working with them, call the worker directly and let him or her know of your concerns for the children.

Inform the social worker at the delivery hospital if the client's emotional problems may put the baby in danger. The hospital social worker will report to the child welfare agency after assessing the mother's ability to care for the infant.

General Anger

When the client's anger is general and justifiable, help diffuse the anger by listening, giving information, and offering referrals.

Your questions may include:

- **How long has she had this problem?** Did she become depressed after the breakup with her boyfriend or has she been depressed most of her life? Has it been continuous or off and on? When is the last time she can remember being truly happy? Does she see any patterns?
- **How has the problem affected her thinking and mood?** For example, has it affected her ability to concentrate or remember things? Does she have periods of irritability or depression?
- **Does she have physical problems because of the emotional problem** such as loss of energy, or problems eating or sleeping?
- **How severe is the problem?** Does she have difficulty doing daily tasks such as working, caring for herself and her family, or taking part in social activities?
- **How has the client dealt with the problem?** How has she coped? Has she sought help from others? What was her experience?
- **What is the client's understanding of her problem?** In her culture what is the view of her kind of problem? Does she have hope for improving her problem? What does she think might help? Who does she think might help her?
- **Consider writing a letter to the person or place she is angry with.** She can send it or keep it for herself.
- **A referral may be appropriate if anger is about eviction or other legal matter.** Offer an appropriate referral (i.e., Tenants' Rights).

Anxiety, Nervousness, or Fears

When a client's anxiety or fears are about life events listening and offering support can be helpful.

Allow the client time to talk. *Tell me what you're most afraid of.*

- Discuss her fears. For example, if she's afraid of labor and delivery, encourage childbirth classes.
- If fears are because of intimate partner violence, see *Spousal/Intimate Partner Abuse Guidelines*.
- If a client describes extreme anxiety or fears that affect her daily functioning (such as she's unable to leave her house alone and has to have someone with her all the time), refer her for mental health counseling. If she refuses, notify your supervisor and the health care provider for evaluation.

Low Risk Situations

When the situation is low risk, help the client deal with her emotional concerns in these ways:

- Assist her on your own. A nonjudgmental, good listener may be all that is needed for some clients with certain kinds of problems.
- Work with a consultant or outside agency

Referrals to Outside Help

If you feel that a mental health specialist is needed, **you can help the client make an appointment with an appropriate specialist.** See *Making Successful Referrals* in the "First Steps" chapter. **Have a list of mental health clinics and therapists who take Medi-Cal or who have sliding scale fees. Make sure they are culturally and linguistically appropriate for your clients.**

Often, the client may not seek outside help even though you recommend it. You may provide a model of a helpful relationship and eventually the client may be persuaded to accept the referral.

Follow Up

- Ask the client about the emotional concerns you discussed at the previous visit
- Observe the client for symptoms you've seen in the past
- Encourage her to express her feelings and be a supportive listener
- Assist the client in finding solutions to her problems and try to provide hope that the problem can be solved or at least improved
- Find out if she followed through on any referrals
- Watch for new symptoms
- Assess whether or not the client is a danger to herself or others and take the appropriate action

Referrals

- Outpatient mental health services available through public and private agencies
- For referrals, call your local departments of health or social services, family service agencies, community mental health centers, Veteran's Administration hospitals, medical societies or universities, or mental health associations
- Psychiatric emergency room at your local hospital
- Suicide prevention crisis line
- Self-help groups
- Religious communities
- Support groups for families of the mentally ill
- SSI (Supplemental Security Income) for financial assistance

Background

Depression is a very common form of mental illness. These guidelines will focus on what mental health professionals call “clinical depression.” Treatment depends on the availability of resources and the client’s motivation. Psychological therapies may include individual or group counseling.

The symptoms may be severe or relatively minor.

Depression may be:

- Chronic (a long-term, continuous problem)
- Episodic (comes and goes)
- Occur only once in a person’s lifetime

Researchers are unable to find a single cause for depression. There seem to be many possible factors which include:

Biological Factors

Depression can be hereditary and often blood relatives will have suffered the same kind of problem.

Psychological Factors

Depression can be triggered by an event for example, loss of a loved one, poor early mother-child interactions, childhood abuse, and managing anger by turning it inward.

What to Look For

We all experience mood changes in our daily lives. Feelings of sadness and disappointment are normal. How can you tell if the client’s depression is serious enough to be considered clinical depression?

Signs of Depression

Mood Problems

- Feelings of sadness over a long period of time
- Crying for no apparent reason

Refer to a supervisor immediately if you suspect that the client is a danger to herself or others.

- Loss of interest in normal activities that once were enjoyable, such as, sex, social events, or family gatherings
- Difficulty doing usual tasks, such as duties at work, housework, or caring for her family
- Feeling hopeless and helpless; feeling unable to cope and no hope that things will be better in the future

Physical Problems

- Disturbances of sleep, appetite, and sexual activity. She may have trouble sleeping or sleep too much. She often will lose her appetite or overeat.
- Lack of energy without doing anything to get tired. Her speech, thought and movement may actually be slowed down.
- Agitation. The person suffers from unpleasant restlessness or tension. She may be unable to relax or sit still.
- Other bodily complaints such as: backaches, headaches, hyperventilation, chest pain, shortness of breath, nausea and vomiting, constipation, and heartburn.

Problems with Thinking

- Difficulty concentrating. She may be so wrapped up in her own thoughts that she has a difficult time paying attention to what is happening around her.
- Feeling guilty, worthless; exhibiting poor self-esteem
- Symptoms of psychosis, most commonly hallucinations and delusions. Refer to the *Emotional or Mental Health Concerns Guidelines* section for more information.

A person you suspect is clinically depressed should have a thorough medical and psychiatric evaluation to determine an accurate diagnosis and the best possible course of treatment. Based on the woman's current symptoms and past psychiatric history, she may be prescribed medication. The physician and the client will consider the risks and benefits. The possible effects of certain medications on the fetus may be less than the risk of a mother with untreated depression.

Steps to Take

Be understanding and supportive. The client may feel isolated and helpless. Don't try to talk her out of her feelings of sadness by saying things such as "things aren't so bad."

Get a brief history of emotional problems in the client's family, especially blood relatives such as parents, grandparents, aunts, uncles, and cousins. This discussion may also give clues as to the client's cultural beliefs and personal attitudes toward emotional problems.

Reassure and inform the client that depression can be treated.

Discuss her available options. Provide a referral to a mental health counselor for evaluation and possible treatment and ensure follow-up.

Raise the client's self-esteem by pointing out what hardships she has overcome and her current strengths. She may be able to draw upon this strength to seek help.

Help identify specific causes of her stress. Help her find possible solutions that would relieve some of the stress that may be contributing to her depression.

Check for severe psychological symptoms, such as:

- Delusions
- Hallucinations

- Disturbed thoughts

Refer to the *Emotional or Mental Health Concerns Guidelines* section for more information.

Prenatal Depression

Many pregnant women suffer from some of the common symptoms of depression, such as fatigue, sleep problems, eating disorders, and lack of sexual interest. These women may or may not be clinically depressed.

Women who have a personal or family history of depression are more likely to be depressed during pregnancy.

Refer the depressed woman to the medical provider for further evaluation and intervention. Based on her current symptoms and past psychiatric history, she may be prescribed medication. Often a pregnant woman fears that medication may harm her unborn baby. The medical provider and the client will consider the risks and benefits. The possible effects of certain drugs on the baby may be less than the risk of untreated maternal depression. Depression may lead to poor nutrition, substance use, and suicide risk.

Strongly encourage the client to follow through on a referral for mental health evaluation and counseling.

Postpartum Emotional Problems

Postpartum emotional problems are common and may be present in one of several forms. They may be caused by hormonal changes, genetic factors, and psychosocial stresses. They include:

Maternity or Baby Blues

About half of all new mothers experience the mildest form of postpartum depression often called the maternity or baby blues. She complains of tiredness and has crying spells that usually start right after the baby is born or as late as two weeks following delivery. After a week or so, the mother starts to feel much better. If she experiences depression once, she will likely have the blues after her next deliveries.

Baby blues can't be prevented, but they can be lessened by knowing ahead of time that such reactions are common in postpartum women. Social support and reassurance are also effective.

Postpartum Clinical Depression

Postpartum clinical depression is more serious, but also less common. About one in every five new mothers experience signs of clinical depression. The consequences of this disease to both mother and child are significant. Depressed mothers often show a more negative attitude toward their children, and a depressed new mother puts significant emotional burdens on family relationships. Solid evidence is mounting that maternal depression is harmful to the baby's development. In addition, there is a possibility of maternal suicide.

The symptoms usually appear between a month after delivery, or as late as one year postpartum. It is more common in women who:

- Have a personal or family history of depression
- Are first-time mothers
- Have mixed feelings about the pregnancy
- Have negative feelings about pregnancy outcomes such as sex of baby, perinatal loss, or who experienced a difficult delivery
- Have other psychosocial stresses such as marital, financial, or housing problems

Many women may be afraid to tell someone about their negative or depressive thoughts and feelings. They often feel quite guilty since they believe that having a new child is a time when they should feel very happy. Postpartum depression is a condition that is very treatable. Leaving it untreated can sometimes affect the quality of bonding and the relationship between a mother and her child.

A woman with serious postpartum depression needs help. Pay attention to suicidal thoughts and symptoms of severe mental illness.

Ask permission of the client to contact family and friends to see if they can provide additional social support. Refer to a new mothers' support group.

Try to help with the other psychosocial stresses in the new mother's life, such as lack of resources.

Be sure to refer the depressed woman to the medical provider for further evaluation and intervention. Based on the woman's current symptoms and past psychiatric history, she may be prescribed medication. The medical provider and the client will consider the risks and benefits together. If the client is breastfeeding, the risk of certain medications on the baby may be less than the risk of a mother with untreated depression. For healthy, full-term babies, the known benefits of breast milk outweigh the potential hazards of most antidepressant medicines.

Strongly encourage the client to follow through on a referral for mental health evaluation and counseling. She may benefit from counseling or short-term medication. In rare cases, she may need to be hospitalized.

Postpartum Psychosis

This serious emotional problem is very rare (about one case in every thousand postpartum women) but can have dangerous consequences. Suicide or killing the baby is seen in up to 10% of untreated cases.

The symptoms usually appear rapidly, one to two weeks after delivery or as late as one year after birth. The client at greatest risk is the person with:

- A history of bipolar disorder (formerly called manic-depression)
- Previous postpartum mental health problems, either psychosis or clinical depression

- A family history of postpartum mental health problems

Some of the symptoms to look for are:

- Rapidly shifting moods
- Manic symptoms such as extreme agitation, restlessness, and distractibility
- Euphoria, insomnia, crying spells, and/or extreme confusion
- Symptoms of psychosis such as auditory or visual hallucinations and delusions. See the *Emotional Concerns or Mental Health Guidelines* sections for more information.
- Obsessions, which often focus on religious themes or an impulse to hurt or kill the infant

Consult with your clinical supervisor or the health care provider for an immediate psychiatric referral for evaluation and treatment. A client who refuses can be considered a danger to herself or others and held for emergency psychiatric evaluation and treatment. See the *Emotional or Mental Health Concerns Guidelines* sections for additional information.

Suicide Risk

Suicidal clients have reached a state of unbearable emotional pain.

It is impossible to absolutely predict who will attempt suicide, but some factors make it more likely:

- Past history of suicide attempts, especially if there is a history of impulsiveness
- History of suicide by one or more close relatives
- High degrees of stress, particularly stress associated with medical illness or the loss of a loved one
- Social isolation
- Depression, substance abuse, and schizophrenia

Females are two to three times more likely than men to attempt suicide, but half as likely to succeed. A client with suicidal thoughts may be at highest risk after the improvement of some of her symptoms, because it is then that she may have enough energy and motivation to carry out a plan.

What To Do If You Think A Client Might Be Suicidal

If a client has symptoms of clinical depression:

Listen for indirect statements about wishing to die such as the client saying:

- *They would be better off without me.*
- *I don't think that I can go on much longer.*
- *I wish that I had never been born.*
- *I might as well give up because I can't make things better.*

Look for certain behaviors, such as:

- Giving away prized possessions
- Frequent risk-taking behaviors and accidents

Talking about suicide may be challenging, but respectful questioning does not increase the client's interest in making a plan..

Ask a series of questions to get at her possible suicidal feelings:

- *How bad does it get?*
- *Do you sometimes feel like giving up?*
- *Have you ever thought of ending your life?*
- *Have you ever thought you might lose control and actually hurt yourself?*
- *Do you have a plan for how you might kill yourself?*
- *Do you have a way of carrying out your plan?*
- *How close have you come to killing yourself?*
- *Do you feel that you will kill yourself in the near future?*

- *What has kept you from killing yourself?*
- *Does anyone know of these feelings?*

If she denies any suicidal thoughts, express your concern for the client's sadness and tell her that you want to know if she has any thoughts of hurting herself in the future.

If she admits to suicidal thoughts, **don't try to handle the situation on your own.**

Let her know that you care about her safety and will need to immediately refer her to your clinical supervisor or a health care provider who has more experience with such situations. Try to remain calm and communicate a sense of hope to the client. If possible, assure her that you will remain with her until she gets the special help she needs.

Try not to leave her alone while you consult with your supervisor. Have another staff person stay with her.

Contact your clinical supervisor or the health care provider who will assess her suicide risk and take the appropriate actions, according to your on-site, high-risk protocols. **Know your protocols before this situation occurs.**

Referrals

- Outpatient mental health counseling services available through public and private agencies
- For referrals call your local departments of health or social services, family service agencies, community mental health centers, Veteran's Administration hospitals, medical societies or universities, or mental health associations
- Psychiatric emergency room at a local hospital
- Suicide prevention crisis line
- Self-help groups
- Your local psychiatric response team

- Religious communities
- Support groups for families of the mentally ill
- In-home support such as Public Health Nursing
- Prepared childbirth classes

Resources

Postpartum Support International

Listing of local Postpartum Depression support groups

www.postpartum.net

Complicated Situations

Immigrant clients have their own emotional concerns which may include homesickness, problems of cultural adjustment, lack of social support, worries about immigration status, post-traumatic stress disorder, etc.

You may have a difficult time finding resources that are linguistically and culturally appropriate. The client may be unable to pay for services. If she is undocumented, she may be concerned that she will be reported to the United States Citizenship and Immigration Services (USCIS), formerly known as Immigration and Naturalization Services (INS). See the *New Immigrant Guidelines* section for additional suggestions.



If you think your depression is severe you should talk with a mental health professional right away. If you are having thoughts of hurting yourself or someone else, seek help immediately by notifying your medical provider or calling 911.

There are times when all of us feel blue, sorrowful, or kind of down. True depression is more than this. It affects the way you eat and sleep, the way you feel about yourself, and the way you think about the world around you. Depression is not something that is imagined or “all in your head”. It is a common illness and treatment can help.

Some Signs of Depression

Depression has certain signs and symptoms. Mark the items that best tell how you have been feeling. It is important to discuss any of these feelings with your medical provider or clinic counselor.

- Feeling sad and/or irritable
- Not enjoying things that used to be fun (being with friends, sports, hobbies, sex)
- Unexpected changes in appetite and/or weight
- Unexpected changes in sleep patterns, sleeping too much, or not sleeping enough
- Feeling tired all the time or having little energy
- Feeling guilty, hopeless, or worthless
- Problems with concentration, memory, and decision-making
- Not caring if you die, thinking about death or even trying to commit suicide

Checking five or more items above may indicate depression.

Understanding the Causes

When a person experiences high levels of stress in their life, such as having a long term illness, relationship problems, and/or money difficulties, they can become depressed. Depression can run in families. Sometimes depression can happen for no reason. People who are depressed see themselves and the world in a negative way.

Treatment

Take a look at your daily life. The following things can help you:

1. A good support system (don't be afraid to ask for help)
2. Learning new ways to handle your stress
3. Regular exercise and getting daily sunlight whenever possible

You may need some medical attention along with professional counseling or “talk” therapy.

For more information, call Postpartum Support International at 1-800-944-4PPD (773), the National Institute of Mental Health at 1-866-615-6464 or your local crisis line, or go to www.postpartum.net.

Si cree que su depresión es grave y está pensando en lastimarse, debe hablar con un profesional de salud mental de inmediato.

Hay momentos en los que todos nos sentimos tristes, afligidos o abatidos. Pero la verdadera depresión es más grave. Afecta cómo come y duerme, cómo se siente sobre sí misma, y cómo piensa en el mundo que la rodea. La depresión no es algo imaginado o “todo en la mente”. Es una enfermedad común y el tratamiento la puede ayudar.

Algunas señales de depresión

La depresión tiene ciertas señales y síntomas. Marque los puntos que mejor indican lo que está sintiendo últimamente. Es importante hablar sobre estos sentimientos con su proveedor de atención de la salud o consejero de la clínica.

- Estar triste y/o irritable.
- No disfrutar de las cosas que antes eran divertidas (estar con amigos, deportes, pasatiempos, relaciones sexuales).
- Cambios inesperados en el apetito y/o peso.
- Cambios inesperados en los patrones de sueño, dormir demasiado o no dormir suficiente.
- Sentirse cansada todo el tiempo o tener poca energía.
- Sentirse culpable, desesperada o despreciable.
- Tener problemas para concentrarse, con la memoria y para tomar decisiones.
- No importarse si se muere, pensar en la muerte o incluso intentar suicidarse

Si marcó cinco o más de los puntos anteriores, es posible que sufra de depresión.

Cómo comprender las causas

Cuando uno tiene una enfermedad de larga duración, relaciones personales difíciles y/o problemas de dinero, se puede deprimir. Puede ser más común en ciertas familias. A veces uno siente la depresión sin razón alguna. Las personas que están deprimidas se ven a sí mismas y al mundo de manera negativa.

Tratamiento

Examine su vida cotidiana. Las siguientes cosas pueden ayudarle:

1. Contar con una buena red de apoyo (no tenga miedo en pedir ayuda).
2. Aprender nuevas maneras de manejar el estrés.
3. Hacer ejercicios físicos con regularidad y exponerse a la luz del sol cada día cuando sea posible.

Es posible que necesite atención médica, así como consejería profesional o psicoterapia.

Para obtener más información, llame al Instituto Nacional de Salud Mental al 1-866-615-6464, a la línea de crisis en su zona o, Postpartum Support International a 1-800-944-4773, www.postpartum.net y busque la pestaña arriba en español.

Background



Adolescence is a transitional period from being a child to becoming an adult. The pregnant adolescent has special psychosocial needs.

The pregnancy pushes her into womanhood when she is still in many ways a child, with many conflicting needs and wants. She will need to care for a dependent infant while still having needs and interests of other teens her age. She may have had little experience in independent problem solving and making important decisions. She probably lives and thinks in the present and often lacks the ability to plan for the future. She is probably greatly influenced by what her friends do and say and resistant to the advice of adults.

Special Legal Rights of Minors

Current California law gives some special legal rights to children under 18 years of age.

Consent to Care

Minors under the age of 12 may consent to receive pregnancy, contraception, abortion, emergency medical services, and skeletal x-ray to diagnose child abuse or neglect. In cases of abuse or neglect, the provider does not need the minor's or parent's consent. In cases of sexual assault services and rape, the provider must attempt to contact the minor's parent/guardian, unless the professional reasonably believes that the parent/guardian committed the assault.

Minors 12 years of age or older may consent to the services above as well as infectious, contagious communicable diseases, sexually transmitted disease care, diagnosis, or treatment, AIDS/HIV testing and treatment, mental health treatment, and other reproductive health related services. The provider is not permitted to contact the parent or guardian without the minor's consent.

Parents are not responsible for payment if the minor receives services on her own under Medi-Cal's Sensitive Services described below. For more information, see

Tell your supervisor right away if you suspect that the teen has been harmed or is in danger of being harmed or of harming herself.

"California Minor Consent Laws" on The National Center for Youth Law's website: www.teenhealthlaw.org under "California Minor Consent and Confidentiality Laws."

Medi-Cal Coverage of Sensitive Services

A young person may be eligible for a special kind of Medi-Cal called "sensitive services" or "minor consent services" to cover services as described above. Under age 12, Medi-Cal covers pregnancy and pregnancy-related services, family planning services, and sexual assault services. Between ages 12 and 21, Medi-Cal covers sexually transmitted diseases and treatment, drug and alcohol abuse treatment and counseling, and outpatient mental health treatment and counseling. These services are confidential.

If a public agency has legal responsibility for a minor, the minor is not eligible for Minor Consent Program services, and the minor must apply for the regular Medi-Cal program.

Medi-Cal may not contact the parents and the parents' income is not considered in determining eligibility; only the teen's own income is counted. It is available to young people in all immigration categories, including undocumented; a Social Security number is not required. For more information, see Medi-Cal's website (www.medi-cal.ca.gov). Go to "Provider Manuals," then "Medical Services," then "Part 2: Obstetrics," then "Minor Consent Program - Minor."

Steps to Take

Interviewing Teens

Interview the teen privately, even if she is accompanied by a parent or boyfriend. Tell the support person you're glad they came to the visit, but it is the federal law

(HIPAA) and clinic practice to interview each client alone for part of each visit. Then you can ask the teen how she wishes to involve family members, her partner, or the father of the baby in her prenatal care.

You may need some **extra time to establish a relationship** with the teen before the psychosocial interview. Give her information about how long the interview will take and the kind of questions you will be asking. See the Interviewing Techniques section in the “First Steps” chapter.

It is very important to have a **nonjudgmental attitude** when working with pregnant teens. They are often very sensitive to adults’ negative attitudes and body language.

Unwanted Pregnancy

Give her a chance to talk about her feelings about being pregnant. Spend some time exploring whether the pregnancy was planned or unplanned and wanted or unwanted. If unwanted, be sure to explore all of her options as outlined in the *Unwanted Pregnancy Guidelines* section.

Because of their emotional and financial dependence on their parents, they are often pressured to do as their parents wish. This may involve making a choice that is not truly their own. If you observe this happening, advocate for the teen’s wishes to be heard. You may want to make a referral for family counseling to help the teen and her parents resolve the crisis before a final decision is made.

The Teen’s Parents

Ask the teen if her parents are aware of her pregnancy. *If yes, how did they react? Are they supportive? If they do not know, how does she plan to tell them? When? How does she think they will react? Would she like to practice with you how she would tell her parents?*

The parents’ reactions may include anger, guilt, sadness, or acceptance. Usually their reactions will be mixed

Living Arrangements

If the family is unable to accept the teen’s pregnancy, she may have to live elsewhere. Help her explore her options.

Can she live with a relative or friend who can provide her with physical and emotional support? Would this be a short-term or long-term arrangement?

Living with Her Boyfriend

Sometimes she will choose to live with the father of the baby and/or his family. Help the teen explore her relationship with her boyfriend.

How will living together affect their relationship? What if she wants to break up with him? How will she do this if she is dependent on him for housing or financial support?

Legal Emancipation

(Special note: being pregnant does NOT, all by itself, qualify a minor as emancipated)

If the client is emotionally and socially mature, she may need to become legally “emancipated” and obtain her own housing. A minor may obtain a court declaration of emancipation if all of the following are true:

- She is 14 years or older
- She is living apart from her parents with parental consent or they are not formally protesting the arrangement
- She is managing her own financial affairs and her income is legally obtained (not through criminal activity)
- The court considers emancipation in the teen’s best interest
- She has entered into a valid marriage, even if she is currently divorced
- She is on active duty in the armed forces
- The court considers emancipation in the teen’s best interest, and so orders it

For more information, refer her to a legal resource that specializes in services to minors; see the *Legal/Advocacy Guidelines* section.

Maternity Homes

Explore the option of living in a residence for teenaged parents, often called a maternity home. These facilities provide safe, stable housing with many support services such as child care, education and job training, counseling, and help in planning her future. She must be willing to live in a structured environment with a group of other teens and their babies. If she is interested, help her locate the nearest residence. Contact your local Adolescent Family Life Program (AFLP) for more information.

Homeless

Homeless pregnant teens have many complicated medical, social, economic, and legal concerns. Find out why she is homeless.

- *Was she a runaway before she became pregnant?*
- *Was her leaving home due to physical, emotional, or sexual abuse?*
- *Was she living in a foster care placement? How long has she been living on her own?*
- *Was she kicked out of her home after her parents discovered she was pregnant?*

Homeless youth may be at a greater risk for substance abuse, poor nutrition, sexually transmitted infections including AIDS, mental health problems, and the threat of violence and injury. They may be involved in prostitution. Refer to guidelines in this section for *Perinatal Substance Use/Abuse, Emotional or Mental Health Concerns, Depression, and Spousal/Intimate Partner Abuse*, if indicated.

In spite of their high-risk status, some homeless youth are reluctant to get services.

Others may want help but are excluded from services such as battered women's shelters or residential

perinatal drug treatment programs because they are under 18 years of age. You may need to locate treatment facilities that specialize in pregnant and parenting teens.

Listen to her carefully and try to establish a trusting relationship with the client.

Your local AFLP can provide case management services.

Financial Assistance

A pregnant or parenting teen under 18 who has never been married and is applying for CalWORKs must live with a parent, guardian, other adult relative, or in an adult-supervised arrangement. There are a few exceptions, such as if she has been kicked out of the house or she would be in danger if she was forced to live with her family.

If she does not have her high school diploma or GED, she is required to participate in the state's Welfare-to-Work Teen Parent Program to receive cash aid, unless she is exempt. The Teen Welfare-to-Work program uses financial rewards and penalties to encourage school attendance and graduation. It also includes supportive services to help the teen attend school regularly such as childcare and transportation, but does not provide case management. If there is an AFLP program in your area, AFLP may provide case management services. Refer the teen to your local AFLP program.

Educational Plans

Encourage the teenager to remain in school and complete her education. She can be helped in doing this by accepting a referral to your local AFLP if your county has one. An AFLP case manager will help her decide whether or not she wants to remain in her current school, attend a special school for pregnant teens, or continue her education through a home-based program.

There are a variety of educational options. Help the teen evaluate her options from an academic and

personal perspective. *Where will she be able to best progress in her studies? Where will she be happiest? Where will her physical and emotional needs as a pregnant teen best be met?*

Acknowledge that at times it will be difficult to deal successfully with both the demands of education and pregnancy. This continues to be true after the baby is born when she will have the challenges of school and parenting. With the client's written permission, you might want to communicate with the client's case manager at AFLP so you can support her plans to finish school.

Social Relationships

Peer groups are important influences for teens. They offer feedback about her attitudes, appearance, values, and behavior. Her pregnancy will probably affect her relationships with her friends. She may be isolated from her old friends and have to make new ones. Ask her if the quality of her friendships have changed.

Father of the Baby

The relationship with the father of the baby is often significant. Sometimes the relationship will end when the pregnancy is discovered. The boyfriend may deny paternity. In many cases, the relationship will continue. The father of the baby may provide financial and/or emotional support depending on his circumstances and desires. **The foundation for his future role as a father is usually laid down during the pregnancy.** If he is a positive figure in the client's life, encourage him to attend prenatal appointments and take part in childbirth preparation classes and hospital tours.

Advise her that all unmarried parents will be asked at the time of delivery if they wish to participate in a statewide Paternity Opportunity Program operated by the California Department of Child Support Services. The program is voluntary. If the parents of a child are not legally married, the father's name will

NOT be added to the birth certificate unless they:

- Sign a Declaration of Paternity in the hospital, or sign the form later
- Legally establish paternity through the courts and pay a fee to amend the birth certificate

Signing the form is the first step in establishing legal rights and responsibilities of the father. Establishing legal paternity is necessary before custody, visitation, or child support can be ordered by the court. The form can be challenged in a court only by using blood and genetics test results that show the man is not the natural father.

For more information on the Paternity Opportunity Program, see the California Department of Child Support Services website (https://www.childsup.ca.gov/Resources/EstablishPaternity.aspx?utm_source=DCSS+Home+Page&utm_medium=Web+Banner&utm_campaign=Paternity+Opportunity+Program+%28POP%29). You can call or download the required forms and information for clients in several languages: 1-866-901-3212.

Follow Up

Encourage the client to participate in any **health education or support groups** designed for teens.

Strongly encourage the teen to accept a referral to **public health nursing** for in-home health monitoring, teaching, and support.

Help her choose a **support person** for labor and delivery.

Prepare the client for her **physical and emotional needs after delivery.**

Help the client, and her family, make decisions in advance about who will care for the baby. This will help to minimize family conflicts and assist with

making roles clearer. Explore questions like:

- *Where is the baby going to sleep?*
- *Who is going to be responsible for feeding, bathing, and changing diapers?*
- *Under what circumstances will the grandparents of the infant babysit?*
- *Perhaps while the teen works or attends school?*
- *Who will watch the baby while she goes out with her friends?*
- *Who will make decisions about how the child is cared for?*

Problems can best be avoided when the teen and her support caregivers agree in advance.

At the postpartum visit, assess her situation as you would any new mother, paying particular attention to family relationships and emotional coping. See the *Parenting Stress Guidelines* section for further suggestions. Be sure the teen has a referral to family planning.

Referrals

- Public Health Nursing
- Adolescent Family Life Program
- Family planning
- Parenting classes
- Parental stress line (“warmline”)

Complicated Situations

Teens Who Use/Abuse Substances

Refer to the *Perinatal Substance Use/Abuse Guidelines* section. Many outpatient and residential drug programs exclude minors (those under 18 years of age). Contact your local drug and alcohol programs for appropriate referrals for pregnant and parenting teens.

Mandated Reporting Responsibilities

Physical and Sexual Abuse and Neglect

If you reasonably suspect that a teen under the age of 18 is being abused or neglected, you have the same reporting responsibilities as with a child. See the *Child Abuse and Neglect Guidelines* section for more information. In many cases, the agency will consider the teen mature enough to protect herself by leaving a dangerous situation and not in need of protection by the child welfare system.

A report for suspected abuse is required even if you think that nothing will come of the report. Be sure to document the report in the medical record. It is a good idea to tell the teen that you must make a report. Even better, have the teen present when you make the phone call. This helps the teen feel that you are not talking about her behind her back.

If the teen tells you she has been abused in the past, but not currently, see the *Child Abuse and Neglect Guidelines* section under the “When Past Abuse is Discovered” section.

Dating Violence

Dating violence is more than just arguing or fighting. Dating violence is a pattern of controlling behaviors that one partner uses to get power over the other, including:

- Any kind of physical violence or threat of physical violence to gain control
- Reproductive coercion, which can include damaging condoms and destroying contraceptives, to ultimately result in pregnancy against the client’s consent
- Emotional or mental abuse, such as constantly putting her down or criticizing her

- Sexual abuse, including making her do anything against her will or refusing to have safer sex; this may include reproductive coercion (putting pressure on a woman to get pregnant against her wishes, which may or may not include birth control sabotage)

If she is battered by someone outside the home, such as a boyfriend, you are usually required to report the assault to law enforcement; they may direct you to report to child welfare, depending on the policies of your county.

Review the *Spousal/Intimate Partner Abuse Guidelines* section. The National Domestic Violence Hotline website (<http://www.thehotline.org/>) has a special site for teens called *When Love Hurts: A Guide on Love, Respect and Abuse in Relationships*.

If you suspect that she has been forced, threatened, or exploited into sexual activity you must report the sexual abuse to Children's Protective Services.

Consensual Sexual Activity of Minors

If the teen has consensual intercourse, the mandatory reporting laws are more complicated. It depends on the ages of both the sexual partners. You are not required to ask the age of the client's partner or father of her baby.

When an adult (18 years or older) has sex with a minor (17 years or younger), it is called "statutory rape." However, you are not required to report all cases of statutory rape, just in some circumstances. The National Center for Youth Law publishes, "When Mandated Reporters Must Report Consensual Disparate Age Sexual Intercourse to Child Abuse Authorities" under "Publications" on their website (www.youthlaw.org), which gives a good summary of the laws. See *Child Abuse and Neglect Guidelines* for information on how to make a report.

Studies have shown that many girls who engage in early sexual activity may have been molested in a past or present relationship and may be in need of protection and mental health counseling. Ask questions about sexual abuse and refer to your clinical supervisor if needed.

Resources

The National Center for Youth Law

A private, nonprofit law office serving the legal needs of children and their families. See "Minor Consent, Confidentiality, and Child Abuse Reporting in California" under "Publications." This document contains information on minor consent, consensual sexual activity, and other topics.

1-510-835-8098 / www.youthlaw.org

California Family Health Council Health Information and Education Division

Produces patient education materials available for a small fee; these include: "Is it Really Love?" in English and Spanish for teens.

1-800-428-5438

<http://www.cfhc.org/learning-exchange>

STEPS TO TAKE

GESTATIONAL DIABETES MELLITUS



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(Client Handouts are indicated in bold)

All Gestational Diabetes sections were reviewed in 2017.

These Steps to Take Guidelines are to be used with your office protocols, which are your facilities' procedures for providers (Health Education, Nutrition, Psychosocial) services and related case coordination.

Gestational Diabetes Mellitus (GDM) 5

MyPlate for Moms for Gestational Diabetes 15

If You Have Diabetes While You Are Pregnant:

Questions You May Have 19

If You Have Diabetes While You Are Pregnant:

Ways to Lower Your Stress 23

If You Had Diabetes While You Were Pregnant:

Now That Your Baby Is Here 25

Any pregnant woman with diabetes should be referred to a California Diabetes and Pregnancy Program (CDAPP), Sweet Success Affiliate, or a diabetes specialist.

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Goals

To help a woman with gestational diabetes understand that she can:

- Have a healthy baby
- Manage her pregnancy and her diabetes
- Understand what she can do to control her blood sugar
- Know where she can go to get help in caring for her diabetes

Background

If a woman develops diabetes during pregnancy, it is called gestational diabetes and she requires special care. Pregnant women with diabetes need to know they can have a successful pregnancy and a healthy baby. Information on diabetes in pregnancy was included in “Steps to Take” to provide CPSP practitioners with general information and background about diabetes in pregnancy and to:

- Understand the goals and concerns of gestational diabetes care
- Provide these women with general healthy eating guidelines to follow until they are seen by a registered dietitian or a diabetes care specialist
- Reinforce and support the woman’s individualized care plan developed by the woman, health care provider, and other diabetes care specialists
- Provide appropriate gestational diabetes education, resources, and referrals

What is Diabetes?

Normally, the body changes foods into sugar called glucose, and releases the glucose into the blood to send to the cells. Insulin, a hormone the body produces in the pancreas, helps glucose enter the cells to turn the glucose into energy. With diabetes, either the body does not make enough insulin or it is not able to use the insulin as normal. As a result, you may

have a problem with high blood sugar. Controlling blood sugar levels in pregnancy can prevent a difficult birth and help keep your baby healthy.

Types of Diabetes

There are different types of diabetes: type 1, type 2, prediabetes and gestational diabetes.

Type 1 diabetes can occur at any age. In type 1 diabetes, a person’s pancreas produces little or no insulin. People with type 1 diabetes must inject insulin several times every day in order to survive.

Type 2 diabetes normally occurs in people over age 40, but has been developing as early as early childhood due to the increased weight of the general population. Type 2 diabetes runs in families and is less common among people with a healthy body weight. Many people with type 2 diabetes can control their blood sugar with diet and exercise. Others may need oral medications and/or insulin to control blood sugar levels. Type 2 diabetes is highest among certain ethnic groups, such as African-American, Native American, Hispanics, Asian-Americans, and Pacific Islanders.

Gestational diabetes mellitus (GDM) is diagnosed only during pregnancy. In this type of diabetes, the woman’s blood sugar rises because of pregnancy-related hormonal changes. Gestational diabetes usually develops during the last half of pregnancy. In most cases, blood sugar levels can be controlled with diet and exercise, but some women may need oral medication or insulin. African-American, Native American/Alaska Native, Hispanics, Asian-Americans, and Pacific Islanders are at higher risk for developing gestational diabetes.

Most women with GDM return to normal blood sugars after delivery. If the woman is overweight or obese, weight loss is recommended to prevent or delay the onset of diabetes.

Why High Blood Sugar in Pregnancy Matters

Women with high blood sugar (hyperglycemia) are at risk for:

- High blood pressure
- Complications during delivery
- Cesarean section
- Infections
- Preeclampsia

Infants born to women with poor glucose control are at risk for:

- Large for gestational age (making delivery difficult)
- Low blood sugar (hypoglycemia) following birth
- Shoulder dystocia
- Premature birth
- Jaundice (yellow skin)
- Respiratory distress syndrome (trouble breathing)
- Miscarriage or stillbirth (fetal death)
- Becoming obese, having diabetes, or heart problems later in life

Children of pregnant women with high blood sugar are at risk for health issues later in life including:

- Obesity
- Cardiovascular disease
- Poor glucose control
- Type 2 diabetes

Who Provides Care for Gestational Diabetes?

CDAPP Sweet Success Affiliates or specially trained diabetes providers care for women who have diabetes during pregnancy. The goal is to improve birth outcomes and maternal health. CDAPP Sweet Success Affiliate care has proven to be cost-effective in preventing the complications of diabetes during pregnancy.

Any pregnant woman with diabetes should be referred immediately to a CDAPP Sweet Success Affiliate or a diabetes specialist. Treatment includes high risk medical management as well as education and support in controlling blood sugar, diet, exercise, and psychosocial

stress. The CDAPP Sweet Success Affiliate team may include a physician, nurse educator, registered dietitian, and behavioral medicine specialist or clinical social worker. Some CPSP providers may refer women to an endocrinologist or a diabetes center for care if a CDAPP Sweet Success Affiliate is not available.

Women with type 1 or type 2 diabetes or a prior history of GDM should seek diabetes care before they become pregnant to achieve control of their blood sugar, in order to reduce the risk of birth defects and miscarriages. Early diagnosis and treatment of gestational diabetes reduces the risks of complications for the woman and the infant. Overweight and obese women should aim for a weight closer to optimal weight for height before becoming pregnant.

Screening

Who should be screened for gestational diabetes and when?

Women who have the following risk factors for gestational diabetes should be screened at their first prenatal visit and may need to be screened more than once during the pregnancy:

Table 1. HIGH RISK INDICATORS FOR EARLY SCREEN FOR HYPERGLYCEMIA OR DIABETES
American Diabetes Association 2011
BMI equal to or greater than 25 (At-risk BMI may be lower in some ethnic groups)
Prior history of GDM
Prediabetes, glucosuria
Unexplained stillbirth or malformed infant
Diagnosis of polycystic ovarian syndrome
Women of ethnic groups with a high prevalence of diabetes: African-American, Latino, Native American, Asian-American, and Pacific Islander
Parent, sibling, or offspring with diabetes
Previous delivery of large-for-gestational-age infant (4000 grams or 8 lbs. 13 oz.)
Chronic use of medication that causes hyperglycemia (e.g. steroids)

All women should be tested for gestational diabetes between 24 and 28 weeks of pregnancy. If the client misses her screening at 24 to 28 weeks gestation, do the screening as soon as possible.

For more information on guidelines for diagnosis of hyperglycemia during pregnancy go to:

<https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/CDAPP.aspx>

What Should the Woman Do if She Has Diabetes and Is Pregnant?

The goal of treatment for all types of diabetes is to keep blood sugar as close to normal as possible. Many women with gestational diabetes are able to control their blood sugar with a meal plan and exercise routine. A pregnant woman with diabetes should:

- Make healthy food choices and follow her meal plan
- Exercise as advised by her health care provider
- Check her blood sugar
- Use insulin or oral medications as prescribed
- Identify ways to manage stress
- Start kick counts at 28 weeks gestation

What Should Women with Gestational Diabetes Eat?

During digestion, the body changes food into sugar. Some foods make more sugar than others, and even foods that are not sweet make sugar in the body. Milk, breads, fruits, and vegetables all produce varying amounts of sugar in the body. These foods are needed for good nutrition, but eating too much at one time can raise the client's blood sugar too high. Many women with gestational diabetes can control their blood sugar by changing some of the foods they eat, eating small more frequent meals, distributing carbohydrates throughout the day and adding physical activity to their daily routine.

There is no "one" meal plan for diabetes. A meal plan should be based on the woman's schedule, food

preferences, cultural practices, and blood sugar levels. For this reason, she should be referred to a registered dietitian who specializes in diabetes and pregnancy or a diabetes specialist for an individualized meal plan. Encourage the woman to follow the nutritional guidelines described below until she is seen by a registered dietitian or a diabetes specialist.

- Complete a *24-Hour Perinatal Dietary Recall* as described in the "Steps to Take (STT) Nutrition" section with input from the client
- Review the handout *California MyPlate for Gestational Diabetes* for general dietary guidelines
- Assess the *24-Hour Perinatal Dietary Recall* and compare it to *California MyPlate for Gestational Diabetes* to offer general advice
- Refer the woman to a CDAPP Sweet Success Affiliate or a diabetes specialist for an individualized diet

In preparation for visiting with the registered dietitian or diabetic specialist, the woman can be advised as follows:

How Often Should the Woman Eat?

The key to good blood sugar control is small meals and a regular eating schedule.

Recommend that the woman:

- Eat three smaller meals and three small snacks spaced two to three hours apart
- Allow no more than 10 hours between her bedtime snack and breakfast
- Eat at about the same time every day

What Foods Should the Woman Limit or Avoid?

Fruit juice, cookies, candies, sodas, and other sweet foods may raise blood sugar too high.

- Encourage her to avoid foods that are high in sugar. They are usually also low in nutritional value.

- Some artificial sweeteners are considered safe and approved for use during pregnancy. Advise the woman to ask her health care provider about using artificial sweeteners.

What Should the Woman Eat for Breakfast?

Because of hormones generated by the pregnancy and during sleep, blood sugar tends to be higher in the morning. Foods that are okay to eat later in the day may raise the blood sugar too high if eaten first thing in the morning. For breakfast, it is recommended to:

- Keep portions small
- Eat a protein food such as cheese, meat, an egg, or low-fat cottage cheese with whole grain bread, crackers, or corn tortillas. The protein may prevent her blood sugar from getting too high.
- Not eat fruit, milk, and yogurt or other foods that contain sugars. Avoid instant cereals, Cream of Wheat®, and dry cereals.

What Can the Woman Drink?

Besides water, other acceptable drinks include sugar-free Kool-Aid®, Crystal Light®, diet soda, and sugar-free mineral water. Regular soda, fruit drink and Kool-Aid® contain sugar and will raise the woman's blood sugar too much. Fruit juice also raises blood sugar quickly and is not recommended, including WIC fruit juices. Important tips:

- It is best to choose water over artificially sweetened drinks and drinks with caffeine
- Using artificial sweeteners in moderation is generally considered safe. Limit to one to two servings per day.
- People who have phenylketonuria (PKU) should not use the artificial sweetener aspartame
- Women can use WIC checks to buy V-8® juice. They should drink in 4 ounce portions. V-8® may not make her blood sugar too high.

How Much Weight Should the Woman Gain?

Weight gain recommendations are the same as for women without diabetes.

- Plot and assess weight gain as described in *Weight Gain During Pregnancy* in the "Nutrition" section
- Weigh and plot the weight grid at each prenatal visit. Refer as needed.
- If overweight or obese women lose weight, evaluate the diet composition and consider ultrasound monitoring for fetal growth before provider finalizes weight gain recommendations.

Exercise

Physical activity lowers blood sugar and is an important part of diabetes care. Before starting an exercise program, the woman should consult her health care provider. Exercise is usually best when done right after meals. See the exercise guidelines in the "Health Education" section for recommendations for physical activity that include aerobic, strength, and flexibility exercises during pregnancy.

Checking Blood Sugar Levels at Home

Blood sugar monitoring will tell the woman how she is doing with her meal and exercise plan. Usually, blood sugar is checked before breakfast and one hour after the start of meals.

- Checking after meals should be done one hour after the first bite
- The woman will need to continue checking her blood sugar throughout her pregnancy
- The CDAPP Sweet Success Affiliate or diabetes specialist will teach the woman to check her blood sugar with a meter. They will explain what kind of supplies she needs and how to get them.

Blood Sugar Goals

The woman should keep her blood sugar levels as normal as possible.

BLOOD GLUCOSE TARGETS DURING PREGNANCY	
Fasting/Pre-meal	60 - 94 mg/dl
Bedtime/Overnight	60 - 99 mg/dl
Peak post meal (test at 1 hour from beginning of meal)	100 - 139 mg/dl

Blood sugar that is consistently 200 mg/dl or more puts the baby at risk for complications, including stillbirth. If the client has a blood sugar value of 200 mg/dl or greater twice, instruct her to call her CDAPP Sweet Success Affiliate or diabetes specialist.

When Insulin or Oral Medications Are Necessary

Many women with GDM can control their blood sugar with a meal and exercise plan. Some women may have to use insulin or oral medications. Although insulin is the treatment of choice for pregnant women with diabetes, new evidence supports the use of some oral diabetes medications in the management of gestational diabetes. The dosing of oral medications depends on the woman's individual needs. She will still need to continue following her meal plan, checking her blood sugar, and exercising.

Insulin is injected into fatty tissue, usually in the abdomen. The amount of insulin needed is different for every woman. If the client needs insulin, she will be instructed to give herself one or more shots a day. Her need for insulin normally increases as she gets further along in her pregnancy.

- Discuss fears the woman may have regarding the use of insulin or oral diabetes medications

- If the woman is not understanding and/or following her medication plan, contact the health care provider

Handling Stress with Diabetes during Pregnancy

A pregnancy complicated by diabetes places additional demands on a woman and her family. She may find herself dealing with fears about her own and her baby's health. The extra medical appointments, dietary changes, and blood sugar monitoring may take time away from her work, family, and personal time. If there are other stresses in her life she may find it difficult to take care of her health.

Some women will have difficulty believing that they have diabetes. They may ask the same questions over and over again as the weeks go on. It is important to provide accurate medical information as well as emotional support during the pregnancy, delivery, and postpartum.

It is important to find out what the woman is most concerned about and what her fears are.

- Complete a psychosocial assessment and provide referrals or services as indicated
- Assess the level of support the woman has to help her manage having diabetes
- Address common concerns by reviewing the If you have diabetes while you are pregnant: Questions you may have handout with the woman
- Discuss any additional concerns the woman may have about diabetes and the adjustments she will need to make

Effect of Stress on Blood Sugar

Stress can increase blood sugar levels. Making positive lifestyle changes and using stress reduction techniques may help the woman control her blood sugar.

- Discuss the effects of stress on blood sugar with the woman

- Review the handout Stress Reducers. Help the woman decide what may work for her.

Other Psychological Concerns

In addition to the normal risks involved with pregnancy, there are certain psychosocial risks related to diabetes. Any woman with identified psychosocial needs should be referred for counseling and support from a mental health professional trained in pregnancy and diabetes care. Pay attention to the following:

- Previous pregnancy loss: If she has had a previous pregnancy loss, she may have fears about the health of this baby
- Family history of diabetes: If she has friends or relatives who have diabetes, she may have beliefs and ideas about diabetes management. She may also have fears about complications from diabetes.
- Previous or current substance use: If she uses or has used substances, she may worry that using needles will lead to a relapse. She may also be concerned about others having access to the syringes.
- Eating disorders: She may have trouble talking about her eating habits with others. Look out for over eating, under eating, bingeing or purging, and resistance to talking about her food habits. Refer clients with possible eating disorders to the health care provider and registered dietitian.

Labor and Delivery

How Does Diabetes Affect Labor and Delivery?

If the woman's blood sugar has been well controlled throughout her pregnancy, she will likely have a normal delivery. The following interventions are standard for all women with diabetes:

- The delivery method is based on the size of the baby and how well the baby is doing
- The woman's blood sugar is checked while she is in labor and delivery

- The baby's blood sugar is checked after delivery

Ongoing Support

The task of managing diabetes is difficult and demanding. The woman will need support and understanding in order to follow her meal plan and check her blood sugar daily. She will need encouragement, especially toward the end of her pregnancy when she is tired and ready to deliver her baby. Keeping her blood sugar well controlled during the last few weeks of pregnancy is important for both the mother's and baby's health.

Address the items below at each CPSP visit. If any concerns are identified, refer to the *CDAPP Sweet Success Affiliate* or diabetes specialist.

- Assess the woman's adjustment to the diabetes diagnosis and the lifestyle changes she has had to make
- Ask the woman if she is having any difficulties following the meal plan, exercise routine, or blood sugar testing
- Record and plot the woman's weight gain or loss at each visit
- At least at each trimester, complete a 24-Hour Dietary Recall, and check to see she is gaining appropriate weight and has access to healthy food. Encourage her to make healthy food choices.
- Encourage the woman to keep a record of food intake and blood sugar readings. Ask her to bring these with her to appointments.
- Report abnormal blood sugar values to the *CDAPP Sweet Success Affiliate* or diabetes care specialist
- Check to see if she is doing her kick counts as instructed. See *Kick Counts* in the "Health Education" section.
- Check to see if she has experienced any changes in her life that make it hard to manage her diabetes
- Review and address any remaining fears or concerns regarding diabetes

Postpartum

Care for gestational diabetes does not end at delivery. Discuss the following topics while the woman is pregnant and preparing for her postpartum care.

Postpartum Adjustment

After giving so much time and energy to the pregnancy, a woman may feel exhausted and let down after the baby is born. She may feel this way even if the baby is healthy. She may miss the frequent medical care visits and support from the health care team.

- Check the mother's adjustment to parenthood
- Check for postpartum depression. Any depression that disrupts her ability to care for herself and/or her baby must be reviewed by a mental health professional. See the guidelines on postpartum depression in the "Psychosocial" section of "Steps to Take."

Breastfeeding

Assure the woman that breastfeeding is especially beneficial to her and her baby and that she cannot give diabetes to the baby through her breast milk. Encourage her to breastfeed exclusively for six months and as long as desirable. The benefits of breastfeeding are discussed in *Breastfeeding* in the "Nutrition" section. The breastfeeding benefits of reducing the risk of obesity, cardiovascular disease, and future diabetes for both the mother and her baby are especially important for a woman with GDM. Refer to a lactation expert as needed. See the postpartum section for nutrition guidance for the mother.

Testing for Diabetes After Delivery

In most cases, following a pregnancy with GDM, blood sugar returns to normal in the weeks after delivery, but up to 25% of women with prior GDM continue to have high blood sugar after their baby is born. About 5% will have type 2 diabetes and about 20% will have pre-diabetes. Every woman who has had gestational diabetes should be tested for diabetes postpartum with an oral glucose tolerance test. There is a high chance that a woman who had GDM will have it with the next

pregnancy, so early screening is very important. The following is recommended for postpartum care for women with prior GDM:

- The woman should see her health care provider early in the postpartum period
- The standard for screening women with prior GDM is a two hour 75-gram oral glucose tolerance test done before six weeks postpartum
- The woman should have her blood sugar tested by her health care provider annually
- Screening for gestational diabetes should occur at the first prenatal visit in the next pregnancy

For more information on guidelines for testing blood sugar and treatment postpartum see: <https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/CDAPP.aspx>

Planning for Future Pregnancies

Encourage the woman to discuss family planning with her health care provider. Progesterone-only birth control can cause increased blood sugar and other types may be recommended.

- Discuss the handout *Now That Your Baby Is Here*
- Refer to *family planning choices* in the "Health Education" section
- Recommend preconception care and keeping her blood sugar in a normal range when planning her next pregnancy
- Maintain normal body weight
- Women who have type 1 or type 2 diabetes need to see their health care provider for diabetes care and receive preconception care for future pregnancies

Risk for Developing Type 2 Diabetes

It is important to understand that many people with type 2 diabetes do not know they have it. Some women who are diagnosed with GDM may have had diabetes before becoming pregnant and not known

it. This is why it is important to screen all women who had GDM four to six weeks after delivery using a two hour oral glucose tolerance test.

A woman who had GDM is at risk for developing type 2 diabetes later in life. If she maintains a normal weight, has healthy eating habits, and exercises regularly, she may avoid developing type 2 diabetes. If she does develop type 2 diabetes she will need to receive preconception care before she plans another pregnancy.

To help prevent the woman from getting diabetes and heart disease, encourage the following:

- Return for postpartum care with the health care provider and ensure her care includes the 75-gram oral glucose tolerance test
- Get an annual A1C blood sugar screening
- Maintain appropriate body weight. If overweight or obese, a slow weight loss is recommended. For overweight or obese women, losing at least 5% to 7% (10 to 14 pounds for a person weighing 200 pounds) of body weight can lower the risk of type 2 diabetes. See *Tips to Slow Weight Gain* in the “Nutrition” section of the CPSP guidelines.
- Continue healthy eating habits using *California MyPlate for Gestational Diabetes* as a guide. If blood sugars remain high, the woman should see a registered dietitian for an individualized plan. Eat foods that are low in fat and sugar. Eat plenty of vegetables and whole grains.
- Maintain a regular exercise routine. Being physically active at least 30 minutes per day, five days per week is important to avoiding type 2 diabetes.
- Breastfeed as long as possible. This may help women with gestational diabetes improve blood sugar and lipid levels.
- Check her lipids (cholesterol and triglycerides) at about six months after delivery or after she stops breastfeeding. Women with type 1 or type 2 diabetes or a history of GDM have a higher risk of elevated lipids, which is associated with heart disease.
- Discuss the handout *If You Had Diabetes While You Were Pregnant: Now That the Baby Is Here*.

Referrals

The first step in caring for the woman with diabetes is to refer her to a CDAPP Sweet Success Affiliate or a diabetes specialist for her ongoing care. This referral will be made by the health care provider caring for her pregnancy. A list of CDAPP Sweet Success Affiliates by county is available at: <https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/CDAPP.aspx#>

The woman will meet with professionals in health education, nutrition, and psychosocial care. They will provide the diabetes management care she needs. The woman may need additional referrals as described in the “Health Education,” “Nutrition,” and “Psychosocial” sections. Refer to *Making Successful Referrals* in the “First Steps” section

Resources

CDAPP Sweet Success Resource and Training Center

CDAPP Sweet Success Guidelines for Care, 2015,
California Diabetes and Pregnancy Program (CDAPP),
Maternal, Child and Adolescent Health Division,
Department of Public Health
[https://www.cdph.ca.gov/Programs/CFH/DMCAH/
Pages/CDAPP.aspx#](https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/CDAPP.aspx#)

*Gestational Diabetes: All You Need to Know About You
and Your Baby*, California Diabetes and Pregnancy
Program, Maternal and Child and Adolescent Health
Division, California Department of Public Health 2014
(English) and 2014 (Spanish).

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*Managing Your Gestational Diabetes: A Guide for
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American Diabetes Association, 1-800--232-6733.

Diabetes in Pregnancy: What to Expect. Jovanovic, Lois.

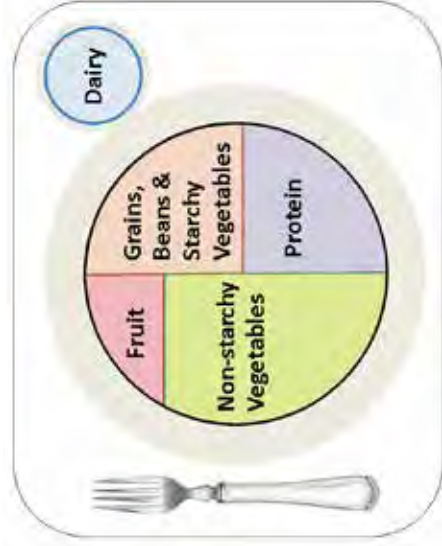
Diabetes Medical Nutrition Therapy. Holler, H.; Green
Pastors, J. (eds.)

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MyPlate for Gestational Diabetes

When you are pregnant and have diabetes, you have special nutrition needs. Use *MyPlate for Gestational Diabetes* to help you manage your blood sugar. This will help keep you and your baby healthy. Every day, eat the number of servings/choices of food shown below. Talk to a registered dietitian (RD) to develop a meal and exercise plan that will meet your needs.

⚠️ Limit Your Carbohydrates. When you have gestational diabetes, the type and amount of carbohydrates matter. Vegetables, Grains, Fruits, and Dairy contain carbohydrates. Some have more and some have less. Eating too many or the wrong type of carbohydrate may raise your blood sugar. Avoid foods with added sugar or white flour, such as cookies, candy and soda.



Vegetables

Eat non-starchy vegetables.

Use fresh, frozen or low-sodium canned vegetables. For diabetes, starchy vegetables like potatoes, sweet potatoes, yams, peas, corn & winter squash count as a Grain, not a Vegetable.

Daily Amount

- **6** or more of these choices:
- 2 cups raw leafy vegetables
- 1 cup raw vegetables
- 1/2 cup cooked vegetables



5 grams (g) carbohydrate per serving

Protein

Choose lean protein.

Avoid bacon, hot dogs & bologna.

Daily Amount

- **6** or more of these choices:
- 1 ounce fish, poultry, lean meat, or cheese
- 1/4 cup cottage cheese
- 1 egg
- 1 ounce nuts
- 1/2 cup tofu
- 2 Tablespoons nut butter



0 g carbohydrate per serving

Grains

For diabetes, beans & starchy vegetables count as Grains.

Eat 100% whole grains. Avoid cold breakfast cereals. Avoid instant rice, noodles & potatoes.

Daily Amount

- **7** of these choices:
- 1 slice whole wheat bread
- 1/2 cup potato or yam
- 1 small whole grain tortilla
- 1/2 cup cooked dried beans, non-instant cereal, corn or peas
- 1/3 cup cooked pasta, rice



15 g carbohydrate per serving

Fruits

Eat unsweetened fruits of all colors.

Do not drink fruit juice. Avoid fruit at breakfast. Limit dried fruit to 1/4 cup a day.

Daily Amount

- **2** of these choices:
- 1 small apple
- 17 small grapes
- 1 cup papaya
- 1/2 banana



15 g carbohydrate per serving

Dairy

Choose only pasteurized plain milk or yogurt.

For diabetes, cheese is in the Protein group. Do not eat yogurt or drink milk at breakfast.

Daily Amount

- **3** of these choices for women or
- **4** of these choices for teens:
- 1 cup 1% or fat free milk
- 1 cup soy milk with calcium
- 3/4 cup of plain yogurt



15 g carbohydrate per serving

Fats & Oils

- Use healthy plant oils like canola, safflower & olive oil for cooking.
- Read labels to avoid saturated & trans fats (hydrogenated fats).
- Avoid solid fats such as lard, shortening & butter.

- Fish has healthy fats. Eat cooked fish at two meals each week.
- Limit oils to 6 teaspoons each day.

0 g carbohydrate per serving

California My Nutrition Plan for Gestational Diabetes

This is my plan until I meet with a registered dietitian (RD) for my personal meal and exercise plan.

EVERY day, I will:

- Eat 3 meals and 3 snacks, 2 to 3 hours apart.
- Eat my bedtime snack so that no more than 10 hours pass before I eat breakfast the next day.
- Drink plenty of fluids. I will choose caffeine-free, sugar-free beverages. I will limit coffee to 2 cups daily & not drink alcohol.
- Limit artificial sweeteners to 1 - 2 servings a day.
- Try to walk for 10 - 15 minutes after each meal, especially breakfast.

Include protein and carbohydrates at each meal and snack.

Eat at least 175 grams (g) of carbohydrates a day. For the amount of carbohydrates in one serving of food, see below:

◆ **Non-starchy Vegetables** = 5g ◆ **Protein** = 0g ◆ **Grains, Beans and Starchy Vegetables** = 15g ◆ **Fruit** = 15g ◆ **Dairy** = 15g

As a sample, meals may look like this:

Breakfast

Eat 15g carbohydrates from the Grains group

- Include:**
- ◆ 1-2 servings Protein
 - ◆ unlimited servings of non-starchy Vegetables

Do not eat Fruit, yogurt or drink milk.

Example of a breakfast:

One egg omelet with cheese & vegetables and one slice toast

Lunch and Dinner



0-1 serving
Fruit

unlimited
servings
non-starchy
Vegetables

0-1 serving
milk or yogurt

2 servings Grains,
beans or starchy
vegetables

2-3 servings
Protein

Eat 45g carbohydrates, not including non-starchy vegetables

- ◆ Choose only one serving fruit, milk or yogurt at lunch and at dinner

Snacks

Eat 15g-30g carbohydrates from Fruit, Grains, or Dairy group

- Include:**
- ◆ At least 1 serving Protein with every snack
 - ◆ unlimited servings of non-starchy Vegetables

Examples of snacks:

- ◆ 1 small tortilla + 1 ounce cheese
- ◆ 2 rice cakes + celery + 2 tablespoons nut butter
- ◆ 1/2 banana + 24 almonds

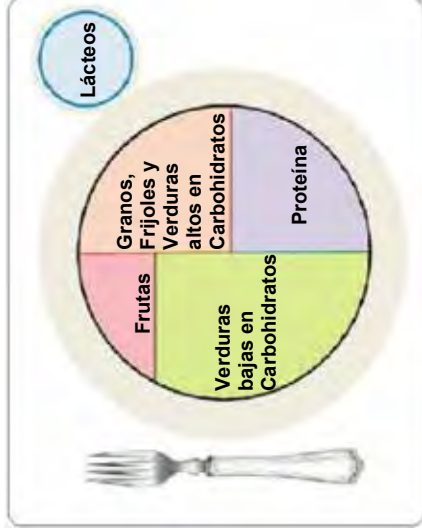


Use MyPlate for Gestational Diabetes for serving sizes and the total number of servings from each group you need every day.

MiPlato para Diabetes Gestacional

Cuando está embarazada y tiene diabetes, tiene necesidades nutricionales especiales. Use *MiPlato para Diabetes Gestacional* para ayudar a controlar su nivel de azúcar en la sangre. Esto ayudará a que usted y su bebé se mantengan sanos. Todos los días, coma toda la cantidad de porciones/variedades de alimentos mostrados abajo. Hable con un dietista certificado para que le ayude a desarrollar un plan de comida y ejercicio que le ayudará a adaptarse a sus necesidades.

⚠ Limite Sus Carbohidratos (hidratos de carbono). Cuando uno tiene diabetes gestacional, el tipo y cantidad de carbohidratos importa. Verduras, Granos, Frutas, y Lácteos contienen carbohidratos. Algunos más y otros menos. Comer demasiado o del tipo incorrecto de carbohidratos puede elevar el azúcar en la sangre. Evite comidas que añaden azúcar o harina blanca, como galletas, dulces, y refrescos (sodas).



Verduras

Coma verduras bajas en carbohidratos.

Use verduras frescas, congeladas, o verduras enlatadas que sean bajas en sodio.

Para la diabetes, verduras altas en carbohidratos como las papas, camote, batatas, chícharos, y elote, cuentan como Granos, no como Verduras

Cantidad Diaria

- 6 o más de estas opciones:
- 2 tazas de verdura de hoja cruda
- 1 taza de verdura cruda
- 1/2 taza de verdura cocida



5 gramos (g) de carbohidratos por porción

Proteína

Escoja proteína baja en grasa.

Evite el tocino, salchichas, y mortadela.

Cantidad Diaria

- 6 o más de estas opciones:
- 1 onza de pescado, aves, carne desgrasada, o queso
- 1/4 taza de requesón
- 1 huevo
- 1 onza de nueces
- 1/2 taza de tofu
- 2 cucharadas de crema/mantequilla de nueces



0 g de carbohidratos por porción

Granos

Para la diabetes, frijoles y verduras altos en carbohidrato cuentan como Granos.

Coma granos 100% integrales.

Evite cereales de desayuno frío. Evite arroz, fideos, y papas que sean instantáneos.

Cantidad Diaria

- 7 de estas opciones:
- 1 rebanada de pan de trigo integral
- 1/2 taza de papa o batata
- 1 tortilla pequeña de trigo integral
- 1/2 taza de frijoles secos cocidos, cereal no-instantáneo, elote, o chícharos
- 1/3 taza de pasta o arroz cocinado



15 g de carbohidratos por porción

Frutas

Coma Frutas de todos colores y no endulzadas.

No tome jugo de frutas. Evite frutas en el desayuno. Limite la fruta seca a solo 1/4 taza al día.

Cantidad Diaria

- 2 de estas opciones:
- 1 manzana pequeña
- 17 uvas pequeñas
- 1 taza de papaya
- 1/2 plátano



15 g de carbohidratos por porción

Lácteos

Elija sólo leche o yogurt natural y pasteurizado.

Para la diabetes, el queso está en el grupo de proteínas. No coma yogurt o tome leche en el desayuno.

Cantidad Diaria

- 3 de estas opciones para mujeres
- 4 de estas opciones para adolescentes:
- 1 taza de leche de 1% o sin grasa
- 1 taza de leche de soya con calcio
- 3/4 taza de yogurt natural



15 g de carbohidratos por porción

Grasas y Aceites

• Use aceites saludables de plantas como canola, cártamo, y aceite de oliva para cocinar.

• Lea etiquetas para evitar grasas saturadas y trans (grasas hidrogenadas).

• Evite grasas sólidas como manteca de cerdo, manteca, y mantequilla.

• El pescado tiene grasas saludables. Coma pescado cocido en dos comidas cada semana.

• Limite aceites a 6 cucharaditas cada día.

0 g de carbohidratos por porción

California Mi Plan Nutricional para Diabetes Gestacional

Este es mi plan hasta que vea a un dietista certificado para mi plan personal de comida y ejercicio.

TODOS los días, yo:

- Comeré 3 comidas y 3 botanas (bocadillos), de 2 a 3 horas aparte.
- Comeré mi bocadillo a la hora de acostarme para que no pasen más de 10 horas antes de comer el desayuno el próximo día.
- Tomaré suficientes líquidos. Elegiré bebidas sin cafeína y sin azúcar. Limitaré el café a 2 tazas diarias y no tomaré alcohol.
- Limitaré endulzantes artificiales a 1-2 porciones al día.
- Tataré de caminar por 10–15 minutos después de cada comida, especialmente después del desayuno.

Incluya proteínas y carbohidratos en cada comida y botana.

Coma por lo menos 175 gramos (g) de carbohidratos al día. Para ver la cantidad de carbohidratos en una porción de comida vea abajo:

- ◆ **Verduras bajas en Carbohidratos = 5g** ◆ **Proteína = 0g** ◆ **Granos, Frijoles y Verduras altos en Carbohidratos = 15g**
- ◆ **Frutas = 15g** ◆ **Lácteos = 15g**

Como ejemplo, sus comidas pueden verse así:

Desayuno

Coma 15g de carbohidratos del grupo de granos

Incluya:

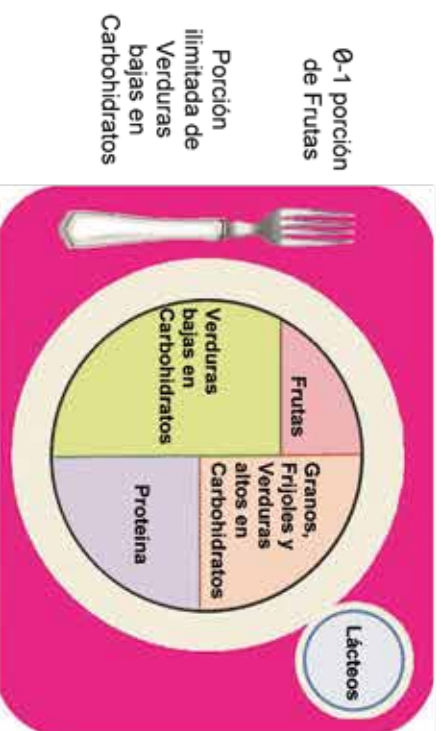
- ◆ 1-2 porciones de Proteína
- ◆ Porción ilimitada de Verduras bajas en Carbohidratos

No coma fruta, yogurt, o tome leche.

Ejemplo de un desayuno:

Un huevo revuelto con queso y verduras, y una rebanada de pan tostado.

Almuerzo y Cena



0-1 porción de Frutas

Porción ilimitada de Verduras bajas en Carbohidratos

0-1 porción de leche o yogurt

2 porciones de Granos, Frijoles, o Verduras altos en Carbohidratos

2-3 porciones de Proteína

Coma 45g carbohidratos, no cuente las Verduras bajas en Carbohidratos.

- ◆ Escoja sólo una porción de fruta, leche, o yogurt en el almuerzo y en la cena.

Botanas

Coma 15g-30g de carbohidratos del grupo de Frutas, Granos, o Lácteos

Incluya:

- ◆ Por lo menos 1 porción de Proteína con cada botana
- ◆ Porción ilimitada de Verduras bajas en Carbohidratos

Ejemplos de botanas:

- ◆ 1 tortilla pequeña + 1 onza de queso
- ◆ 2 tortas de arroz + apio + 2 cucharadas de crema/mantequilla de nueces
- ◆ 1/2 plátano + 24 almendras



Utilice *MyPlate para Diabetes Gestacional* para información sobre el tamaño de las porciones y el número total de porciones de cada grupo que necesita todos los días.



If You Have Diabetes While You Are Pregnant: Questions You May Have

Why Did I Get Diabetes in This Pregnancy?

There are many reasons why people get diabetes. Sometimes just being pregnant can trigger it as pregnancy increases the need for insulin. You may have a family history of diabetes. It may have to do with your age, your race, or your weight.

What Can I Expect to Happen While I Am Pregnant?

- You may need to come for check-ups more often
- You may need more tests
- You may need to go to a diabetes specialist. You may be referred to a California Diabetes and Pregnancy Program (CDAPP), Sweet Success Affiliate. The team may include a dietitian, a behavioral medicine specialist or social worker, and a nurse, along with your health care provider. They will help you understand and manage your diabetes.
- A dietitian can help you with

an individualized meal plan to meet your needs

- A nurse can teach you how to check your blood sugar and control your diabetes
- A behavioral medicine specialist or social worker can help you learn to relax to lower the stress that comes with being pregnant and having diabetes
- They will all encourage you to exercise. Being active can lower your blood sugar.

Will I Have to Take Insulin?

Insulin is a hormone produced by your body. If your body does not make enough insulin, your health care provider may prescribe insulin.

- Insulin helps keep your blood sugar under control
- Controlled blood sugar helps you and your baby stay healthy

Do I Have to Give Up Everything I Like to Eat?

No! But you will need to learn what the foods you eat do to your blood sugar. Talk to the registered dietitian to see if you can fit some of your favorite foods into your meal plan.





If You Have Diabetes While You Are Pregnant: Questions You May Have

Will My Baby Have Diabetes?

Most likely, your baby will not have diabetes. Your child may have a greater risk of getting diabetes later on in life. To lower the chances of that happening you can:

- Eat a healthy diet and help your family eat healthy food
- Keep your blood sugar under control while you are pregnant
- Breastfeed your baby to lower the chance your baby will have diabetes later

Will I Have Diabetes After the Baby Is Born?

If you had gestational diabetes while you were pregnant, it will most likely go away after giving birth. However, you are at a greater risk for developing type 2 diabetes later in life.

You may have had type 2 diabetes before you were pregnant. If you did, you will still have it after your baby is born.

Will I Have Diabetes in My Next Pregnancy?

It is likely that you will have gestational diabetes in your next pregnancy. Here's what you can do:

- Get tested for diabetes six weeks after your baby is born
- Get tested every year. That will help you find out if you have diabetes.
- If you do get diabetes, it is very important to see your doctor before you plan for another pregnancy
- If you get pregnant again, be sure to get tested for diabetes right away. That way you can get the care you need to have a healthy pregnancy.
- Maintain a healthy weight by eating healthy foods and being physically active to lower your chances of having diabetes





Si Tiene Diabetes Durante el Embarazo: Preguntas que se Puede Estar Haciendo

¿Por qué Tengo Diabetes en Este Embarazo?

Hay muchas razones por las que puede tener diabetes. A veces puede ocurrir simplemente por estar embarazada, ya que el embarazo aumenta la necesidad de insulina. Puede ser que tenga antecedentes familiares de diabetes. Puede tener que ver con su edad, raza o peso.

¿Qué Puede Pasar Durante el Embarazo?

- Es posible que tenga que venir a consultas con más frecuencia
- Es posible que necesite pruebas adicionales
- Es posible que tenga que ir a ver a un especialista en diabetes. La pueden remitir a una filial del Programa "Sweet Success" de Diabetes y Embarazo de California. El equipo del Programa puede incluir a un dietista, un especialista en medicina de la conducta o un trabajador social, y una enfermera, así como su proveedor de atención de la salud. La ayudarán a comprender y manejar su diabetes.
- El dietista le puede ayudar a hacer un plan de comidas personalizado para cumplir con sus necesidades
- La enfermera le puede enseñar

a medir su nivel de glucosa en la sangre y controlar su diabetes

- El especialista en medicina de la conducta o trabajador social le puede ayudar a aprender a relajarse para reducir el estrés que acompaña a la diabetes durante el embarazo
- Todos la alentarán a que haga ejercicios físicos. La actividad física puede bajar el nivel de glucosa en su sangre

¿Tendré que Tomar Insulina?

La insulina es una hormona producida por su cuerpo. Si su cuerpo no fabrica suficiente insulina, es posible que su proveedor de atención de la salud le recete insulina.

- La insulina ayuda a mantener bajo control su nivel de glucosa en la sangre
- Si su nivel de glucosa en la sangre está bajo control, tanto usted como su bebé se mantendrán saludables

¿Tengo que Dejar de Comer Todo lo que Me Gusta?

¡No! Pero tendrá que saber el efecto que tienen las comidas en su nivel de glucosa en la sangre. Hable con el dietista licenciado para ver si puede incluir algunas de sus comidas preferidas en su plan de comidas.





Si Tiene Diabetes Durante el Embarazo: Preguntas que se Puede Estar Haciendo

¿Mi Bebé Tendrá Diabetes?

Lo más probable es que su bebé no tenga diabetes. Su hijo puede correr un riesgo mayor de tener diabetes más adelante en la vida. Para reducir las posibilidades de que esto ocurra:

- Coma una dieta saludable y ayude a que su familia coma alimentos saludables
- Mantenga su nivel de glucosa en la sangre bajo control durante el embarazo
- Dele pecho a su bebé para reducir la posibilidad de que tenga diabetes más adelante

¿Tendré Diabetes Después de que Nazca El Bebé?

Si tuvo diabetes gestacional durante el embarazo, probablemente desaparezca después de dar a luz. Correrá un mayor riesgo de desarrollar diabetes tipo 2 más adelante.

Es posible que haya tenido diabetes tipo 2 antes del embarazo. Si es así, la seguirá teniendo después de que nazca el bebé.

¿Tendré Diabetes Durante Mi Próximo Embarazo?

Es probable que tenga diabetes gestacional durante su próximo embarazo. Lo que puede hacer es:

- Hacerse una prueba de diabetes no más de seis semanas después del nacimiento de su bebé
- Hacerse una prueba de diabetes todos los años. Eso la ayudará a saber si tiene diabetes
- Si tiene diabetes, es muy importante que vea a su médico antes de planear otro embarazo
- Si vuelve a quedar embarazada, hágase una prueba de diabetes de inmediato. Así podrá obtener la atención que necesita para tener un embarazo saludable.
- Para reducir las posibilidades de tener diabetes, mantenga un peso saludable, coma comidas saludables y realice actividad física





If You Have Diabetes While You Are Pregnant: Relax and Lower Your Stress

STEPS TO TAKE

Your blood sugar level can go up when you are stressed. So it's a good idea to identify different ways to lower your stress.

Here Are Some Ways to Help You Relax:

Breathe deeply.

Sit comfortably and put your hand on your stomach.

- Take a deep breath. Use the muscles in your stomach, not your chest.
- Feel your stomach lift up about an inch as the air goes in
- Breathe out all the way
- Feel your stomach go down about an inch

Now, breathe this way slowly.

- Breathe in and count to six
- Breathe out and count to six
- Do this three or more times
- Practice doing this every day

Relax your muscles.

Soften the tightness in your muscles.

- Tighten up, and then relax your muscles — one at a time
- Start with your feet and work up (Flex your feet upward to keep from getting cramps in your calves)
- Remember to breathe!

Take time to imagine.

Think about a place where you like to be — a place that is quiet and restful.

- Picture it in your mind
- Think about what you might see, hear, feel, touch, or taste
- When you feel stressed, think about being in this relaxing place

Lower the stress in your life.

Pay attention to what makes you feel stressed.

- Try to make changes in your life to avoid that stress
- Try doing the things on this sheet
- Figure out what works best for you

Take time for yourself.

- Call a friend
- Read a book, watch a movie, or listen to music
- Relax in a warm bath
- Do crafts or a favorite hobby
- Rest for half an hour or more in the middle of the day
- Take a few moments to sit in silence and think peaceful thoughts

Get the exercise you need.

Ask your health care provider about what exercises you can do safely. For example:

- Go for a walk
- Go swimming
- Join a pregnancy exercise class

Get some support.

All of us need someone who will listen to us.

- Find a good friend, co-worker, or relative you can talk to
- Talk with them about what it is like to have diabetes
- Talk to your health care team about any problems you may have

Cut down on what you do.

Find ways to let others help you at home and at work. It's okay to ask for help. Maybe they can:

- Do the dishes or the laundry
- Shop for you
- Cook a meal
- Take care of the kids





PASOS A SEGUIR

Si Tiene Diabetes Durante el Embarazo: Relájese y Reduzca su Estrés

Su nivel de glucosa en la sangre se puede elevar cuando está estresada. Así que es una buena idea identificar las distintas maneras de reducir el estrés.

Estas Son Algunas Maneras de Ayudar a Relajarse:

Respire profundo.

Siéntese en una posición cómoda y coloque la mano en su panza.

- Inhale profundamente. Use los músculos de su estómago, no los de su pecho
- Sienta cómo se levanta el estómago aproximadamente una pulgada cuando aspira aire
- Exhale todo el aire
- Sienta cómo se baja el estómago aproximadamente una pulgada

Ahora respire lentamente de la siguiente manera.

- Inhale y cuente hasta seis
- Exhale y cuente hasta seis
- Repítalo tres o más veces
- Practique esta respiración todos los días

Relaje sus músculos.

Suelte la tensión en los músculos.

- Tensione y después relaje los músculos, uno a la vez
- Empiece por los pies y vaya subiendo (flexione los pies hacia arriba para evitar calambres en las pantorrillas)
- ¡No se olvide de respirar!

Tómese tiempo para imaginar.

Piense en un lugar donde le gustaría estar, un lugar tranquilo y descansado.

- Imagínese lo
- Piense en lo que podría ver, escuchar, sentir, tocar o saborear
- Cuando está estresada, piense que está en este lugar descansado

Algunas maneras de reducir el estrés en su vida son.

Preste atención a lo que la hace sentir estresada.

- Intente hacer cambios en su vida para evitar ese estrés
- Intente hacer las cosas que se describen en esta hoja
- Conozca lo que funciona mejor para usted

Dedique tiempo a sí misma.

- Llame a un amigo
- Lea un libro, vea una película o escuche música
- Relájese dándose un baño tibio
- Haga artesanías o dedíquese a un pasatiempo
- Descanse durante media hora o más en el medio del día
- Tome unos pocos minutos para sentarse en silencio y pensar pensamientos pacíficos

Haga el ejercicio físico que necesita.

Pregúntele a su proveedor de atención de la salud qué ejercicios puede hacer sin peligro. Por ejemplo:

- Salga a caminar
- Vaya a nadar
- Participe en una clase de ejercicios para mamás embarazadas

Obtenga apoyo.

Todos necesitamos a alguien que nos escuche.

- Encuentre a un amigo, compañero de trabajo o pariente con el que pueda hablar
- Hábleles sobre lo que siente al tener diabetes
- Hable con su equipo de atención de la salud sobre cualquier problema que tenga

Reduzca la cantidad de cosas que hace.

Encuentre maneras de dejar que otras personas la ayuden en la casa y en el trabajo. Está bien pedir ayuda. Quizás la puedan ayudar a:

- Lavar los platos o la ropa
- Ir de compras
- Cocinarle una comida
- Cuidar a los niños





If You Had Diabetes While You Were Pregnant: Now That Your Baby Is Here

Because you had diabetes when you were pregnant, you need to take special care of yourself and your baby. These tips will help:



Breastfeed your baby.

- It is good for you and your baby. It helps lower your blood sugar and may help keep your baby from getting diabetes.
- Ask for help and get the support you need
- Talk to your health care provider about your breastfeeding questions and concerns

Keep eating healthy foods.

- Eat foods low in fat and sugar
- Eat foods high in fiber. Snack on fruits and vegetables.
- Ask your health care provider to refer you to a registered dietitian
- Stick to water and cut out sweet drinks. Limit fruit juice.

See your health care provider.

- Let them know you had diabetes when you were pregnant
- Make an appointment to have your blood sugar checked

Get a blood sugar test at the lab. This test will let you know if your diabetes has gone away.

- Get a blood sugar test at your six week check-up
- Get a blood sugar test once a year

Find out about birth control.

- Talk to your health care provider
- Tell them you had diabetes when you were pregnant
- Get a birth control method that is safe for someone who has had diabetes

Get plenty of physical activity.

- Take a walk every day
- Talk to your health care provider about activity that is right for you
- Try to make your life more active each day

Keep a healthy weight.

- Losing weight can prevent diabetes the next time you are pregnant
- A healthy body weight can help prevent type 2 diabetes
- Talk to your health care provider about a healthy weight for you

Have your blood fat (lipids) checked.

- Get this test six months after your baby is born or after you have stopped breastfeeding
- Be sure to get a blood sugar test annually and before you get pregnant again
- If you have diabetes, see your health care provider before you get pregnant



Si Tuvo Diabetes Durante el Embarazo: Ahora que Llegó el Bebé

Como tuvo diabetes durante el embarazo, tiene que tomar cuidados especiales para usted y su bebé. Estos consejos ayudarán a usted y a su bebé:



Dele pecho a su bebé.

- Les hace bien a usted y a su bebé. Ayuda a reducir su nivel de glucosa en la sangre. Puede ayudar a que su bebé no desarrolle diabetes.
- Pida ayuda y obtenga el respaldo que necesita
- Hable con su proveedor de atención de la salud sobre las preguntas y preocupaciones que tenga sobre dar pecho

Siga comiendo alimentos saludables.

- Coma comidas con bajo contenido de grasas y azúcar
- Coma comidas con alto contenido de fibra. Coma frutas y verduras para los bocados.
- Pídale a su proveedor de atención de la salud que la remita a un dietista licenciado
- Beba agua y elimine las bebidas dulces. Limite el jugo de fruta que bebe.

Vea a su proveedor de atención de la salud.

- Avísele que tuvo diabetes durante el embarazo
- Haga una cita para examinar su nivel de glucosa en la sangre

Hágase una prueba de glucosa en la sangre en un laboratorio. Esta prueba le dirá si desapareció su diabetes.

- Hágase una prueba de glucosa en la sangre en su consulta a las seis semanas después del parto
- Hágase una prueba de glucosa en la sangre una vez al año

Aprenda sobre los métodos de control de natalidad.

- Hable con su proveedor de atención de la salud
- Avísele que tuvo diabetes durante el embarazo
- Use un método de control de natalidad que sea seguro para una persona que tuvo diabetes

Haga suficiente actividad física.

- Salga a caminar todos los días
- Pregúntele a su proveedor de atención de la salud qué actividad le conviene hacer
- Intente que su vida sea más activa todos los días

Mantenga un peso saludable.

- Si baja de peso, podrá prevenir la diabetes en su próximo embarazo
- Un peso saludable puede ayudar a prevenir la diabetes tipo 2
- Hable con su proveedor de atención de la salud sobre lo que se considera un peso saludable para usted

Hágase una prueba de grasa (lípidos) en la sangre.

- Hágase esta prueba seis meses después del nacimiento de su hijo, y después de dejar de dar pecho
- No se olvide de hacerse una prueba de glucosa en la sangre todos los años y antes de volver a quedar embarazada
- Si tiene diabetes, vea a su proveedor de atención de la salud antes de quedar embarazada

STEPS TO TAKE

APPENDIX



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(Additional Information)

These Steps to Take Guidelines are to be used with your office protocols which are your facilities' procedures for providers (health ed, nutrition, psychosocial) services and related case coordination.

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Goal

During the course of a pregnancy various laboratory and diagnostic tests will be ordered for the client. The information included in this section is designed to assist in providing the client with basic information on why the tests are ordered and when they are performed, as well as a description of the procedure and what the results might indicate.

Laboratory Tests

Hemoglobin/Hematocrit

Why: This test tells the medical provider if the client is anemic, which means she does not have enough iron in her red blood cells. Lack of iron can restrict the amount of oxygen that gets to her cells. Hemoglobin or hematocrit is required to determine WIC program eligibility. See Anemia in the Nutrition section for additional information.

When: Usually at the first prenatal visit and often again at 24-28 weeks. Sometimes it is repeated at the postpartum visit, especially if the client had heavy blood loss during delivery or during the postpartum period.

Procedure: Blood is drawn from a vein, usually in the arm.

Results: Test results of less than 11 gms for hemoglobin or less than 33% for hematocrit may indicate anemia; however, variations in these values can also be related to normal pregnancy changes. Clients whose results indicate anemia should be encouraged to eat foods high in iron and vitamin C. See the handouts on Anemia in the Nutrition section of this manual.

Rh/ABO factors

Why: Everyone has a blood type and a factor, Rh and ABO being the more commonly identified ones. When a woman who has a negative Rh factor is pregnant with a baby who has a positive Rh factor, the opposite factors can react to one another and harm the baby. The baby may be born severely anemic and, in rare cases, may die.

When: Blood tests ordered at the first prenatal visit will determine if the client is Rh negative or positive. If she is negative, the tests will further determine whether she has already been sensitized. If she is not sensitized, the test will be repeated at 28 weeks.

Procedure: Blood is drawn from a vein, usually in the arm.

Results: The test determines sensitivity to Rh. If the client is Rh negative and remains unsensitized at 28 weeks, she will be given Rh Immune Globin (RhIG). After delivery, if the baby's blood type is Rh positive, she will be given another injection of RhIG or Rhogam to help prevent sensitivity from developing, which could impact future pregnancies.

Urinalysis

Why: Urine may give indications of kidney problems, diabetes or infection, even though the client may not be aware of symptoms. All of these conditions can have serious consequences for the mother and the baby.

When: At the first prenatal visit and at each subsequent medical obstetric visit.

Procedure: The client is asked to urinate in a specimen container. If the specimen is to be cultured, she will be asked to obtain a "clean catch" specimen (practice protocols should include instructions).

Results: Specimens positive for protein may indicate kidney problems or pregnancy-induced hypertension; glucose may indicate the client has diabetes; and a positive culture is an indication of possible infection. All of these conditions require further evaluation by the medical provider.

Rubella

Why: Rubella, or German measles, is a viral disease that causes a generally mild illness. During pregnancy, however, a Rubella infection, especially in the first trimester, can cause serious congenital anomalies in the baby.

When: The test for Rubella antibodies is usually performed at the first prenatal visit.

Procedure: Blood is drawn from a vein, usually in the arm.

Results: A person is generally considered immune to Rubella if their test shows antibodies present at a ratio greater than 1:8. However, sometimes when a woman has been vaccinated for Rubella her results may show less than 1:8, even though she is immune. If the test shows no immunity and the client has not been immunized, she should be offered a Rubella vaccination after delivery that will protect her for future pregnancies.

Procedures

PAP Smear

Why: This is a screening test used to determine whether a woman has cancerous or precancerous cells on her cervix. The cervix is the part of the uterus (or womb) that is in the upper part of the vagina.

When: Done as part of the pelvic examination conducted at the first obstetric visit.

Procedure: The medical provider will use a small implement (wooden, like a small tongue depressor, or sometimes a small brush) to scrape a few cells from the cervix that are then placed on a small glass slide and sent to the laboratory for microscopic evaluation. The procedure is not painful.

Results: Actual wording of the test results may vary from laboratory to laboratory, but generally they give some indication whether or not abnormal cells were found. Sometimes cells are identified that are abnormal but not cancerous. These may be related to infections and should be evaluated by the medical provider.

Ultrasound

Why: This procedure allows the medical provider to check the size and position of the baby and the placenta and to check for multiple babies and internal organs. This is helpful in determining if the baby is growing well, whether there might be complications during delivery, and if there are congenital anomalies.

When: Can be performed at any time during the pregnancy. Timing depends on what the medical provider is trying to evaluate. Ultrasound is not recommended on a routine basis or only to determine the sex of the baby.

Procedure: Ultrasound is not an x-ray. The procedure uses sound waves to produce a picture of the baby and the contents of the uterus (similar to how a submarine uses sonar). A lubricating gel is placed on the client's abdomen and a scanner is rubbed over the entire abdomen. The sound waves are converted into a "picture". Other specific preparations may be necessary and the client should be referred to the laboratory that will do the ultrasound or check the practice procedure manual for those done onsite. Often the woman will be asked to drink fluids to fill her bladder prior to the ultrasound.

Results: The results depend on why the test was ordered. Some things it might show are: the baby's size and development as an indication of when the baby is due, which is important if a cesarean section is possible or to prepare for other pregnancy complications; determine the baby's position; see if the baby is growing at an appropriate rate; and to guide needle placement in amniocentesis.

Amniocentesis

Why: The fluid that surrounds the baby in the uterus can provide the medical provider important information about the baby. For instance, tests can determine if a baby has a genetic disorder such as Down's syndrome or Tay-Sachs disease, a neural tube

defect such as spina bifida (open spine), immature lungs (important if preterm labor threatens), and Rh disease in clients who have already been sensitized.

When: As indicated, usually in the second or third trimester when there is sufficient amniotic fluid.

Procedure: An ultrasound is done to show the medical provider where the baby, placenta, cord, and pockets of fluid are located. A local anesthetic is used on the abdomen at the site of insertion and then a very fine needle is inserted through the abdominal wall and uterus into the “bag of waters”. A very small amount of fluid is removed and sent to the laboratory for analysis. The client may feel some “pressure” as the needle is inserted. In general, the procedure is not painful.

Results: The woman will remain on a maternal/fetal monitor to make certain that the procedure does not start premature contractions. Occasionally this procedure can cause the woman to have premature labor. The provider may nick the umbilical cord, which can result in an immediate C-section. There is a small chance of infection from this procedure.

Screenings

Syphilis

Why: Untreated maternal syphilis can result in fetal death or can damage the infant’s internal organs and long bones in addition to the consequences of untreated infection in the mother and her sexual partners.

When: A screening for syphilis is required at the first prenatal visit. Women who are at high risk for sexually transmitted diseases (multiple sexual partners during the pregnancy and/or a partner with multiple sexual partners) should have another test during the third trimester.

Procedure: The test for syphilis is identified as Venereal Disease Research Laboratory (VDRL) or as rapid plasma reagin (RPR), both of which are tests on blood usually drawn from a vein.

Results: Either test will give results that indicate no infection, probable current infection or previously treated infection. Patients with suspected current infection not only need appropriate treatment but also need to be interviewed for previous sexual contacts and need to notify those people regarding their need for testing and possible treatment. Your local Health Department can assist you with this process. Infants born of women with syphilis infection during pregnancy will also need to be tested their birth. For additional information concerning sexually transmitted infections, see the Health Education section on STIs.

Chlamydia, Herpes, Gonorrhea

Why: These three diseases are sexually transmitted and each has the potential to harm an infant born while the mother is actively infected.

When: In some practices, all women are routinely screened for these infections; in others, they are screened only when the woman is symptomatic or gives an at-risk history such as multiple sexual partners or is the partner of someone with multiple sexual partners. A woman with a herpes infection will probably notice painful blister-like sores in the genital area. Women with chlamydia and/or gonorrhea may or may not have a vaginal discharge.

Procedure: All of these infections can be diagnosed by examination/culture of the cervical secretions taken during a pelvic examination with a speculum. Laboratories usually provide instructions as to the appropriate handling of such specimens.

Results: Each test will give an indication of whether a current infection is present or not. Each infection has specific treatment and follow-up procedures that are the responsibility of the medical provider. Additionally, these infections are reportable to the local Health Department and also require sexual contact follow-up, with which the Health Department can assist. For additional information concerning sexually transmitted infections see *STIs* under Health Education.

HIV

Why: State law requires that all pregnant women be offered an HIV test in addition to education about HIV infection and the risks and benefits of testing (See HIV in the Health Education section). Many women who were later found to be HIV positive did not have identifiable risk factors. Thus it is important to talk about HIV testing as an important part of general preventative health services in addition to the importance of lowering perinatal transmission.

When: The test should be offered at the first prenatal visit but can be done at any time during the pregnancy.

Procedure: The most common test for antibodies to HIV (direct testing for HIV virus is not done as a screening procedure) is done on blood drawn from a vein in the arm. It is important to remember that specific written consent is required before doing an HIV test.

Results: Most generally the results will be negative (no evidence of infection) or positive (evidence of antibodies). Occasionally the test results are “indeterminate”, which usually indicates that the test needs to be repeated; necessary follow-up for this test result should be decided by the medical provider. Positive test results should only be given by the medical provider or by a staff person who has extensive experience giving HIV positive test results and/or crisis intervention skills. It is important to remember that negative test results may not actually reflect the patient’s HIV status as a person may be infected, and infectious, but not have developed sufficient antibodies to result in a “positive” test. This situation usually applies to the individual who engaged in risk behavior in the three months just prior to the test. Further testing will show more definitive results.

Serum Alpha Fetoprotein (AFP)

Why: Increased levels of serum alpha Fetoprotein have been associated with a higher risk of having a baby with a neural tube defect (defects of the spinal column, anencephaly, spina bifida).

When: The test must be done at 16 to 20 weeks of pregnancy.

Procedure: The test is performed on blood taken from a vein in the arm.

Results: Test results are given in a range, with positive tests being elevated. However, a positive test does not necessarily mean that the baby has a neural tube defect and those tests need to be followed by an amniocentesis and ultrasound.

Diabetes — Glucose tolerance test (GTT)

Why: Diabetic women have three time the potential for giving birth to babies with heart defects. They are also at risk for large babies and increased fetal mortality.

When: At about 24 weeks of pregnancy, usually between the 24th and 28th week of gestation. Some women may be screened more than once (See the Gestational Diabetes section of these guidelines).

Procedure: The client will be asked not to eat or drink after midnight the night before the test. Blood will be drawn for the fasting blood sugar and then she will be asked to drink a very sweet soda-like liquid. Her blood sugar will be checked one hour later to measure the amount of sugar in her blood.

Results: The test will show if the woman’s blood sugar level is within normal limits. If her blood sugar level is not within normal limits, more tests may be required.

Background

Managed Care is a coordinated approach to providing health care services. The goal is to provide prompt quality service in a cost-effective manner. Over the past few years, the State of California has expanded managed care within the Medi-Cal Program in order to improve women's and children's access to preventive and primary care health services.

Many of the most populated counties within California have Medi-Cal managed care systems already in place, and others are in the process of developing such systems. If you currently see Medi-Cal patients who are enrolled in a managed care system, or if you are expecting to see managed care patients in your practice, the following information may be useful to you.

Steps to Take

Eligibility and Enrollment

Enrollment in Medi-Cal managed care is required or mandatory, for some people, and optional for others. People in the mandatory category include:

- Those on CalWORKs
- Medically Indigent Children

People receiving Supplemental Security Income (SSI) are in the optional group for Medi-Cal managed care. You may have some patients in your practice who are on Medi-Cal and never enroll in a managed care plan. Contact your local Medi-Cal managed care plan(s) for the specific aid codes that are covered. This eligibility information is subject to change under welfare reform.

In most counties, there is more than one Medi-Cal managed care plan. It is important to know which plan each of your patients belongs to, so that you can receive the appropriate information to best meet their needs. Your patients may carry cards from their

specific plan that will help you to determine their eligibility and benefits. You can also use the patient's Benefits Identification Card (BIC), or the Automated Eligibility Verification System (AEVS) to get eligibility and enrollment information.

Because you may have patients from more than one plan in your county, it is important to have information on all of the plans. Try to establish a contact person at each plan that can give you information on member benefits and provider requirements.

Disenrollment

There are certain situations in which a member is automatically disenrolled from a Medi-Cal managed care plan. Some of those are:

- Member moves out of the plan's service area
- Member no longer qualifies for Medi-Cal benefits
- Member has changed aid codes and now has a code that is not covered by the plan
- Member does not keep up with paperwork needed to maintain qualification - may still be eligible, but not qualified

Members may also voluntarily disenroll from their managed care plan and enroll in another plan. The managed care plan(s) in your county may have different disenrollment procedures.

Primary Care Physician

In managed care, the usual way that a member accesses care is through her PCP (Primary Care Physician). All members are to receive a physical exam when they first enroll with their managed care plan, and regularly thereafter. The PCP will then monitor the care of the member on an ongoing basis, to be sure that all of the member's health care needs are being met. The member should discuss all of her health-related concerns with her PCP.

The PCP provides standard care, including:

- Routine examinations
- Preventive screenings
- Treatment of routine injuries and illnesses

A PCP also coordinates the patient's care, and offers assistance to patients in getting the full benefits of the managed care systems. The PCP refers patients to specialty services as needed, and monitors the care that the patient receives from other providers.

Obstetric care is an exception to this rule. In order to increase access to early prenatal services, members may self-refer to OB providers. You may provide routine perinatal services to Medi-Cal managed care patients without prior authorization if you are a provider in the patient's managed care plan.

If the OB doctor is not the member's PCP, it is important to coordinate with the patient's PCP so that all care needs are met. The OB provider must refer the patient back to the PCP for any primary care needs that arise during pregnancy, and at the conclusion of perinatal care. Prior Authorization is not needed for routine prenatal care services.

OB Services in Managed Care

Managed care plans follow the American College of Obstetrics and Gynecology (ACOG) standards as the standard for services provided to Medi-Cal pregnant women.

In addition, pregnant members are to receive support services consistent with the CPSP program requirements. These services include but are not limited to initial Health Education, Nutrition, and Psychosocial assessment, trimester reassessments, postpartum assessments, care plan development, and interventions. Each plan may implement these requirements in slightly different ways, so it is important to contact the Medi-Cal managed care plan to determine what their requirements are. It is also important to find out if the plan requires use of specific forms and/or written protocols.

NUTRITION TOOLS



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Perinatal Food Group Recall

To be completed by a CPSP Practitioner while reviewing *What Should I Eat?*

My Pyramid Plan for Moms <http://www.nal.usda.gov/wicworks/Topics/PregnancyFactSheet.pdf>

On a typical day, how many servings of:

1. Fruit do you eat?

- 1 serving is:
- 1 cup or piece of fruit
 - 1/2 cup 100% fruit juice
 - 1/2 cup dried fruit

1st Tri	2nd Tri	3rd Tri	Post
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Never
Fewer than 2 servings/day
2 or more servings/day

Advise patient to:

- Aim for 2 or more servings/day.
- Eat a variety of fresh, frozen or canned fruits each day.
- Choose fresh, frozen and canned fruits without added sugars.
- Limit fruit juice

Preferred fruits:

2. Vegetables do you eat?

- 1 serving is:
- 1 cup raw or cooked vegetables
 - 2 cups raw leafy greens

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Never
Fewer than 3 servings/day
3 or more servings/day

Aim for 3 or more servings/day.

- Eat a variety of fresh, frozen or canned vegetables without added sauces or salt.
- Choose some vegetables that are dark green or orange.

Preferred vegetables:

3. Milk Foods do you eat?

- 1 serving is:
- 1 cup milk or yogurt
 - 1 1/2 to 2 oz. cheese
 - 1 cup calcium fortified soy milk

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Never
Fewer than 3 servings/day
3 servings/day*
More than 3 servings/day
*4 servings/day for teens

Aim for 3 servings/day.

- Choose nonfat or low-fat (1%) milk.
- If patient does not use milk products, refer to *STT Do You Have Trouble with Milk Foods?* and *Foods Rich in Calcium*.

Preferred milk foods:

4. Meat and Beans (Protein Foods) do you eat?

- 1 serving is:
- 1 oz. meat, fish or poultry
 - 1 egg
 - 1/2 oz. or small handful nuts
 - 1 tablespoon peanut butter
 - 2 tablespoons seeds, such as sunflower
 - 1/4 cup cooked dry beans, peas, lentils
 - 1/4 cup or 2 oz. tofu

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Never
Fewer than 6 servings/day
6 - 7 servings/day
More than 7 servings/day

Aim for 7 servings/day.

- Grill, broil or bake instead of fry.
- Take skin off poultry before/after cooking.
- Eat lean meat (15% fat or less).
- Eat 12 oz. of fish per week. Choose water-packed and low-mercury fish, e.g., canned light tuna
- Limit high-fat meats like sausage, hot dogs and bologna.
- If patient is vegetarian, review *STT "Vegetarian Eating."*

Preferred protein foods:

On a typical day:

5. How many servings of Grains do you eat?

1 serving is: • 1 slice bread • 1 cup dry cereal • 1/2 cup cooked rice, pasta or hot cereal • 1 small corn or 1/2 small flour tortilla	Never	Advise patient to:			
	Fewer than 6 servings/day	<input type="checkbox"/> 1st Tri <input type="checkbox"/> 2nd Tri <input type="checkbox"/> 3rd Tri <input type="checkbox"/> Post	<input type="checkbox"/> Aim for 6-8 servings/day.		
	More than 8 servings/day	<input type="checkbox"/> 1st Tri <input type="checkbox"/> 2nd Tri <input type="checkbox"/> 3rd Tri <input type="checkbox"/> Post	<input type="checkbox"/> Avoid highly sweetened cereals.		

6. Do you eat Whole Grains ?

• Whole grains include: • Whole-grain bread, pasta or tortillas • Brown rice, oatmeal (old fashioned, not instant)	Yes	<input type="checkbox"/> Choose whole grains at least half of the time.			
	No	<input type="checkbox"/> 1st Tri <input type="checkbox"/> 2nd Tri <input type="checkbox"/> 3rd Tri <input type="checkbox"/> Post			

Preferred whole grains: _____

7. Do you eat solid fats such as lard, stick margarine, butter or shortening?

Yes	<input type="checkbox"/> Use liquid oils from plants for cooking and in dressings.
No	<input type="checkbox"/> Aim for 2 Tablespoons/day of oils like canola, olive or corn oil or soft tub margarine. <input type="checkbox"/> Avoid fried foods. <input type="checkbox"/> Bake, broil, steam, or microwave.

Preferred healthy plant oils: _____

8. How many cups of these beverages do you drink per day?

• Regular soda, fruit drinks or punch, sports drinks • Caffeinated drinks like coffee, tea, soda or energy drinks	cups	<input type="checkbox"/> 1st Tri <input type="checkbox"/> 2nd Tri <input type="checkbox"/> 3rd Tri <input type="checkbox"/> Post	<input type="checkbox"/> Avoid sugary drinks.
	cups	<input type="checkbox"/> 1st Tri <input type="checkbox"/> 2nd Tri <input type="checkbox"/> 3rd Tri <input type="checkbox"/> Post	<input type="checkbox"/> Aim for no more than 1 coffee drink per day.

Preferred healthy beverages: _____

9. Do you eat these extra foods ?

• Candy, chocolate, chips, cookies • Donuts, muffins, biscuits, cakes • Ice cream, frozen yogurt • Sour cream, mayonnaise	Yes	<input type="checkbox"/> Limit foods high in fat and sugar.
	Yes	<input type="checkbox"/> Choose low or non-fat products.
	Yes	<input type="checkbox"/> Choose fruits, vegetables, nuts and seeds as snacks.
	Yes	

Preferred healthy snack foods: _____

In the "Advise Patient to" Section, check and date items that the client is willing to improve/change. Incorporate this into the client's Individualized Care Plan.

Signature	Title	Date	Time	NOTES:
1st Tri				
2nd Tri				
3rd Tri				
Post				

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Name: _____

Weight Categories for Women According to Height and Pre-pregnancy Weight (lbs)¹:

Height	Under Weight (BMI <18.5)	Normal Weight (BMI 18.5-24.9)	Over Weight (BMI 25-29.9)	Obese (BMI ≥ 30)
4'7"	< 80	80-107	108-128	> 128
4'8"	< 83	83-111	112-133	> 133
4'9"	< 86	86-115	116-138	> 138
4'10"	< 89	89-119	120-143	> 143
4'11"	< 92	92-123	124-148	> 148
5'	< 95	95-127	128-153	> 153
5'1"	< 98	98-132	133-158	> 158
5'2"	< 101	101-136	137-163	> 163
5'3"	< 105	105-140	141-169	> 169
5'4"	< 108	108-145	146-174	> 174
5'5"	< 111	111-149	150-179	> 179
5'6"	< 115	115-154	155-185	> 185
5'7"	< 118	118-159	160-191	> 191
5'8"	< 122	122-164	165-196	> 196
5'9"	< 125	125-168	169-202	> 202
5'10"	< 129	129-173	174-208	> 208
5'11"	< 133	133-178	179-214	> 214
6'	< 137	137-183	184-220	> 220
6'1"	< 140	140-189	190-227	> 227
6'2"	< 143	143-194	195-233	> 233
6'3"	< 148	148-199	200-239	> 239

BMI = Weight (lbs.) ÷ Height (in.)² X 703

Recommended Weight Gain¹:

Mark One: **Single** **Twins**

Underweight **28-40 lbs.** N/A

Normal **25-35 lbs.** 37-54 lbs.

Overweight **15-25 lbs.** 31-50 lbs.

Obese **11-20 lbs.** 25-42 lbs.

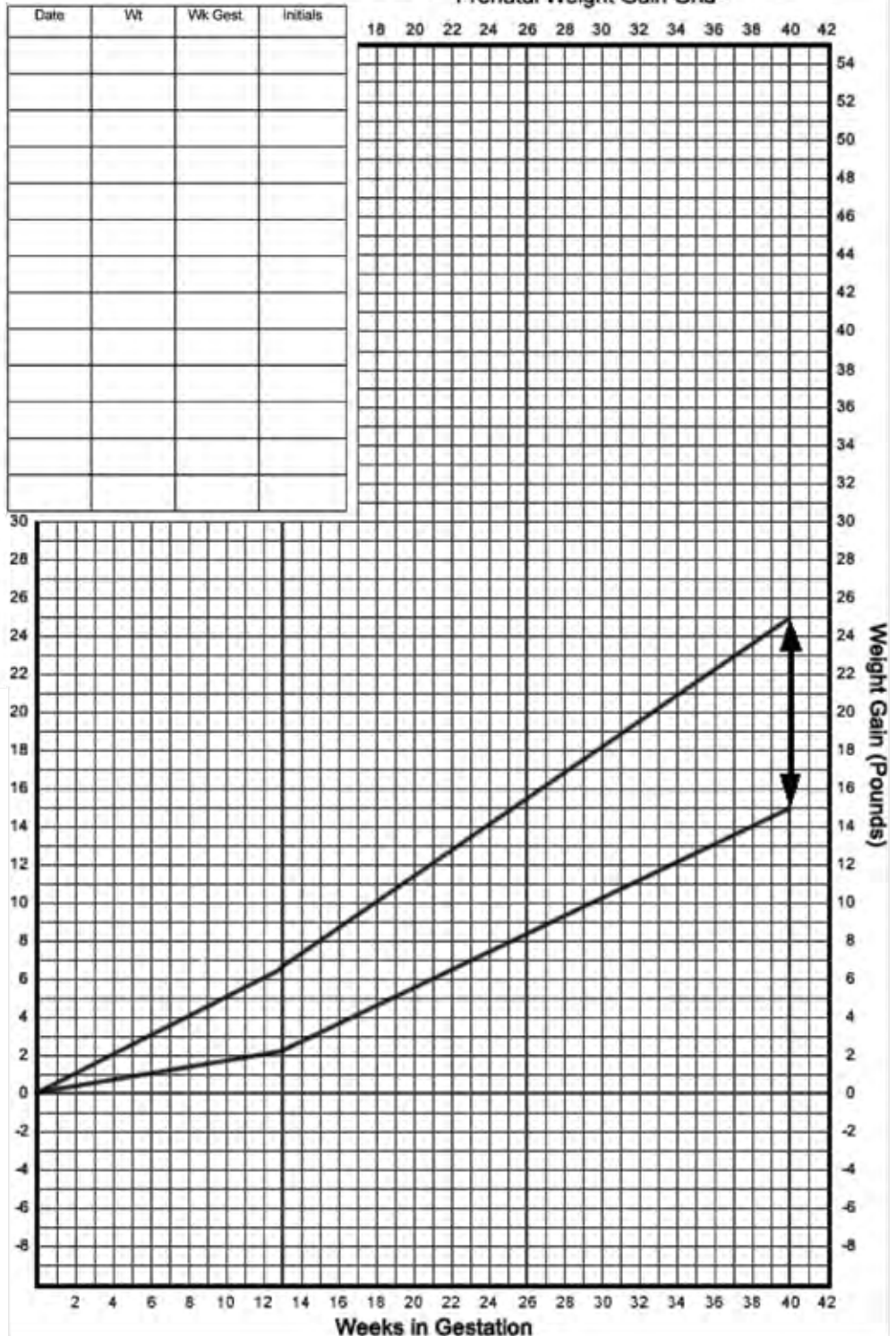
Pre-pregnancy Weight: _____

Height: _____

¹ IOM, 2009. *Weight Gain During Pregnancy: Reexamining the Guidelines*. Washington, DC: National Academies Press.

² Per Personal Communication with the Committee to Reexamine IOM Pregnancy Weight Guidelines

Pre-pregnancy Overweight Range Prenatal Weight Gain Grid²



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WIC REFERRAL FOR PREGNANT WOMEN

Health Care Provider:

Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits since program eligibility requirements must be met.

Patient's name (last, first) _____ Address (street, city, ZIP) _____ Telephone number _____ Birthdate _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> Est. date confinement _____ / ____ / ____ Date last preg. ended _____ / ____ / ____ Gravida _____ Para _____ Pregravid weight _____ lbs. </td> <td style="width: 50%; vertical-align: top;"> Blood test date _____ Hemoglobin _____ gm/dl. _____ / _____ and / or Hematocrit _____ % </td> </tr> </table>	Est. date confinement _____ / ____ / ____ Date last preg. ended _____ / ____ / ____ Gravida _____ Para _____ Pregravid weight _____ lbs.	Blood test date _____ Hemoglobin _____ gm/dl. _____ / _____ and / or Hematocrit _____ %
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Height _____ ins. Weight _____ lbs.	<p style="text-align: center;">WOMAN'S CURRENT (PRENATAL)</p> <p>PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN:</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Multiple Pregnancy</p> <p><input type="checkbox"/> Hypertension <input type="checkbox"/> Tuberculosis _____+PPD _____INH</p> <p><input type="checkbox"/> Previous poor pregnancy outcome / history (specify): _____</p> <p><input type="checkbox"/> Other current or historical conditions (specify): _____</p>		
<p>PLEASE LIST ANY CURRENT MEDICATIONS / SUPPLEMENTS PRESCRIBED:</p> _____ _____ _____ _____			
<p>IMPRESSIONS / COMMENTS:</p> _____ _____ _____ _____			
<p>LOCAL WIC AGENCY</p> Name of physician / health care provider / group / clinic _____ Telephone Number: _____ Date _____ IMPORTANT: Must be signed by health care provider			

The United States Department of Agriculture (USDA) prohibits discrimination in its programs on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, or marital or family status. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audio tape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue, SW, Washington, DC, 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

Health Care Provider:
 Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits since program eligibility requirements must be met.

Patient's name (last, first) _____ Address (street, city, ZIP code) _____ Telephone number _____ Birthdate _____																	
WOMAN'S CURRENT (After Delivery) Height _____ ins. _____ / ____ / ____ Weight _____ lbs. _____ Measurement date _____ Hemoglobin _____ gm/dl. _____ / ____ / ____ and/or _____ Blood test date _____ Hematocrit _____ %	PREGNANCY OUTCOME <table style="width:100%; text-align: center;"> <tr> <td style="width:15%;">Full-Term (37 wks.)</td> <td style="width:15%;">Preterm</td> <td style="width:15%;">Sm. Gest. Age</td> <td style="width:15%;">Fetal Loss</td> <td style="width:15%;">Stillbirth</td> <td style="width:15%;">Sex</td> <td style="width:15%;">Sex</td> <td style="width:15%;">Sex</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> Please describe any medical conditions affecting the infant(s): _____ _____ _____	Full-Term (37 wks.)	Preterm	Sm. Gest. Age	Fetal Loss	Stillbirth	Sex	Sex	Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN. <input type="checkbox"/> C-Section <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other current or historical medical conditions (specify): _____ _____ _____ _____ _____	PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED: _____ _____ _____ _____ IMPRESSIONS/ COMMENTS: _____ _____ _____ _____																
LOCAL WIC AGENCY Name of physician/health care provider/group/clinic _____ Telephone number: _____ IMPORTANT: Must be signed by health care provider _____ Date _____	Name of physician/health care provider/group/clinic _____ Telephone number: _____ IMPORTANT: Must be signed by health care provider _____ Date _____																

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Pediatric Referral

WIC Agency:
WIC ID#:

SECTION I: Complete this section to assist the patient with WIC eligibility, WIC services, and appropriate referrals. Whenever a therapeutic formula is prescribed, complete both Sections I and II.

PATIENT NAME: (First) _____ (Last) _____		DATE OF BIRTH: _____	
CURRENT HEIGHT/LENGTH: (within 60 days) inches	CURRENT WEIGHT: (within 60 days) lbs	MEASUREMENT DATE: _____	BIRTH WEIGHT / LENGTH: lbs / inches
CURRENT BMI: (within 60 days) BMI percentile: _____ %			
<p>HEMOGLOBIN OR HEMATOCRIT TEST is required every 12 months when normal and every 6 months when abnormal.</p> <p>Hemoglobin (gm/dl) or Hematocrit (%) _____ Lab Result Date _____</p> <p>LEAD TEST (recommended at 1-2 years of age): _____ mcg/dL</p> <p>IMMUNIZATIONS are up-to-date: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available</p>			
<p>BREASTFEEDING ASSESSMENT (birth to 12 months): <input type="checkbox"/> Fully breastfeeding <input type="checkbox"/> Never breastfed <input type="checkbox"/> Feeding breastmilk & formula <input type="checkbox"/> Discontinued breastfeeding Date: _____</p> <p>SOY REQUEST FOR CHILD: To substitute soy milk & tofu for cow's milk & cheese, check or write a condition below: <input type="checkbox"/> Cow's milk protein allergy <input type="checkbox"/> Severe lactose intolerance <input type="checkbox"/> Vegan <input type="checkbox"/> Other: _____</p>			
COMMENTS:			
HEALTH PROFESSIONAL NAME		MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP	
HEALTH PROFESSIONAL SIGNATURE			
PHONE NUMBER		TODAY'S DATE	

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SECTION II: Complete ALL boxes below when therapeutic formula is prescribed. Incomplete information may delay issuance of WIC foods.

<p>DIAGNOSIS:</p> <p><input type="checkbox"/> Prematurity <input type="checkbox"/> GERD or reflux <input type="checkbox"/> Food allergy: _____</p> <p><input type="checkbox"/> Failure to thrive <input type="checkbox"/> Dysphagia <input type="checkbox"/> Other: _____</p> <p>FORMULA / MEDICAL FOOD: _____</p> <p>DURATION: _____ months AMOUNT: _____ oz / day</p> <p>This prescription is: <input type="checkbox"/> New <input type="checkbox"/> Refill</p> <p>NOTE: The patient will receive 13 quarts of cow's milk in addition to therapeutic formula unless <i>DO NOT GIVE</i> is checked for cow's milk (see WIC Food Restrictions).</p>	<p>WIC FOOD RESTRICTIONS: The patient will receive WIC foods in addition to the formula prescribed. Please check all foods listed below that are NOT appropriate for the diagnosis.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Category</th> <th style="width: 40%;">WIC Foods</th> <th style="width: 15%;">Do Not Give</th> <th style="width: 25%;">Restriction / Comment</th> </tr> </thead> <tbody> <tr> <td rowspan="2">Infants (6-12 mo)</td> <td>Baby cereal</td> <td></td> <td></td> </tr> <tr> <td>Baby fruit / vegetable</td> <td></td> <td></td> </tr> <tr> <td rowspan="6">Children (1-5 yr)</td> <td>Cow's milk</td> <td></td> <td></td> </tr> <tr> <td>Cheese</td> <td></td> <td></td> </tr> <tr> <td>Eggs</td> <td></td> <td></td> </tr> <tr> <td>Peanut butter</td> <td></td> <td></td> </tr> <tr> <td>Whole grains *</td> <td></td> <td></td> </tr> <tr> <td>Cereal</td> <td></td> <td></td> </tr> <tr> <td></td> <td>Beans</td> <td></td> <td></td> </tr> <tr> <td></td> <td>Vegetables / fruits</td> <td></td> <td></td> </tr> <tr> <td></td> <td>Juice</td> <td></td> <td></td> </tr> </tbody> </table> <p><small>* whole wheat bread, corn/wheat tortilla, brown rice, barley, bulgur, or oatmeal</small></p>	Category	WIC Foods	Do Not Give	Restriction / Comment	Infants (6-12 mo)	Baby cereal			Baby fruit / vegetable			Children (1-5 yr)	Cow's milk			Cheese			Eggs			Peanut butter			Whole grains *			Cereal				Beans				Vegetables / fruits				Juice		
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<p>HEALTH COVERAGE: Refer the patient to the health plan or Medi-Cal for a medically necessary formula or medical food. WIC only provides these products when they are NOT a covered benefit by the patient's health plan or by Medi-Cal.</p>																																											
<p>Provide patient's health insurance information:</p> <p>Private insurance: _____</p> <p>Medi-Cal managed care: _____</p> <p>Other: _____</p> <p>Regular Medi-Cal (fee-for-service) _____</p>	<p>Check action taken:</p> <p>Submitted justification to health plan _____</p> <p>Submitted justification to pharmacist _____</p>																																										
<p><i>If the patient requires a therapeutic formula and does NOT have health insurance, check ALL boxes below that apply:</i></p> <p><input type="checkbox"/> Gave formula samples</p> <p><input type="checkbox"/> Referred to Medi-Cal</p> <p><input type="checkbox"/> Referred to WIC</p> <p>QUESTIONS: Call 1-888-942-9675 or 1-800-852-5770. Health Professionals: Go to www.wicworks.ca.gov; click Health Care Professionals; then click WIC contacts for MDS.</p>																																											

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