





An introduction to the *Agenda di Gravidanza*

*NOTE: This booklet in English has been prepared to help you understand and make use of the original **Agenda di Gravidanza**: this booklet is a translation in English of almost all the pages of the original Agenda which, with the help of this booklet, you should try to read and hopefully understand even if written in Italian; in fact, the Agenda is a clinical tool of work for your caregivers and a record of your pregnancy and you must keep it with great care.*

The Agenda di Gravidanza (=Pregnancy Diary) is an integrated management of essential information for the pregnant woman to be used by caregivers for recording her clinical data, by the woman herself to follow and understand her Pregnancy Care Pathway (=Percorso Nascita ¹) and by both together to improve communication and understanding. Understanding for the woman is an essential moment because some clinical actions may involve decisions that she must understand in all their implications for her and her baby.

The *Agenda di Gravidanza* is being offered by the Piedmont Region to every pregnant woman so that she can follow and better understand the progress of her pregnancy throughout her complete *Percorso Nascita*.

The *Agenda* makes available to the pregnant woman information, dates and deadlines, suggestions and forms to fill in with her own data. It is up to each single health service or doctor to implement a specific care plan for those women who need additional or specialized care. The *Agenda* indicates which public services are available near to her residence such as health centres, baby and mother clinics, specialized doctor's surgeries, test laboratories, ultrasound scans, *Punti-Nascita* (= *obstetric unit*) in order to make each *percorso-nascita* accessible and respectful of the personal choices of each woman. Access to services may be:

- **direct**, i.e. without the need of a specific *impegnativa* ² for *consultori* (Family planning clinics) and *Punti Nascita* (Obstetric Unit)
- **indirect**, i.e. needing a specific *impegnativa* for specialized surgeries and test laboratories.

All *impegnativa* for basic health services that you need during your pregnancy are available inside the *Agenda di Gravidanza* and are *ticket-free*. In case of high-risk pregnancy, each doctor of the National-Health-Service will specify additional health services that will be *ticket-free* only if he will specify the exemption-code M50 and the week-of-pregnancy at the time of request.

An accurate reading and updating of the Agenda di Gravidanza are essential for helping the woman and the caregivers in making informed and appropriate choices. Pregnancy is a time of family choices and therefore it is important for you to be informed about the pros and cons, i.e. advantages and disadvantages of different care options available to you.

Aware that each mother is unique, different from all others, as every child is unique and different from all others, there are many ways to experience pregnancy, delivery and birth. The information and scientific evidence gathered here can help you in making informed-choices necessary in this period of your life. An informed-choice is one based on objective information but also on your needs and your sensations.

Hoping that this document will be useful to you, please keep in mind that the Agenda is by no means a substitute for appointments with your caregivers (midwife or doctor).

You may find information also on websites and informative publications but keep in mind that in any case it is safer to refer to scientifically proven information. For those who wish to use Internet the suggested websites are listed at page 3 of the Agenda di Gravidanza (written in Italian).

Keep clear that foreigners without documents are entitled to the same services (i.e. tests, appointments with caregivers, antenatal classes) *ticket-free*. However, they must first refer to an *ISI-Centre* (to be found in most ASL) and get an STP-code (STP means *straniero temporaneamente presente* = temporary foreigner).

Children are entitled to paediatric visits, laboratory tests and other check-ups until six years of age *ticket-free* and, by paying a ticket, also after six years.

Those mothers who are without documents can ask for *permesso-di-soggiorno* (residence permit) at the *Questura* (Central Police Office) for health motives for the entire duration of pregnancy and for an additional period of 6 months after the child's birth (even if she is not living with a partner), just by providing a medical certificate attesting her state of pregnancy.

¹ **Percorso Nascita** is the collection of all the health-care services offered by the Regione Piemonte to a pregnant woman and her baby during pregnancy, labour, delivery, breastfeeding and postnatal period.

² **Impegnativa** is the medical request form written by a doctor of the National Health Service to obtain service by a laboratory or another professional.

What is the Agenda-di-Gravidanza?

The Agenda di Gravidanza intends to improve communication and cooperation between the pregnant woman and the caregivers for pregnancy and birth:

- it is a *binder* where you can store all relevant pregnancy filled documents of yourself and your baby.
- it is a *file* recording a complete history of all the data collected by caregivers about the pregnant woman and the newborn to be shared with other caregivers.
- It is a *guide* showing to you all the steps along your pregnancy, informing you about disease prevention and health promotion, helping you to choose among the various available paths.
- it is a *means to improve communication and collaboration* amongst the caregivers for promoting, preventing, diagnosing and care-giving of both mother and child.

The information contained in this Agenda will hopefully help you during pregnancy in supporting the *informed consensus* part of every medical act. Informed consensus means that caregivers and you, as a patient, will try to find the best solution by evaluating together all the advantages and risks that any medical decision may involve. However, the *information* of the Agenda in no way can replace a relationship with your caregivers but can certainly help in stimulating and enriching it.

To continue the dialogue between caregivers and family, another Agenda, the AGENDA-della-SALUTE-del-BAMBINO (BABY HEALTH DIARY), will be given to his mother when the baby is born. Here will be collected useful information for building a health pathway for the child, with the aim to assure prevention and offer appropriate health assistance.

How to use the Agenda di Gravidanza?

Pregnant women, like you, can obtain the Agenda from *Consultori Familiari*. Every woman should take care of her own Agenda which will be:

- *filled in and updated by caregivers*, public or private, whom you will have chosen for your pregnancy;
- *integrated with the "Guida ai servizi per il percorso nascita" (Guide to Services of Pregnancy Care Pathway)* which you can get from your ASL of residence;
- *integrated in the proper sections with outcomes of laboratory tests, hospital recoveries, emergency visits;*
- *enriched by the Servizio Sanitario Regionale (Regional Health Services)* with educational messages for health promotion as well as prevention.

Even if not familiar with Italian language you should still try, with help of this booklet, to leaf through the Italian Agenda di Gravidanza finding the different items such as Impegnative, forms filled by your caregivers with your clinical data, pictures, etc.

To help you reading the Agenda please note that on each page the following symbols have been used:

- I** on the pages specifically designed to inform you about pregnancy's care
- I** on the pages to be filled by caregivers with your clinical data;
- (*)** the asterisk indicates *evidence-based information* which is the basis for the recommended assistance. Items without an asterisk denote just *good clinical practices*.

This booklet, as the Agenda, is divided into chapters showing the most important steps of the birth pathway in chronological order of your pregnancy. We suggest that you read them, *step by step*, as your pregnancy progresses in time.

Only the green pages of the original Italian Agenda have been translated in this booklet, the white pages have not been translated and are not included in this booklet. They are intended to be filled in by your caregivers; however, you should try to fill in advance the white boxes that you find in this booklet in order to help your caregivers to fill them with your data.

Please keep clear that, in this booklet, all references to the pages of the Agenda are references to the pages of the original Agenda di Gravidanza, which are written in Italian!

The only exception is the Table of Contents of the next page where, for each topic, we have put side-by-side the corresponding page number in this booklet and the page number of the Agenda-di-Gravidanza.

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Some useful Addresses for your own Percorso Nascita

Professional following your pregnancy: (midwife or doctor)

<i>Surname (family name)</i>		<i>Name</i>
<i>Address</i>		
<i>Landphone</i>		<i>Mobile</i>
<i>Opening times of ambulatory/studio (doctor's surgery/office):</i>		

Medico di base (Practitioner)

Stamps as needed

<i>Surname</i>	
<i>Name</i>	
<i>Address</i>	
<i>Landphone</i>	
<i>Opening times of doctor's surgery/office:</i>	

At the first appointment with the midwife or doctor you should ask exactly what to do, where and whom to contact in case of an emergency.

Contacts for a possible Emergency

Hospital:	
<i>Reparto (Ward)/emergency:</i>	
<i>Hospital address:</i>	
<i>Telephone</i>	

Planned Place of Birth

<i>Hospital:</i>
<i>Obstetric Unit:</i>
<i>Address</i>
<i>Telephone</i>

Lifestyle and Pregnancy (page 13 of the Agenda)

Pregnancy is a period when you are more motivated to follow a healthy lifestyle, from which your present and future health of mother as well of your child will have advantages. Many factors contribute to defining your lifestyle: in particular, your dietary habits, your physical activity and habits, food integrators and use of harmful substances.

Dietary information: *a good diet may help your pregnancy and growth of the baby (fetus is the term indicating your baby when in your body). Food is an important part of your tradition and habits and unless you have recently undergone big variations in your bodyweight or periods of anorexia or bulimia³ or nutritional problems, there is little need for you to change your habits during pregnancy. Your pregnancy hormones will naturally guide you to follow an adequate diet: the craving for or refusal of certain foods over others, a change of your taste, the need to increase the number of your meals or decrease the quantity are precise signals. In any case, if you are following a special diet, you should inform your midwife or your gynaecologist.*

Foods

Good eating habits are the same in your pregnancy as throughout your life.

As a pregnant woman you need:

- plenty of fruit and vegetables (5 times per day) preferably in season: bread, pasta, rice, and other cereals, dairy foods, meat, eggs, fish, to provide nutrients, vitamins, minerals, and fibre.
- avoid fasts as well as big meals
- drink plenty of water, especially between meals
- moderate consumption of sweets, animal fats, sugar and salt
- eat fresh food or well-cooked (when uncertain of hygiene during preparation)
- avoid ready-prepared meals (especially when you are doubtful about hygiene during preparation or packaging)
- reheat food thoroughly
- choose dishes prepared on the spot rather than ones left on display (if you are eating out)

People often have false ideas on what should a pregnant woman eat. For lack of scientific evidence there are often conflicting points of view on what should pregnant women eat.

Hygiene of food and hands is particularly important during pregnancy. Food-acquired infections (such as toxoplasmosis, salmonella, listeriosis) can be harmful to the baby. The main one is toxoplasmosis (page...).

If the toxotest (which is one of the first blood tests) is negative, it means that you have never contracted toxoplasmosis and thus you have no antibodies protecting you against toxoplasma. In this case you need some simple precautions:

- wash carefully all fruit and vegetables
- avoid eating raw meat
- wear gloves when handling raw meat or wash hands immediately after handling
- wear gloves while gardening and wash hands well after all contacts with soil
- if you have a cat in your home, avoid changing the cat litter or use gloves: however it is not necessary to send the cat away during your pregnancy.

In past centuries a thorough hand washing has been one of the biggest assets assuring health of mother and baby at delivery time. Still today this simple practice is a valid prevention throughout pregnancy, in particular for women looking after small children as the virus (cytomegalovirus) can pass through their urine and stools and cause disease to the baby.

Further suggestions referring to *hygiene and food preparation and storage* are available page 29 of booklet

Folic acid* *is the only nutritional supplement which has been scientifically demonstrated to be useful for every woman from two months before conception up to the first three months of pregnancy (recommended dose is 0.4 milligrams per day).*

° **Vitamin D**, *when there is little exposure to the sun* or for those following a vegan diet**

° **Iron** *when anaemia, due to inadequate iron, is verified.**

Use of harmful substances

Smoking: *the negative effects of smoking on pregnancy and baby's health are well documented.* Smoke is the most frequent cause of avoidable diseases. The worst harm is to the placenta, the organ which supplies nourishment and fetal growth. Smoke increases the risk of miscarriage, reduces fetal growth, increases death of newborns and respiratory diseases in children.*

³ Anorexia is an alteration in eating behaviour which reduces food intake to the extreme; bulimia is an alteration manifested by excessive uncontrolled overeating.

The effect of smoke depends on the quantity (=dose dependent): the more cigarettes you smoke per day, the higher the risk. Pregnancy may motivate you to quit smoking, a decision that can then be continued afterwards. It may

help to speak about it with your midwife or doctor for helpful advice and references. To a lesser degree passive smoke (from smokers living near the woman) can also be harmful.

Alcohol: *the negative effects of alcohol on pregnancy and baby's health are well-documented*; high consumption may cause: miscarriage, fetal malformation, delayed fetal growth and mental delay after birth.*

Damage caused by alcohol might be permanent in your child and as a safe level of alcohol consumption is yet to be ascertained, it is best for you not to drink during pregnancy.

Women who choose not to abstain completely are advised to drink alcohol only after the first three months of pregnancy and in small amounts, during meals, and not more than one glass of wine or one can of beer per day.

The pregnancy in woman who regularly use alcohol in large amounts is considered a high risk pregnancy and must be followed by specialized assistance and help.

Drugs (e.g. heroine, etc): *the negative effects of drugs on pregnancy and baby's health are well-documented*; habitual use during pregnancy damages differently depending on the type of drug used. The most frequent are: miscarriage, fetal malformation, preterm delivery, reduced fetal growth, withdrawal symptoms in the baby at birth, greater risk of perinatal death, or in the first months after birth, alterations in child's behaviour and learning ability while growing. The pregnancy of women who use drugs regularly is considered high risk and must be followed by specialized care and help.*

Habits:

Sexual intercourse: *scientific evidence show that sexual intercourse during pregnancy causes no problem to the mother or baby*. Some clinical conditions, such as vaginal bleeding, invasive diagnosis, uterine contractions, etc. , may require a temporary suspension. Pregnancy may affect your sexual desire; such variations should be considered normal and respected by both partners.*

Physical Activity: *some physiological and morphological changes occur during pregnancy such as temporary softening of ligaments, useful for giving birth. Moderate physical exercise (e.g. walking or swimming) are good for circulation and overall wellbeing.* Avoid activities that require a lot of muscular exertion, high-impact sports or sports where falling is a risk.*

Travel: *if planning to travel to countries requiring certain vaccinations, it is advisable to follow the indications provided by the Centri di Medicina dei Viaggi (Centre of Travel Medicine). For detailed information for Centres in the Piedmont Region contact local ASL or consult the site: www.ilgirodelmondo.it (under section for travellers with health issues/pregnancy)*

Air Travel: *due to lack of movement on long flights, venous thromboembolism is a risk, but there is no evidence of greater risk during pregnancy; however it is advisable to wear compression stockings to reduce the risk.* Since each airline company has its own policy regarding flying during pregnancy, it is advisable to contact the company directly when booking a flight.*

In general, normal pregnant women may fly until the 36 week and until week 32 for twins. In any case, after 28 weeks, the pregnant woman should carry a medical certificate confirming her good health, normal pregnancy and the expected date of delivery.

Travelling by car: *numerous studies document that even pregnant women may benefit by correctly wearing a seatbelt.* There is no evidence that the use of a seatbelt is harmful to either mother or baby. Although the Italian law permits pregnant women exemption from using a seatbelt (Legge 284, 4 agosto 1989, art. 1), using a seatbelt is always recommended, except for certain exceptional medically-certified cases.*

During long car trips it is advisable to plan breaks for stretching your legs, emptying the bladder, changing position, reactivating circulation.

Body care: *physical changes during pregnancy (e.g. increased volume in the abdomen and breasts, changes in capillary circulation, etc) may encourage an increased attention to your body care. Generally there is no need to change your personal habits or cultural traditions regarding personal hygiene.*

As there are not yet studies available concerning the efficacy and safety of all substances used in hair colourings, waxes, mark creams, body lotions or intimate hygiene products, you should use your common sense when using hygienic or cosmetic products and carefully read the labels in order to check their use in pregnancy.

Psychological wellbeing: *during pregnancy, in your mind and in that of your partner, turns out and becomes stronger the idea that a baby is growing in your body along with feelings and emotions that will indirectly affect your baby's wellbeing. At times it may be difficult to widen the scope of your mind, because a lot of space is taken up by immediate life concerns (work, the couple's relationship, stress variables, etc) or from the weight of past situations (other pregnancies, relationship with both parents, childhood experiences, etc). You should take the time to reach and maintain not only physical, but also psychophysical wellbeing by sharing your emotions, anxieties, and expectations with people you trust, such as other women, or chosen professionals (midwife, doctor, gynaecologist, psychologist). Those who have been supporting psychologically women state that "silence does not help".*

At the beginning of your pregnancy it may be useful for you to consider some elements of your own lifestyle that will influence a positive outcome of the pregnancy.

Dietary Habits: varied vegetarian vegan

Food: what and how much in the morning and the evening

Breakfast :
 Lunch :
 Dinner :
 Between meal snacks :
 Between meal drinks :
 Other information.....

SMOKING

Smoking during pregnancy? NO YES Type..... Number of cigarettes per day

Exposure to passive smoke ? NO YES

History: *have you smoked in the past ? When did you quit ? Does anyone else in the family smoke ?*

ALCOHOL

Drinking before pregnancy NO YES

Drinking during pregnancy? NO YES more than 30 g° per day? NO YES

° more than 2 glasses of wine /day or more than 2 cans of beer/day or more than 2 units of spirits /day

DRUGS

Use of drugs NO YES if yes: occasional regular

Which.....
 Way of assuming.....
 Dose.....
 History.....

DIARY OF HEALTH ASSESSMENTS DURING PREGNANCY (page 20 of the Agenda)

The woman's health affects the progress of the pregnancy: a healthy woman, with no chronic illness, who takes no medicine or drugs, is more likely to have a normal pregnancy, delivery and postnatal period and to deliver a healthy baby. This type of pregnancy is defined "physiological pregnancy without risk" (about 85% of women) and in this case the woman can choose to be followed by either a midwife or a gynaecologist.

A woman with a pathology, in therapy with drugs or for whom diseases or problems arise, needs additional care from an gynaecologist who, if necessary, will be in contact with other specialists. This type of pregnancy is defined "high risk or pathological pregnancy". Depending on the risk or pathology present, there may be different courses even to the point of requesting highly specialized competencies in maternal and/or fetal diseases* available only in specialized units.*

A physiological pregnancy needs to be checked every 4/6 weeks, for a high risk pregnancy more checkups may be needed. In any case it is advisable that the woman be cared for in a continuous way, throughout the entire pregnancy, by the same professional or group of professionals.*

At each appointment (*Bilancio di Salute*) your midwife or doctor will check on you and your baby progress and provide clear information and explanation. At each appointment you should have the chance to ask questions and discuss any issues.

The woman gives information about her physical and psychological health; the midwife or doctor collects the anamnesi (history) and on the basis of scientific evidence and professional experience, evaluates clinical data, reassures and clarifies doubts for the woman about pregnancy, delivery and breastfeeding, about welcoming the baby and baby care, about anything she wants to know. It may be useful for you to make notes about questions and doubts to clarify with caregivers before you meet them.

An appointment around week 10 is useful for obtaining information about *screening tests and/or antenatal diagnoses*; it is highly recommended for any woman who already has a disease and/or uses medicines. In any case the first appointment should be made within the third month of pregnancy.

The first appointment lasts longer than subsequent ones in order for the professional to be able to gather health information about you, your partner and your respective families. Bring along all the tests already done, especially documentation about blood type, past illnesses, previous gynaecological appointments, *pap-test* results (especially the most recent one) and anything that may seem important regarding you and your baby health.

During the first appointment the progress of your pregnancy will be evaluated using the following basic clinical examinations:

- external palpation of the uterus to check its tone starting from week 12,
- measurement of the symphysis-fundal distance*, with a tape measure, to measure the development of the uterus and monitor fetal growth (week 16)
- auscultation or visualisation of fetal heartbeat by ultrasound (from week 12)
- measure of blood pressure*
- measure of bodyweight

Starting from week 16-20 you will report your sensations and fetal movements.

At the **first appointment** the professional will also do:

- pelvic examination and possibly a Pap test if the last one was more than three years prior
- breast examination
- measurement of height and weight to calculate her body mass index for better defining her body constitution.

At the next appointment, but only in case of clinical indications, it will be necessary to perform:

- vaginal examination in the case of contractions or other problems
- ultrasound scan if the midwife/gynaecologist finds anomalies in uterine development (for ultrasound scans see page 15 of the booklet)

During the appointment routine tests will be assessed and more will be prescribed if clinically needed (for the recommended tests see the form on page 16 of the booklet)

You may ask to be accompanied by a trusted person (your partner or other trusted person) to your health assessments (bilanci-di-salute). Scientific evidence shows that the recording of events at various stages of the pregnancy in a single document (that you will bring with you to each appointment and that the midwife or doctor will carefully update), allows giving care and better results in terms of health, for both mother and newborn.*

Summary of all the appointments provided by the Pathway for a Physiological Pregnancy

This list of appointments highlights the information that you will discuss each time with your caregiver. Checking off the points can help you to remind them.    *

Week	Information about:
8 - 13	<ul style="list-style-type: none"> <input type="checkbox"/> services for Pathway for a Physiological Pregnancy <input type="checkbox"/> general state of health ° <input type="checkbox"/> healthy lifestyle during pregnancy <input type="checkbox"/> advantages in continuing to take folic acid <input type="checkbox"/> maternity rights <input type="checkbox"/> recommended laboratory tests <input type="checkbox"/> screening for prenatal diagnosis <input type="checkbox"/> ultrasound scans for the first trimester <input type="checkbox"/> accessing ultrasound scans in the second trimester °° <input type="checkbox"/> clinical check-up results (pressure, weight, development and tone of uterus, fetal heartbeat, vaginal examination and perineum check) <input type="checkbox"/> possible additional care for the presence of risk factors <input type="checkbox"/> accessing national programme "Mamme libere dal fumo" (Smoke-free Mothers)
°	This indicates a general health assessment to make with the practitioner who knows your entire history of health/illness.
°°	In order to schedule and book a second-trimester ultrasound scan the best time for the first appointment lies between week 9-11.
14 - 18	<ul style="list-style-type: none"> <input type="checkbox"/> results of routine tests performed during the first trimester + tests to be done before the next appointment including possible invasive prenatal diagnosis <input type="checkbox"/> clinical check-up results (blood pressure, weight, uterine development, fetal heartbeat) <input type="checkbox"/> antenatal classes (description of classes, how to sign-up, etc)
19 - 21	<input type="checkbox"/> second trimester ultrasound scan
19 - 23	<ul style="list-style-type: none"> <input type="checkbox"/> results of tests done + tests to be done before the next appointment <input type="checkbox"/> clinical check-up results (arterial pressure, weight, uterine tone, symphysis-fundal distance measurement, fetal heartbeat i.e. heartbeat of the baby, fetal movements)
28-32	<ul style="list-style-type: none"> <input type="checkbox"/> results of tests done + possible tests to be done before the next appointment <input type="checkbox"/> clinical check-up results (blood pressure, weight, uterine tone, symphysis-fundal distance measurement, fetal heartbeat, fetal movements) <input type="checkbox"/> possible ultrasound scan if clinically advised
33 - 36	<ul style="list-style-type: none"> <input type="checkbox"/> results of tests done + possible tests to be done by the next appointment <input type="checkbox"/> clinical check-up results (blood pressure, weight, uterine tone, symphysis-fundal distance measurement, fetal heartbeat, fetal movements) <input type="checkbox"/> possible ultrasound scan if clinically advised <input type="checkbox"/> ask caregiver how to access the Bilancio-di-Salute at your chosen Punto-Nascita
36 - 37	<input type="checkbox"/> Bilancio-di-Salute at the chosen Obstetric Unit
38 - 40+6 days	<ul style="list-style-type: none"> <input type="checkbox"/> symphysis-fundal distance measurement, fetal heartbeat, fetal movements and possible vaginal examinations <input type="checkbox"/> monitoring of pregnancies exceeding 41 weeks (cardiotocographic check=CTG and testing the amniotic fluid=AFI)
41	<ul style="list-style-type: none"> <input type="checkbox"/> clinical check-up results (blood pressure, weight, uterine tone, symphysis-fundal distance measurement, fetal heartbeat, fetal movements, CTG, AFI) <input type="checkbox"/> possible need to induce labour (stage of pregnancy and method)
Hospital Discharge	<ul style="list-style-type: none"> <input type="checkbox"/> how to get check-up of midwife/doctor during first weeks after birth (=postpartum period): involution of the uterus, checking the perineum, possible advice on contraceptives- <input type="checkbox"/> how to get breastfeeding help and consultations <input type="checkbox"/> postnatal group encounters

PERSONAL DATA (page 24 of the Agenda)

Information reported in the Agenda is invaluable for suitable and personalised assistance. All personal data are confidential and part of the woman/midwife-doctor relationship, guarded by the Law on Privacy (Decreto Legge 196/2003).

Some data, completely anonymous, is collected in the **Certificato di Assistenza al Parto (Birth Assistance Certificate)** (Legge nazionale Decreto Ministeriale n. 349 del 16 luglio 2001) filled in by whoever will assist the woman at the birth. By using regional and national statistical analyses, these data will help improve the standard of maternity care. The statistical data are available at the site (see Agenda page 3)

The following data are included in the Certificato-di-Assistenza-al-Parto:

- *age, place of residence, citizenship, level of study, work activity, marital status of mother and father*
- *date of marriage for married couples*
- *number of appointments made during pregnancy, services used, number of ultrasound scans*
- *data about previous pregnancies, pregnancy in course, prenatal care, prenatal class attendance*
- *type of labour and delivery and baby's condition at birth.*

*It is important that the **information be accurate** as it will be transcribed on the woman's health documents and on the baby's documents.*

At the **woman's discretion, information identifying** (name, surname, residence) **the father** of the newborn **can be left undisclosed.**

In any case, the Certificato-di-Assistenza-al-Parto requires information regarding citizenship, birth date, place of birth, level of study, professional situation and position. To assure good care to the baby at birth and growing up, information about the biological father are essential (birth place, state of health, etc).

For the woman who does not plan to recognise her baby, the newborn will be guaranteed anonymity in all health records, as provided by the Italian Law, and information about the mother will not be connected with that of the newborn.

Nevertheless, for the Certificato-di-Assistenza-al-Parto **the following information is obligatory:** year (**only**) of birth, citizenship, place of birth of the woman.

Anamnesi (Health History)

To have a complete clinical view of a person it is very important to know his/her past health problems and those of his/her close family. Putting these events together with the doctor's help is called "**anamnesi**" (from the Greek "memory") or **health history**. The anamnesi shows if the woman is healthy and if the pregnancy can be considered physiologic, that is without risk factors, or at risk.

In the future your current Agenda-di-Gravidanza will be an essential element of anamnesi for your next pregnancy.

Ethnic group information is important: to be born and raised in a country different from where one is living may be different in regards to feminine sexuality, pregnancy, birth and childcare. Communicating with the caregiver can better help realise maternity/parent plans and better respond to one's own needs. Moreover, one's ethnic group may be important clinically, as some illnesses are more common in some ethnic groups than others (e.g. Mediterranean anaemia is more frequent in populations from the Italian islands: sickle-cell anaemia is more frequent among central West Africans, etc)

A cultural mediator or an interpreter can facilitate communication between caregivers and people of other cultures providing reciprocal understanding.

Information about work activity, level of study, and marital status help personalise assistance and identify specific need (e.g. identify possible risk factors in the work environment; information regarding maternity benefits and rights of working mothers and information about officially recognizing the child page 30 of the booklet support services for mothers under 16 years of age and for those mothers in difficulty page 32 of the booklet.*

Your mother-tongue:		Cultural Mediator Requested	YES	NO
Interpreter Requested	YES	NO		

Information about work activity			
PROFESSIONAL SITUATION	PROFESSIONAL POSITION	ECONOMIC ACTIVITY	
Employed	Entrepreneur	Agriculture/hunting/ fishing	
Unemployed	Free Lancer	Industry	
Looking for first job	Executive	Commerce/Public	
Housewife	Employee	Public Administration	
Student	Self-employed	Other private services	
Retired	Worker		
Other conditions	Military, police and religious	Furlough	yes no
Information not given	Never had steady work	Start ... week of pregnancy	

Level of Study						
Degree	Secondary School	Vocational School	Middle School	Elementary School	No school	Not given

Marital Status						
Unmarried	Separated	Divorced	Widow	Information not given	Married	Date of marriage

Father's Personal Information						
Surname			Name			
Birth date	City/town	State/Province	Birth nationality			
Place of residence	State/Province	Region	ASL			
Address if other than mother's						
Landphone Teleph.			Mobile			

Information about work activity			
PROFESSIONAL SITUATION	PROFESSIONAL POSITION	ECONOMIC ACTIVITY	
Employed	Entrepreneur	Agriculture/hunting/fishing	
Unemployed	Free Lancer	Industry	
Looking for first job	Executive	Commerce/Public service/hotelling	
Househusband	Employee	Public Amm.	
Student	Self-employed	Other private services	
Retired	Worker		
Other conditions	Military, police and religious		
Information not given	Never had steady work		

Level of Study						
Degree	Secondary School	Vocational School	Middle School	Elementary School	No school	Not given

Family Anamnesi (Family Health History) (page 26 of the Agenda)

Looks within both families of the couple for genetic diseases or diseases caused by other causes (such as hypertension, diabetes, congenital heart problems, mental development, malformation syndromes); it is worth evaluating possible interventions of prevention, or possible diagnoses and therapies, for either mother or baby. Data relative to the father's health (genetic diseases, man's lifestyle,), factors which may influence the health as well as the environment where the baby will live are important in the family anamnesi.

For hereditary diseases it is useful to know that:

- it is important to tell the midwife or doctor all that is known or presumed regarding verified diseases in the family.
- the midwife or doctor will look for all the elements to respond to doubts, perhaps consulting other specialists.
- for some hereditary diseases a prenatal diagnosis can be done by consulting a geneticist (= a specialist for hereditary genetic diseases) for evaluating whether this baby is at risk and thus propose specific exams during pregnancy or after birth.

A **genetic consultation** can be useful when:

- in your family there have been cases of physical handicaps and/or mental, or there are cases of genetically transmitted diseases.
- the parents are relatives (e.g. cousins)
- in the woman's history or the partner's there have been clinical data worth evaluating or investigating further by a geneticist (for example more than 3 miscarriages).

For the family health history (family anamnesis) special attention should be paid to the possible presence of certain diseases::

Mother Family	DISEASES
	Diabetes
	Hypertension
	Eclampsia
	Repeated miscarriages or stillbirth
	Trombosis

Mother Family	Father Family	DISEASES
		Reccurent family diseases
		Malformation
		Congenital hearth disease
		Learning difficulties
		Psychiatric disease

Any additional information that may seem important should be communicated to the midwife or doctor.

Personal Anamnesi (Your own Health History) registers past illnesses or those in course, surgical operations, allergies, use of medicines, frequent variations in weight, emotional and psychological wellbeing, work record, possible abuse or violence, obstetric-gynaecological health records.

Anamnesi of Use of Medicines: allows evaluating whether to go on with current therapies for chronic diseases and analysing the type of medicines prevalently used. Pregnancy is a good time to reflect on your attitude to the use of medicines (traditional medicine, alternative medicine, occasional use, over the counter medicines, doctor-prescribed medicines).

Telephone number for consultation on medicines-and-pregnancy: 800883300 (Medicine Information at the Mario Negri Institute).

Your weight before the start of your pregnancy is a good reference for evaluating possible significant fluctuation with respect to ideal weight which is calculated by using a body mass index (see table 28 of the Agenda). Obesity or extreme thinness are risk factors for a pregnancy and need additional care.

Emotional and psychological health history: for Bilanci di salute in pregnancy and in postpartum, tell the caregiver if you had feelings of depression before your pregnancy, with little interest or pleasure in your daily activities, or if you had psychotherapeutic and/or pharmaceutical treatments. This information is useful for personalized care and offering support also after delivery.

Work risks: most jobs are not risky during pregnancy; only some may be harmful wither for the workload involved or for exposure to substances harmful to pregnancy and/or the baby. In Italy there are specific laws concerning working women's rights.* (page 32 of the booklet)

Domestic Violence: statistics report that one in four women at some time in her life is victim of domestic violence often starting during pregnancy. Violence may have different forms, including physical, sexual and psychological. Once the violence starts, it often worsens during and after the pregnancy. For anyone in this situation **it is right** to speak about it with the midwife or doctor for the serious consequences that these acts can have on the woman and the baby.

There is a regional network for listening and taking care of women who are victims of domestic violence (Health Centres, Social Services, Volunteer Associations, Emergency, Police etc), during pregnancy contact **Centro SVS (Soccorso Violenza Sessuale= Sexual Violence Aid)** at the Regina Margherita Hospital-Sant'Anna in Torino tel.011 3134180.

A Health Assessment with your own doctor may help to reconstruct the history of your past diseases such as:

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney or urinary tract disease
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Migraines	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Sexually transmitted diseases STI
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Depression	<input type="checkbox"/> Exposure to tuberculosis
<input type="checkbox"/> Weight fluctuation	<input type="checkbox"/> Psychiatric problems	<input type="checkbox"/> Asthma or respiratory problems
<input type="checkbox"/> Haemoglonipathy/thalassaemia	<input type="checkbox"/> Muscular-skeletal problems	
<input type="checkbox"/> Thrombosis	<input type="checkbox"/> Surgical operations.....	
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Other	

Your habitual use of medicinal drugs (which ones, doses):

All additional information that seems important should be communicated to the midwife or doctor.

Obstetric/Gynaecological History (page 30 of the Agenda)

Menstrual history (regularity or irregularity of menstruations, date of the start of the last menstruation) is useful for calculating the week of pregnancy along with the ultrasound scan of the first trimester.

The obstetric history includes clinical data and emotions related to this pregnancy and to previous deliveries (spontaneous vaginal birth, or complicated, caesareans), to miscarriages and abortion, stillbirths, medically assisted conception, postnatal haemorrhages, postpartum blues, newborn's conditions. Speaking about previous experiences can help orientate both the caregiver regarding what care to offer as well as the woman seeking out possible support. In the case of past complications it may be necessary to plan a more intensive monitoring during pregnancy, delivery and later on the newborn.

If you had one previous **miscarriage** it must be emphasised that you still have good chance to still have full term pregnancies. In the first three months of pregnancy, a miscarriage is not unusual (10-15 pregnancies out of 100). It is often linked to problems of the fetus rather than to maternal problems. There is not yet any therapy proven to be efficacious for avoiding such miscarriages.

After 13 weeks the risk of miscarriage rapidly decreases: in most cases the causes are usually not foreseeable. In case of repeated miscarriages a full term pregnancy is still possible, but it is advisable to begin an additional care.

A **preterm birth** is when the baby is born before week 37: about 6 out of 100 births. A preterm birth in a woman's anamnesis increases the risk of it happening again. The earlier the birth, the greater the newborn's need for intensive care.

Women who have had a caesarean section stand a good chance to have a spontaneous vaginal birth next pregnancy.

The labour of a woman who has had a **previous caesarean section** will be checked more intensively to make certain that the uterus contracts regularly despite the previous surgery and to reduce the risk of breaking the uterine scar. If there have been more caesarean sections, a spontaneous birth is not advised.

The following information is useful for the obstetric history:

<input type="checkbox"/> Previous infertility/subfertility <input type="checkbox"/> Infertility treatments in current pregnancy <input type="checkbox"/> Infections in genital system <input type="checkbox"/> Previous positive vaginal cytologic smearl <input type="checkbox"/> Last Pap-Test date:..... result:.....	<input type="checkbox"/> Previous gynaecological operations <input type="checkbox"/> Female genital mutilation <input type="checkbox"/> Pelvic or lower limb fractures <input type="checkbox"/> Postnatal depression in previous pregnancies
If more than 3 years have passed since the last Pap test the woman should be invited to contact "Prevenzione Serena" in order to get a free test	

Menstruations	Date of the start of last	<input type="checkbox"/> Certain <input type="checkbox"/> Uncertain	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular
Regular cycles	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular come.....		
Contraceptives	Which	Type	Stopped the

Record of previous births

year	week E.g.	Outcome	Newborn	Breastfeeding
		<input type="checkbox"/> Miscarriage. <input type="checkbox"/> IVG/ITG <input type="checkbox"/> Vaginal birth <input type="checkbox"/> Caesarean section for..... <input type="checkbox"/> operated birth..... Start of labour: Anaesthetics: Recovery/ bleeding Perineum Recovery summary	Sex Weight gr..... Current Health	Exclusively mother's milk formonths Mixed feeding untilmonth Breastfeeding difficulties

PRENATAL SCREENING AND/OR PRENATAL DIAGNOSTICS (page 42 and 98 of the Agenda)

Nearly all babies are born healthy, only about 3 babies in 100 have a malformation or hereditary disease. Some are identified before birth using specific examinations, while others can only be identified at birth. This is because not all diseases are preventable or can be diagnosed early despite present technological progress.

*Information about prenatal screening and prenatal diagnostics for chromosome disease and malformations will be discussed at the first appointment. For an **informed choice** whether or not to do the tests you need to well understand the significance of evaluating all risks and advantages. Before birth only some chromosomes (corpuscles inside the cell that transmit genetic information coming from either the mother or the biological father) diseases can be searched, for example Down syndrome.*

*Diagnostic tests before birth, for identifying Down syndrome (three chromosomes 21 instead of two) and other rare chromosome diseases are **invasive tests**: because they are done on amniotic fluids or on the placenta tissues taken from inside the uterus, it turns out that a miscarriage can be caused one case in a hundred.*

Therefore an attempt is made to select which women should undergo invasive tests: hopefully only those in which the screening or their age show greater risk for having a Down syndrome baby.

Selection and successive prenatal diagnosis, when necessary, is done by:

- Calculating the level of individual risk for each woman: **screening test**.
- If the screening shows higher risk values a diagnostic exam is done
- Examining the results of the diagnostic test, the woman/couple **chooses** whether or not to carry the pregnancy to term.

The limitations and advantages at each step must be clear to the woman. They require an in-depth discussion with the caregiver in order to choose whether or not to adhere to a diagnostic course or accept the natural course of events.

1. **Screening Tests:** the "personalised" risk of Down syndrome is calculated by ultrasound scan along with a dose into the mother's blood of substances produced by the baby and the placenta. The result of the screening shows how much risk the woman has of having a baby with Down syndrome compared to other women with the same characteristics.

The result says negative or with low risk when the risk is very low; positive or with increased risk when the risk is above threshold levels: in this case a diagnostic test is offered and the woman can choose whether or not to do it.

The prenatal non-invasive screenings are offered to all pregnant women. The ones available today are:

- Nuchal translucency= ultrasound at week 11-13.
- Combined test=nuchal translucency + a blood test at week 11-13, + successive blood tests at week 15-17. Additional information betters the precision of the results and allows evaluating also the risk of spina-bifida (malformation of the spinal column).
- Tri-test (triple test)= blood test of mother's blood which can be done until week 20. The test is less precise but it is the only one available for those who did not do the previous ones on time.

Non-invasive screenings carry no risk to the woman's and baby's health. Women with a calculated low risk are more than 90%: they will not need invasive tests. An invasive test is proposed to those with increased risk.

*Let it be clear that a prenatal screening is limited to signalling a potential "risk of having a Down syndrome baby". It is **never** a diagnosis and therefore:*

- a result of "increased risk" **does not mean** that the disease is definitely present, but only suspect: out of 40-50 women who do the invasive test after an increased risk screening result, **only one** will actually have a diseased baby. This means that the majority of positive screenings are in reality, fortunately, "false positives" and this is because some transitory situations of the metabolism baby-placenta can have alternate doses.
- a "low risk" result does not completely exclude the presence of chromosome disease, even if it is highly unlikely. When a Down syndrome baby is born to a woman with a negative screening, the result is said to be a "false negative": fortunately this happens for only one woman in every 3500-4000 women that have had a negative screening result. This can happen because sometimes a baby, even if diseased, has a metabolism that completely matches the normal one.

2. **Diagnostic tests** are only offered to those women who have increased risk as a result of the screening. Women over 35 years of age at the time of conception can choose whether to do a screening or directly request a diagnostic exam. Maternal age is important because the risk of this chromosome anomaly increases with age. Diagnostic tests, as said before, are invasive tests. The results clearly express if the baby is affected or not by Down syndrome or other rare chromosome diseases.

The diagnostic tests available are:

- Chorionic villus sampling: placenta material is taken through the mother's abdomen (in some rare instances it may be taken from the uterine cervix). The sample can be taken from week 10 of the pregnancy (the risk of miscarriage increases if done before).
- Amniocentesis: a sample of amniotic fluid is taken from the mother's abdomen. The sample is usually taken between week 15 and 17 of the pregnancy. With the same sample the alphafetoprotein can be measured for the diagnosis of anomalies of the neural tube (spina bifida)

The time needed to carry out the classic diagnostic tests (cariotype or chromosome map) take a minimum of 14 days.

These tests can be done in the doctor's surgery and do not require a hospital stay. However it is better to choose a medical centre which regularly performs large numbers of these treatments and so benefits from their experience. This may mean a visit to a hospital far from home.

For malformations/diseases which can currently be diagnosed with the prenatal screening/diagnoses pathway there are not yet known in-utero therapies, therefore once you are told what the situation is, you can evaluate with the help of the hospital gynaecologist if a late interruption of the pregnancy is possible.

After the ninetieth day of the last menstruation (limit by law for voluntary interruption of pregnancy) the law provides for interrupting the pregnancy in particular cases, with a medical certificate:

- *when the pregnancy or delivery may be dangerous for the woman's life,*
- *when pathological processes have been verified, including those relative to relevant anomalies or malformations of the baby, which can be a serious danger to the physical or psychological health of the mother.*

The following consent form summarises the above information and discussing with the caregiver allows for a reasoned choice whether to use or not the prenatal screening examinations.

"Consent form for screening of chromosome anomalies"

I am aware that the decision to undergo a screening test is my choice and is not an obligatory routine test.

I have been informed about the possible limitations of the screening test and of the prenatal diagnosis techniques for Down syndrome (also trisomia 21 or mongolism) and for trisomia 18.1.

I understand that there is no therapy available for Down syndrome nor syndrome 18.

Furthermore I have been informed that, if the preceding anomalies are found before the baby has autonomous life, my possible request to interrupt the pregnancy will be evaluated by the doctor of the Health Service where I go to verify if conditions are such for accepting my request, according to the norms of Law 194/1978.

I understand that the diagnosis of chromosome anomalies can currently be done only by invasive techniques where amniotic fluid (amniocentesis) or placenta tissues (chorionic villus biopsy) are taken and that after each one of the above, there may be a miscarriage in about 1% of the cases.

It has been explained to me that there are screening tests which allow identifying the risk, that is the probability that a baby is affected by Down syndrome, in a more precise way compared to simply using maternal age.

In particular, I have been given information regarding the following screening tests:

1. Nuchal translucency test (NT)
2. Combined Test (nuchal translucency + duo test)
3. Integrated Test
4. Integrated Serum Test
5. Tritest

I have understood that if a screening test is "positive" (that is there is a higher risk of Down syndrome or trisomia 18) it is possible to proceed to a diagnosis by amniocentesis or by a chorionic villus sampling, and that if the screening test is "negative" (low risk) further examinations are not recommended, even if this does not mean that "certainly" the baby is not diseased.

I have discussed with the midwife or doctor Dr. regarding the ability of the screening test to correctly identify baby actually affected and the possibility of false positive and false negative results.

Signature of the caregiver.....

I consider this information sufficient and complete and I declare to have completely understood the information given to me.

Having the above clear, I decide to

Not undergo screening tests *signature*

Undergo screening tests *signature*

ULTRASOUND SCANS (page 38 of the Agenda)

The ultrasound scan permits seeing the internal organs of the body using ultrasounds (=sound waves at high frequency that the human ear cannot hear) which pass through the tissues and are reflected in different ways depending on the texture of the tissues it meets (bone, soft tissues, cavities, etc). The probe placed on the maternal abdomen sends waves inward and receives echoes (=returning waves). The waves are reflected from different internal organs producing images on the ultrasound monitor.

Ultrasound scans recommended in low risk pregnancy are:

- one by week 13*,
- another between week 19-21*
- Other ultrasounds are needed only if clinically indicated.

In the first months of pregnancy the ultrasound scan checks the number of babies and fetal cardiac activity; moreover, it measures the length of the baby, evaluating if its development corresponds to the stage of pregnancy calculated according to the last menstruation, shape of the uterus and ovaries.

*From the second trimester with the measurement of the head, of the abdomen, of the femur it is possible to evaluate if the growth of the baby is normal. In this period also the insertion of the placenta can be seen, the quantity of amniotic fluid and the shape of some organs. The note of the **second ultrasound scan** (week 19-21) will describe: number and size of baby/babies; presence of heartbeat, correspondence of weeks of pregnancy also calculated on the basis of the last menstruation. In particular, the ultrasound scan of this gestational age describe the anatomy of the baby: head, spinal column, chest (lungs, heart), abdomen(stomach, abdominal walls, kidneys, bladder), arms and legs. For this reason it is also called a "morphological" ultrasound scan.*

The note will also include reasons for possible further diagnostic tests when suspect or pathological images are seen. Measurements found in the ultrasound scan are then noted on graphs that allow following the rate of growth and to compare them with average growth curves of the same gestational age.

Being able to detect a malformation depends on many factors: the thickness of the maternal abdominal walls, the position of the baby, the quantity of amniotic fluid, the gravity of malformation. For this reason it is possible that some fetal anomalies cannot be found at the ultrasound scan. Some fetal anomalies manifest late (from the 7th-9th month). Experience gained until now suggests that the basic ultrasound scan at week 19-21, in a physiological pregnancy permits identifying about 50% of the major malformations. These ultrasound scans do not aim at finding so called minor malformations (e.g. malformation of hands, feet, etc). Due to intrinsic limitations of the method, even today some anomalies, even important ones, may not be detected by ultrasound scans.

Ultrasound scans have been used in obstetric practice for more than 30 years, and until now, harmful effects have not been found, not even in the long term. However, it is advisable to only do the ones recommended by scientific evidence or necessary for further clinical examination. 3D ultrasound scans (ECO 3D, ultrasound scans based on three dimensional reconstructions of the ultrasound scan elaborated by computer) do not add useful information except in very particular situations.

In some cases during the health assessment ultrasound scans may be used simply as a clinical support instrument for seeing: in the first trimester the presence of the ovular chamber, the embryo, the heartbeat; in the third trimester which part of the baby is present in the maternal pelvis and/or the position of the placenta and/or the quantity of amniotic fluid especially when the pregnancy goes over week 41.

LABORATORY TESTS (page 40 of the Agenda)

Laboratory tests done during pregnancy serve to verify the physical progress of the woman during pregnancy as well as the absence of diseases that could have negative effects on mother and baby. In the Agenda you may find all the **Impegnativa** for doing the tests provided by the Pathway for a Physiological Pregnancy. The tests included in the **Impegnativa**, that you may find in the Agenda, are the ones needed for evaluating the welfare of mother and baby and are ticket-free i.e. without any cost.

The white boxes in the test-table highlight which week the tests must be done. The tests in the first box are blood tests and regard the red, white and platelet blood cells, blood sugar, testing for infections that can cause problems for the baby (syphilis, HIV, rosalia, toxoplasmosis, hepatitis B). Urine tests are recommended once a month. After 34 weeks a vaginal-rectal tampon test for Streptococco B (which could infect the baby during passage through the birth canal) is recommended.

Situations that require additional care may require more specific tests as requested by the doctor: these will be made using ordinary medical request forms. They are without cost if the pathology or relative exemption code (M50) is indicated on the request (impegnativa).

All other tests that may be requested are at the expense of the user.

Preprinted Impegnative contained in the Agenda may be used for doing laboratory tests and ultrasound scans only at public laboratories of the Piedmont Region including hospital Gradenigo and Cottolengo of Torino.

On each Impegnativa you must attach the label with the number (for labels see page 46)

You may book the test by phoning directly at the CUP (Centro Unico di Prenotazione=Main Booking Centre) which will offer the first slot available in the province you belong to. It is up to you to select it according to your needs (time, vicinity to home, overlap of tests).

When booking by CUP it is worth having at hand: the Agenda, already open to the page with the Impegnativa for the test that you need, and a pen for noting the appointment.

The operator will ask you for the number of the Impegnativa which you will find on its upper right corner ending with the letter G (the letter G stands for gravidanza =pregnancy).

The operator will also ask for Numero di tessera sanitaria (i.e. Health-card number) and codice-fiscale (i.e. your fiscal code). For temporary present foreigners the operator needs also the STP or ENI or TEAM number. Surname and name of the woman who must do the tests and the type of test required which are listed on each Impegnativa.

At the end of the call, the operator will communicate to you the date of the test, the name of the laboratory or diagnostic service where the appointment has been made.

EMERGENCIES (page 44 of the Agenda)

In general, in order not to overload the Emergency Room with incorrect requests of service and therefore obtain suitable feedbacks you should know that access to service is organized on the basis of strict priority selection.

- Red-code: for those cases requiring urgent prompt care
- Yellow-code: for less-urgent cases that can be postponed in case of another red code
- Green-code: for those cases not requiring an urgent treatment
- White-code: for those less serious cases who can tolerate also long wait-times (and in those cases the payment of a ticket will be requested as a participation to the cost).

On page 44 of the Agenda you will find the list of those Hospitals with Emergency Rooms (Pronto Soccorso) having an obstetrician on duty 24 hours a day for emergencies of the Percorso-Nascita.

You should know that an Emergency Room is not prepared to make Health assessments: an E.R. must respond to real urgencies and not to normal routine request of service. Health assessments should be done with Consultori and other obstetric services of an ASL.

If you observe warning symptoms such as bleeding, violent headaches, acute abdominal pains, uncontrollable vomit, fever, contracted uterus, reduced fetal movements, during normal working hours you should always try to consult your caregivers before accessing an E.R. Your caregiver knows you and your pregnancy and may advise better. During not-working hours please call the numbers indicated at page ...of the Agenda.

If you are raped or subjected to any violence when pregnant you should always address the E.R. (Pronto Soccorso) and in all cases you should take with you the Agenda di Gravidanza together with anything that might help to understand the problems.

FETAL GROWTH (page 36 of the Agenda)

*Fetal growth is the increased dimension of the body (weight, length, chest, abdomen, head circumferences etc.), maturation of the organs and perfection of **abilities** to be born and to survive outside the uterus (some activities of the baby such as movement, tactile sensitivity, hearing, sleep-alert phases are already present in fetal life). Already from prenatal life the baby is able to learn, to memorise and adapt to different situations. With birth the baby will continue to grow in a new environment trying to identify the primary caregiver, that affectionate and emotional continuity that contributes to his wellbeing.*

Movement: *the baby moves from the first few weeks of life; movement allows changing position avoiding that the skin always touches in the same places and could be injured; moreover these exercises help the bones, muscles and nerves grow in the correct way. From week 20 of pregnancy nearly all the motor patterns of the adult are present, for example, sucking, sneezing, swallowing, shifting. The baby can put its thumb in mouth, touch hands to head, move the umbilical cord, observe and touch the surrounding walls. The mother begins to feel the baby around week 16-20.*

Sense of balance: *inner ear development appears very early and allows the baby to regulate its movements in function of the mother. In general, when the mother is still, the baby moves and vice versa.*

Skin: *touch appears from week 7, usually in the mouth and face area, on the palms of the hand, on the soles of the feet and then on the body. At birth the baby knows very well the pleasant sensations associated with touch.*

Smell: *from week 7 the olfactory nerve forms. The baby smells aromas from foods the mother eats and the uterine environment. These stimulate the development of sensitivity and of olfactory memory that will help recognise the mother's smell when born.*

Taste: *Taste buds are present from week 13, the same period that swallowing activity starts as well as opening and closing movements of the mouth. The baby tastes the amniotic fluid it is immersed in and continues to appreciate flavours belonging to the mother's dietary habits also through breast milk.*

Sight: *this is the least stimulated sense during pregnancy. However, when placing a strong light on the mother's belly, the baby reacts, trying to move away from the bright light and turning the head away.*

Hearing: *maturation starts at week 8 and at week 25 the baby reacts to external sounds. Uterine life is not immersed in silence: she hears respiration, heartbeat, intestinal movements, the mother's voice reaches her ear with greater intensity than any other sound.*

Sleep-Alert Rhythms: *from week 7 the baby alternates periods of tranquil sleep of 5-10 minutes where there is little movement, with more active sleep states followed by alert states. In the last weeks of pregnancy the periods of tranquil alert increase with little movement; the baby moves more during the night and sleeps a lot during the day due to the change of maternal hormones needed for birth.*

Measurement of symphysis-fundal distance *(fig. page 37) can show the correct growth of the baby using a tape measure, calculating the distance between the upper edge of the pubic bone symphysis and the bottom of the uterus. This measurement is noted on the week 24 table and compared to the fetal growth curve. It is measured at each appointment and, if possible, by the same health service caregiver. An alteration of regular uterine growth requires additional assistance.*

The individual percorso-nascita is a harmonious combination of the assistance programmes available and your personal choices. Information about the main aspects which are important for you to express your expectations are offered in this section.

ANTENATAL CLASSES (page 74 of the Agenda)

Antenatal classes provide information and listening to your needs during your pregnancy, sharing experiences with other women and support helping you in making decisions.

WHO (World-Health-Organisation) emphasises the importance of exchange not only with caregivers, but also with other parent couples.

Maternity, parenthood, are certainly not learned in a class. In our society, where daily life is organised in a way that isolates and exchanging experiences is reduced, taking time to share within the couple and with other couples, with other women and with caregivers helps reduce anxiety and uncertainties.

The objective of the antenatal classes is to help:

- *explore and understand your own emotions as well as physical and social changes during your pregnancy.*
- *share expectations and fears about labour, delivery and newborn care*
- *learn about the physiology of labour, birth and breastfeeding*
- *learn about labour support*
- *clarify doubts arising from your personal needs*
- *increase confidence in your own ability to deliver and take care of the baby*

Antenatal classes are also a time for preparing the body physically for birth. From the physical point of view it is not important to learn techniques but to practice movements, positions and ways of breathing which can be helpful during the different phases of labour/delivery.

Group meetings may continue after delivery for postnatal support to the new parents, to promote infant massage which enhances wellbeing and parent-child bonding and for breastfeeding support.

Antenatal classes are held in Consultori, Obstetric unit and private centres.

PLANNING PLACE OF BIRTH (page 76 of the Agenda)

98% of babies in Piedmont are born at Obstetric unit in public regional hospitals. The other 2% at home or in private institutes.

Every ASL has at least one Obstetric unit; the characteristics of each are described in the "Carta dei Servizi" (giving information on the Services offered by each ASL). Some of the information about the style of caring mother and baby in each Obstetric unit can be found on the Regione Piemonte site under "Nascere in Piemonte" e "Promozione e sostegno dell'allattamento al seno"

Where to give birth is your choice. In case of clinical conditions that require specialized care and/or intensive care for mother and/or baby (extreme prematurity, pre-eclampsia, etc) it is better even before delivery to orient towards a Obstetric unit that can provide such additional care (such as Neonatal Intensive Care) to avoid transferring mother and/or baby in case of need. Such Obstetric units are Sant'Anna Hospital in Torino, Maria Vittoria Hospital in Torino, Santa Croce Hospital in Moncalieri, Hospital Maggiore in Novara, Hospitals Santa Croce and Carle in Cuneo, Cesare Arrigo Hospital in Alessandria.

In order to make an informed choice it is best for you to discuss options with the professional who has followed your pregnancy. The professional can give advice on the basis of direct experience, but also on the basis of professional knowledge of the characteristics of the different Obstetric units. Indications from the World Health Organisation and from scientific studies recommend it is best in all sectors of health to preferably refer to those services that care for enough patients to maintain a high level of competency. For Obstetric units this threshold level is at least 500-births-per-year.

Each Obstetric unit should make the admission and hospital stay comfortable for the mother, the baby and the family. With suggestions from women ongoing improvement of this process can continue through criticisms and sharing the experience. The woman together with her little one is the protagonist of delivery/birth; the caregivers can offer their experience to accompany her through the birth and caring for her baby.

A caring for the newborn that allows mother and baby to be together from birth, sharing the first hours of life, and afterwards, rooming-in allow continuing the intimacy of the previous nine months and facilitate familiarity. Experiencing the continuity of the birth, holding the little one as soon as possible, attaching to the breast, caring for the baby, facilitate the hormonal change that are the basis of the natural mother-baby bond and the start of breastfeeding.*

Homebirth is also possible. Women who choose to deliver at home can receive a partial refund of the expenses for a free-lance midwife according to the "profilo assistenziale per l'assistenza al parto extra ospedaliero" (out of hospital birth care pathway) which can be consulted on the Regione Piemonte website. Choosing homebirth implies a foreseeable physiological pregnancy and low risk delivery, moreover a reference hospital must be identified in advance.

LABOUR SUPPORT AND PAIN-RELIEVING STRATEGIES (page 77 of the Agenda)

Continuous support and emotional support during active labour favour a positive delivery/birth experience, less pain, and promotes mother and newborn health. This means being able to count on help, reassurance, comfort, presence of trusted people and professionals, to face and experience as best as possible the fatigue, joy, fear and pain. The choice of such person (partner, friend, mother, sister, etc.) depends on your own needs.*

A midwife will be present to help you have a safe birth and offer support. However the hope that the same midwife who followed your pregnancy will be able to stay with you during labour is rarely possible. Becoming familiar with the selected Obstetric unit before delivery and meeting the team of midwives can help reduce your anxiety due to the newness of the place.*

Labour pain is particular as it is not a symptom of illness, but a natural part of delivery.

Labour pain perception is subjective and is influenced by physical condition, emotions, social, cultural and care. If the woman is well and the baby is in the right position, the birth canal wide enough, pain is usually supportable. The woman's personal resources and the natural production of hormones that accompany uterine contractions and the descent of the baby into the birth canal as well as the start of the mother-baby bond allow a physiological evolution of labour that makes the pain tolerable.

Strategies for pain management can be natural or pharmaceutical:

Natural with no use of medication

- **continuous support*** during pregnancy and birth
- **a one-to-one care** (one woman, one midwife) at the time of labour and delivery
- **emotional support*** communication, information, listening, common decision making
- **comfort measures:** being able to move during labour, choosing birth position*, a comfortable birth environment, low lights, music if desired, massages from partner or midwife
- **immersion in water*** warm tub baths or warm showers
- **relaxation techniques**

These strategies and techniques, in general, reduce the need for pain medication, reduce the need for medical intervention for delivery (use of oxytocin, episiotomies, caesarean section) and increases the woman's satisfaction.

Pharmacological, using medications: *the one most used is epidural analgesia which involves inserting a tube for injecting the analgesic drug in the epidural space in the lumbar zone of the spinal column, near the nerves that transmit pain sensations related to uterine contractions. It is available only in some Obstetric units, requires an anaesthesiologist appointment, some anaesthesia tests and a consensus agreement from the woman. The woman who chooses epidural analgesia should know that:*

<p>Advantages are:</p> <ul style="list-style-type: none"> - it is efficacious in reducing labour pain - it is indicated in some pathologies or in support to some operations 	<p>Disadvantages are:</p> <ul style="list-style-type: none"> - increases the probability of an operated vaginal delivery - increases the probability of intravenously administered oxytocin during labour - increases the probability of raised temperature - requires frequent and intensive monitoring of maternal and fetal conditions (cardiotocography, maternal pressure and temperature) - increases the number of newborns subjected to evaluation and antibiotic treatment due to maternal fever - increases the number of newborns with jaundice as a secondary effect of the oxytocin
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Eating during labour: *a lot of energy is consumed during labour; so it is worth drinking and eating as desired* with preference for small, easy-to-digest meals, compatible with own clinical conditions.*

Delivery (page 78 of the Agenda)

In a physiological course the newborn and the mother are predisposed for a vaginal birth. With spontaneous vaginal birth there is: less pain and it is easier to recuperate after the birth, greater self-esteem, better relationship with the baby, less frequency of postnatal depression, calmer baby, better breastfeeding experience, less infections for both mother and newborn.

A woman at term of a physiological pregnancy, with a vertex presentation (the head is the first part that appears at birth) with a labour that begins spontaneously, is likely to deliver spontaneously vaginally. In the case of breech presentation (the bottom is the first part that appears) or the shoulder, or the placenta is inserted in such a way to be risky to the birth (placenta praevia) or, in the presence of some maternal and/or fetal pathologies e.g. pre-eclampsia, HIV positive, large baby, etc.) the probability of a caesarean is high. In these situations the "cesareo programmato" (planned caesarean section) needs of additional tests, anaesthesiologist appointment, planned date of operation.

The caesarean section is a surgical operation (incision of abdomen and uterus). The operation lasts on average 25-45 minutes and depends on the technical difficulty met, usually done in epidural anaesthesia (blocking sensitivity altering the general state of awareness).

The side effects of a caesarean that should be known are:

- longer recovery
- more pain and minor possibility to move and take care of your baby in the days after birth
- greater risk of infection
- greater risk of anaemia
- greater difficulty starting breastfeeding and relating to the baby
- greater risk of maternal mortality
- risk for successive births: greater frequency of placenta previa (position of the placenta that blocks fetal passage in the birth canal), breaking of uterus etc.

Vaginal birth has always been safer for the mother and it is still so today, despite improved surgical techniques and support.

Some maternal and/or fetal problems in pregnancy or in labour (e.g. detached placenta, fetal suffering) may require an "emergency caesarean".

In very particular cases the woman, in absence of health problems to her or the baby for reasons of anxiety, fear, previous negative experiences, may think of needing a caesarean section. These situations should be discussed with the midwife and with the gynaecologist and possibly with a psychologist to reach an informed decision.

POSITIONS IN LABOUR AND DELIVERY (page 79 of the Agenda)

There is no one position recommended for labour and delivery: the midwife may propose the ones most favourable for the progression of the birth and pain management and invite the woman to choose what is most comfortable. Usually back lying positions are not advised*. The possibility to move* , keeping a vertical position during the dilating phase or squat/kneeling on all fours during the expulsive phase, seems to help reduce the time of labour and delivery and allow for greater wellbeing because it can help the newborn's rotation and descent, thus reducing the mother's pain. Other theoretical advantages are:

- greater use of gravity favouring the baby's descent
- better positioning of baby in the birth canal
- more efficient uterine contractions for dilating the uterine cervix and reducing the duration of the dilation phase of labour
- reduce the expulsive phase with less pain
- less request for analgesia
- less risk of compressing mother's blood vessels that carry blood to the placenta
- less risk of undergoing an **episiotomy** (cut used to facilitate the birth going from the vagina towards the perineum)

CARE OF THE NEWBORN (page 80 of the Agenda)

The baby's wellbeing and the quality of its future life depend on the style of reception experienced at the moment of birth. Since the fetal period, the baby has **skills** and ability and therefore is sensitive to environmental stimuli that occur around the labour and birth: sounds, voices, noises, lights, handling, maternal positions, temperature, smells. Intimacy and calm of the baby's birth environment facilitate physical and emotional wellbeing, and offer the newborn moments of contact and "acknowledgement" from the mother. The first relationship experiences of the newborn are very important for all future ones.

The first objective of caring for the newborn is to verify if the baby needs only his mother's care or also medical help. Therefore it is important to know the history of the pregnancy, the progression of labour and birth and the way of coping outside of the uterus (start of breathing, skin colour, heartbeat frequency). When there are no problems the mother and baby should be able to stay together in close contact with no interruption, in a natural way.

From the first hours of life nature offers optimal conditions for favouring bonding between mother and baby and the wellbeing of both. The baby looks around, eyes wide open, turns his head towards human voices, the faces around him attract him more than inanimate objects; the distance a newborn can see **is from 20 to 30 centimetres** which is the distance between his eyes and his mother's when held or fed at the breast. Skin-to-skin contact with the mother warms him the best way, and along with early breast suckling, increases the mother's hormones which tranquilise and save energy; distance and absence of suckling produce "stress" hormones of alarm and consume energy.

In the case of caesarean section, if the mother's anaesthesia has not been total, it is possible with the help of caregivers present at the birth, to not distance the baby from the mother allowing them to find an immediate contact, even if the baby may have slow reactions.

Once out of the delivery room, to favour the continuation of their close bond, mother and baby should stay in the same room in case of vaginal birth or caesarean birth. This lets the mother get to know her baby's requests and respond to them on time, reassuring him of her maternal competence and getting her into the habit of resting while the baby sleeps.

The daily care of the newborn is very simple and requires most of all being in tune with his life rhythm. The day is divided into numerous periods of sleep alternated with requests for food and cuddling. At birth there are no differences between day and night rhythms. Only as the weeks pass do the nocturnal periods of sleep lengthen with a night-time feeding which is very important because of its nutritional value.

Gradually mother and baby will find a harmonious life balance: it is important that the mother is not frightened or think she is inadequate for the situation.

"Healthy mothers orient towards their jobs as mothers during the last months of pregnancy, putting themselves in the baby's place, developing an extraordinary ability to identify with him making her able to respond to the newborn's needs in an incredibly unique way that no teaching could equal" (Winnicott, English paediatrician psychoanalyst who carried out in depth studies on mother-newborn relationships).

The best place to develop the mother-baby-family rapport is certainly in the home. Generally if the mother and baby are well, hospital discharge is suggested after 48-72 hours in case of vaginal birth and after 3-5 days in case of caesarean section. Personal needs to anticipate/delay the return home, unrelated to clinical motives are evaluated case by case.

The return home needs a bit of organising for safe transport* of the newborn (using an approved car seat) and for selecting times for an intimate and tranquil welcoming home of mother and baby.

DONATION OF UMBILICAL CORD BLOOD (page 84 of the Agenda)

Umbilical cord blood contains **staminal cells** similar to those in the bone marrow where red, white and platelet blood cells originate. For their characteristics some blood diseases can be cured such as aplastic anaemia and leukaemia. The cord blood is usually used to cure these diseases in children, even if lately they have also been used successfully in adults.

Blood is taken from the umbilical cord in a sterile bag after cutting and before the placenta is expelled. It is not painful for the baby or the mother. There are no negative effects on the health of the mother and newborn connected to the practice of donating the cord. Cord blood can be taken both in vaginal birth and in the caesarean section.

In order to donate the cord it is necessary to check with the midwife/gynaecologist the suitability of the donation by evaluating your state of health and tests you have done, the availability of the blood test at the Obstetric unit selected by you, sign a consensus form after having discussed with a professional and then, after 6 months from birth, you must undergo a new exam.

Once all the controls have been done, the blood banks will send the data to the Registro Italiano (Italian Registry) which is in touch with the world Registry (which collects over 356.000 donators, more than 18,000 Italians) where it is possible to obtain blood if a child is affected by a disease curable by an umbilical cord blood transplant and, if it is compatible, the transplant is then made. In this case, the blood donation is alien or altruistic, that is for curing a person other than the one donating.

In Italy, the blood collected is preserved, frozen at -196°C , at one of the blood banks for collecting and preserving the cord. In Piedmont the Regional Blood Bank is in Regina Margherita Hospital-Sant'Anna in Torino (tel. 011 3135568, <http://www.Piemonte.airt.it/Attività/Cordonale.html>).

On average 30% of the samples collected can be used for transplants. The sample is discarded when:

- the umbilical cord blood is less than 50cc (amount of stamina cells too low)
- sterility not reached while collecting sample
- the newborn has infections or disease at the 6-month control

The Italian law provides that the donated blood be made available to any patient with the clinical characteristics of compatibility for such "donation" (i.e. for any sick person who may gain advantage from a transplant of cord cells). In the case of relatives (brothers or parents) affected by a disease curable with staminal cells from the cord, the preservation of the cord blood is authorised to be stored in the public blood bank for family use (**dedicated donation**)

Autologal (self) conservation (i.e. made for curing the donor herself in the case of successive disease) has not shown to be an efficacious practice, and therefore it is not currently recommended. In Italy the institution of blood banks for collecting cord blood for autologal transplants is not allowed.

This practice, unsupported by proof of efficacy and not recommended by international guidelines, has given life in some countries to commercial initiatives which escape institutional control. However it is always possible to turn to foreign blood banks, asking the Ministero della Salute (Ministry of Health) authorisation to export cord blood, by consulting-even by telephone-at the Centro Nazionale Trapianti (<http://www.trapianti.ministerosalute.it/cnt/>). The Direzione Sanitaria (Health Administration) of the hospital must be forwarded such request in order to follow it through lawfully. The relative expenses (from collection to delivery to foreign blood bank) are the family's.

BREASTFEEDING (pag 82 of the Agenda)

Breastfeeding is the natural continuation of the nutrition the mother provided to the baby through the **placenta** in pregnancy. During pregnancy and labour-delivery the maternal body prepared for breastfeeding through numerous changes which readied the mammary glands and the maternal body to stock up for milk production. Nature gave the baby the instinct to guide him/her to the maternal breast: the hormones from the birth increase the heat in the zone of the breasts and his/her sense of smell guides her towards the breast: if placed on the mother immediately after birth, he/she will move towards the nipple, take it in her mouth and begin suckling. Understanding how nature planned for the birth allows the mother and the caregivers to organise help from the very first moments and days of the baby's life in a way not to interfere with the normal start of breastfeeding. Once started, the repeated suction of the baby will regulate the quantity of milk produced at each feed and also its quality, in particular the concentration of fats.

The World Health Organisation recommends in the first days after birth some behaviours that constitute an objective for all the Obstetric units of Regione Piemonte.

help the mother to have skin-to-skin contact immediately after birth so that the first feed is spontaneous
show mothers how to breastfeed and how to keep the mil flow even if they are separated from the newborn.
do not give the newborn foods or liquids other than maternal milk except under precise medical prescription
put the baby and mother in the same room 24 hours round the clock during hospital stay
encourage breastfeeding every time the baby wants to feed
do not give pacifiers or dummies during the breastfeeding period
help create support groups for breastfeeding even after hospital discharge

All Obstetric units have to reconcile mother and baby needs with the organisational needs of the hospital which means respecting some rules. It is advisable for you to learn the rules of the ward (visiting time for families, father's stay, rooming-in, length of stay for natural birth and caesarean birth, etc.) to improve the comfort of the hospital stay.

Every woman who wants to can breastfeed. Out of 100 women only 2 or 3 cannot breastfeed due to a serious physical or psychological disease. Breasts have many shapes and sizes which are all able to produce milk; even small breasts function very well.

In the last 50 years, there have been many changes in our society that have dispersed our knowledge and competence regarding breastfeeding. Today mothers who wish to breastfeed need to receive the correct information as well as support from relatives, other expert mothers and competent health caregivers to prevent and overcome serenely some difficulties that can make breastfeeding difficult and demanding.

It is useful to discuss the choice to breastfeed while you are still pregnant with the caregiver of reference and/or attend breastfeeding classes programmed at the Consultori and Obstetric units, involving your partner and perhaps even grandmothers at this informative moment so that the entire family shares the indispensable knowledge for efficacious support to the breastfeeding woman

History for breastfeeding

previous breastfeeding	<input type="checkbox"/> NO	<input type="checkbox"/> YES	for how many months
problems in previous breastfeeding:			
.....			
doubts/fears:			
.....			
constraints: work			
other			

Exclusive breastfeeding for at least 6 months:

<p>Why yes*</p> <p>-because it is good, nutritious, always ready.</p> <ul style="list-style-type: none"> • It is the most digestible food. • it is always fresh, clean, at the right temperature; • it has the ideal nutritional composition: proteins, sugars, fats, vitamins, iron, antibodies; • it has the “growth factors” specific for the maturation of the baby’s organs • the fats contained are appropriate for brain development • protects against most common infections in the environment where the baby lives (artificially fed babies have more respiratory, gastrointestinal and urinary infections, more otitis, more meningitis) • better response to vaccinations • reduced risk of sudden infant death syndrome, infant diabetes, orthodontic problems and baby bottle cavities • protects against some diseases in adulthood (hypertension, obesity, cardio-vascular disease, diabetes, tumours, and chronic intestinal diseases) • night feeds and travel are easier • it is an economic savings for the family <p>advantages for the mother:</p> <ul style="list-style-type: none"> • less risk of postnatal haemorrhaging • faster physical recovery after delivery • less risk of breast and ovary cancer • easier to bond with baby • postnatal depression less frequent • less incidence of osteoporosi 	<p>Why not</p> <p>clinical contraindications against breastfeeding are very rare the World Health Organisation acknowledges those listed in the table on the next table. For women in this situation the Regione Piemonte will provide artificial milk for 6 months free of charge.</p> <p>sometimes breastfeeding is abandoned for fear of encountering difficulties (e.g. pain to nipples, engorgement, mastitis, little milk, early return to work...)</p> <p>It is useful to know that the problems listed above can easily be prevented: by placing the baby to breast as soon as possible after birth, making sure the latch on the breast areola is correct (see page 110), following the baby’s spontaneous rhythms to adapt how much the breast produces to baby’s needs and asking help from caregivers and/or mothers with more experience.</p>
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Conditions contraindicated to breastfeeding, as suggested by the World Health Organisation (WHO):

<ul style="list-style-type: none"> • HIV sieropositivo • postnatal psychosis • breast cancer • alcoholism and/or drug addiction • some rare newborn congenital diseases (e.g. galactosemia) 	<ul style="list-style-type: none"> • permanent assumption of contraindicated medicines °° • extensive breast surgery • hepatitis in acute phase • herpes sores on the nipples • sieropositivo to HTLV (rare form of leukaemia)
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Gratuitous supply of substitute for maternal milk. (DGR N 13-8266 del 25/02/2008): a **free-of-charge supply of substitute for maternal milk** is provided by the Regione Piemonte, to mothers subject to absolute contraindications to breastfeeding, continuative or temporary, as indicated by the WHO

PHYSIOLOGY OF BREASTFEEDING (page 108 of the Agenda)

*Breastfeeding should be a pleasure for both mother and baby. The "starting up" is demanding: it may be tiring and require a spirit of adaptation to the new situation. **Knowledge of the mechanism provided by nature** for breastfeeding, confidence in **one's own resourcefulness** and in the **baby's skills** are of great help overcoming initial difficulties.*

Even women who do not breastfeed benefit by knowing about the natural mechanisms at the basis of breastfeeding and of the mother-baby bond in order to follow knowingly the baby's rhythms and to enjoy skin-to-skin contact with the little one even if using the baby bottle.

How does breastfeeding function?

Nature has seen to the smallest details: at birth the breast is ready to make milk and the newborn has the instinct and ability to suck. From the first feed onward, it is the baby's suckling that stimulates and produces the flow of milk - thanks to the action of two hormones: prolactin and oxytocin. Only when the baby is no longer put to the breast does milk production stop. Prolactin acts on the mammary to produce milk. The more frequent the suckling the greater the quantity of prolactin produced and thus the quantity of milk in response to the baby's requirements. Frequent suckling is mostly at the start of breastfeeding when the baby needs to let the breast know how much milk is needed, then afterwards, at times when the baby's needs increases in proportion to his growth (this period is called "scatti di crescita" "growth spurts").

*In the first feeds the newborn receives colostrum, a highly nourishing substance rich in antibodies that gradually enriched with water, transforms into milk. With subsequent feeds, stimulating the prolactin, each time, increases the quantity of milk that leads to the so called "montata lattea" (milk comes in). The mother will feel the breast more full, warm, reddened at times and a bit sore. For breastfeeding to start **frequent suckling and the correct latching on the breast** are very important: if the baby suckles frequently with a good latch on the areola of the breast and nipple the milk flow will not be painful. Cool packs between feeds and manual expression of the areola to reduce pressure and facilitate suckling, will soon eliminate any discomfort. These natural principles must be known by those who are near the mother to avoid giving advice that may confuse and interfere with the physiological start of breastfeeding (for example suggesting that breastfeeding should follow a fixed schedule, proposing diagnosis such as "too little milk", or advising to integrate with other drinks).*

The other hormone fundamental to breastfeeding is oxytocin: at the time of birth it helps the baby leave the uterus and enhances maternal instinct, and afterwards makes the milk flow to the breast, enriching it with fats during the feed. For all these characteristics oxytocin is called the love hormone. This hormone is greatly affected by emotional states: if the mother is well and serene (even if tired), does not feel pain, feels supported by relatives and caregivers, if no one confuses her or makes her feel inadequate, she will produce plenty of oxytocin which, besides facilitating breastfeeding, will increase her and the baby's wellbeing. The father plays an important role in this delicate balance protecting and helping his partner.

For pleasurable breastfeeding it is useful to know that:

- *the mother's milk is always good, it is always nourishing, quantity does not diminish over time.*
- *Once breastfeeding has started it is normal for the baby to suddenly increase the number of feeds. The mother should not immediately think that it is due to a reduction of her milk production, when, instead, it is more likely that it is due to an increase in the baby's growing needs ("appetite comes by eating!").*
- *milk does not accumulate in the breasts between one meal and the next, as once thought, but is produced during each feed via the baby's suckling.*
- *there are no foods contraindicated for breastfeeding women*
- *cracked nipples are prevented in the first days by paying attention to the correct latch on the areola and nipple, offering the breast as shown on page 110, without worrying about detaching and repositioning the baby if the baby's latching on is causing pain. It helps to take her to breast with mouth wide open. Do not be afraid to ask the nurses and midwives of the Obstetric unit for help when in difficulty. The only cure for healing cracked nipples is to help your baby to latch on well!*
- *there is a correct technique for manual expression of the areola to help the mother, if necessary, to avoid engorgement and to manage painful milk flow. It may be helpful to express a few drops of colostrum or milk to relieve pain in the nipple (page 107).*
- *in addition to the Punti di Sostegno (support places) for breastfeeding, mother groups can certainly be a good resource, not only for pleasurable breastfeeding, but to share fears, anxieties and moments of discomfort that every mother has starting breastfeeding and relating to her little one, but also to share the joys and the satisfactions that babies give their mothers.*

BIRTH CHOICES (page 86 of the Agenda)

Frequently during your pregnancy your thoughts as mother, as those of your partner, are projected to the moment of birth and when you will meet your baby. These thoughts are often full of expectations and fear.

On occasion of the Health Assessment of week 36-37 of pregnancy at the chosen Obstetric unit, it is helpful to discuss with the caregiver your expectations for that special moment.

Below is a list of main elements of care for labour and delivery for which there are often different options available. Expressing your own wishes will help birth caregivers to offer possibly the most personalised care.

Obviously these choices must be considered with flexibility by you, as sometimes the clinical or the assistance circumstances might go off the physiological course, and an additional care may be needed which may not always be compatible with all your choices

Some particular choices, not yet supported by evidence of efficacy, in absence of organisational conditions or in contrast to laws and principles in vigour, may not be satisfied. It is suggested that their feasibility be discussed beforehand with the Obstetric unit chosen.

In order to have the best birth experience you should discuss with your midwife/doctor the points listed below. How to realise your choices will be analysed in greater detail on occasion of the Health Assessment at the chosen Obstetric unit. Obviously your choices will be satisfied compatibly with a physiological progression of labour and delivery :

Birth's planning

Your preferences for delivery

Entrusted (by you) person who will be present during labour

Labour's planning

Care for the Baby: Skin-to-skin

Feeding the baby

Rooming in

Planned Length of stay in hospital.....

Donation of the umbilical cord.....

.....

MATERNAL-FETAL HEALTH ASSESSMENT AT THE OBSTETRIC UNIT (page 88 of the Agenda)

At week 36-37 your baby has matured the skills for birth; the Maternal-fetal Health Assessment should be planned at the Obstetric unit chosen by you for the birth or identified as suitable for your clinical situation. In the case of home delivery an evaluation of the suitability of home birth must be made and the documentation sent to the hospital identified as the reference for a possible transfer.

In this Health Assessment the following points must be re-evaluated:

a) the history of the pregnancy as recorded in your Agenda; b) mother's and baby's health; c) how your organism is physiologically predisposed to birth (position of your baby, level of the bottom of the uterus, sporadic contractions,...); d) possible elements of risk for your delivery; e) checks done during pregnancy including those recommended between week 33 and 37.

Your medical record (Cartella Clinica), to be used for admission in the Obstetric unit, is now prepared and the care planned for the next weeks of pregnancy will be shown to you including the monitoring for fetal wellbeing from week 41 +0 days, if the birth has not occurred.

In the presence of doubts about the mother's and baby's health which had not previously emerged, additional specific checks will be requested (e.g. more blood tests, ultrasound scan, cardiotocography) and additional and more frequent appointments.

If a caesarean section is needed, pre-operation tests will be requested to be done at the hospital (their cost is included in the hospital care for caesarean section).

This Health Assessment is also a time to clarify doubts that you may still have (e.g. admission to the Obstetric unit, especially at night, if other relatives can assist, etc..) and verify if the hospital can meet your choices (e.g. specific clinical situations, pain management in labour with immersion in water and epidural analgesia, umbilical cord blood donation, etc.)

PREGNANCY BETWEEN WEEK 37 AND 41 (page 90 of the Agenda)

Even if the exact birth's day is unpredictable, most babies are born around week 40 of pregnancy: a theoretical date is calculated from the first day of the last menstruation. In reality the moment of birth can vary as much as 4/5 weeks with respect to the theoretical date, in fact a pregnancy is considered to be at-term if it takes place between week 37 +0 days and week 42+0 days.

In this last period the baby perfects maturation of some functions (e.g. the ability to breathe), gains weight and gets in position for birth. From week 38 the mother usually breathes better because the "abdomen is lower" and begins to feel contractions in preparation of labour.

If your legs, wrists or face do swell, if you have loss of blood or amniotic fluid, stomach pains, vision problems or other disturbing sensations or the baby does not move as usual you must go immediately to the hospital to exclude maternal and/or fetal risk conditions.

*Your **care plan** varies according to your characteristics (e.g. nulliparous or iparous women) and is realised in collaboration with the Obstetric unit and the professionals who have followed your pregnancy.*

*If your pregnancy extends over 40 weeks or there are clinical indications, a cardiotocography will be done to evaluate fetal wellbeing and the quantity of amniotic fluid (**AFI**). Additionally a "membrane sweep" may be proposed* during the vaginal examination for reducing the need for medical induction in labour. The membrane sweep may be annoying, painful, cause bleeding and may cause accidental breaking of the membrane.*

Induction consists in starting labour using medications (prostaglandine via vagina, oxytocin intravenously administered or by amnioressi (breakage of amniotic membrane with an instrument)).

Generally labour is induced by week 42 +0 days because going beyond often results in conditions of suffering or fetal mortality.

WHAT TO PREPARE FOR HOSPITAL while waiting for the birth

1. Your Agenda della gravidanza
2. Identification documents
3. Tessera Sanitaria (Health card). For foreign women from EU countries TEAM card. For women from non-EU countries or without a residence permit an STP code (stranieri temporaneamente presenti) which is given at the ISI (Information Salute Immigrati= Immigrant Health Information)
4. Personal belongings for mother and baby as suggested by the Obstetric unit of your choice
5. Full tank of petrol in your car and parking vouchers

WHEN TO GO TO THE HOSPITAL FOR DELIVERY

1. when your contractions become regular in intensity, frequency and duration for at least two hours;
2. when there is loss of "waters" (amniotic fluid), especially if the colour of the liquid is not clear (green, brown, or yellowish) it is important to go to hospital immediately
4. when more than a few drops of blood are lost
5. in any cases of doubt

PHYSIOLOGY OF LABOUR-DELIVERY (page 103 of the Agenda)

*Nature has programmed birth in every detail: usually it is the baby that signals the beginning, stimulating uterine contractions and getting into position conducive to birth. In this way the baby expresses **his skills for birth**. This usually happens at the end of pregnancy, that is after week 37. The physiological progress of labour is influenced by the progress of the pregnancy and favoured by environmental conditions*: intimacy, space to move freely, absence of disturbing stimuli and /or interference (light, noise, deferrable questions and manoeuvres) in respect to your need to isolate yourself from the outside in order to let the stages of birth follow their natural course. Labour progression is individual and depends on many factors.*

Already in the weeks before labour, there are some symptoms that pre-announce the true labour stage:

occasional or irregular contractions- are tightenings felt like internal compressions in the belly that may also be associated with a painful sensation low down or in the lumbar area (about the position of the kidneys); they can occur throughout the day or evening, can sometimes be painful, but at this stage, they do not intensify rather they diminish and go away in a short time;

loss of mucous plug – the mucous plug is a white, yellow or brown-coloured gelatine that forms at the start of pregnancy inside the cervix of the uterus to protect the baby from the outside environment. At the end of pregnancy the contraction acting on the uterine cervix can make the mucous plug come out (no longer held by the walls of the cervix). Loss of the mucous plug is not an imminent sign of delivery, it can in fact happen several weeks before the start of labour;

backache- it is a menstrual type pain, due to small contractions that are not always felt. It can last several hours or can be a dull presence throughout the day;

loss of transparent vaginal fluids - due to hormones that prepare for labour; they can be mistaken for loss of amniotic fluid, but unlike this they are not continuous.

During the course of labour there are 4 different phases called:

- | | |
|--|--|
| 1 early signs of labour | 2 active or dilating phase (also called stage I) |
| 3 expulsive phase (also called stage II) | 4 delivery of the placenta (also called stage III) |

With early signs of labour the woman physically and emotionally prepares for labour. Then it takes place the "transformation of the cervix of the uterus", indispensable for the next phase. The cervix to the uterus from 3-4 cm shortens and becomes completely flat to allow for progressing to delivery. These early signs of labour can last from a few hours to some days.

In the hours before labour (from a few hours to more than 24), there may be the following symptoms:

- **contractions** become regular in intensity (they all produce the same pain), duration (you can feel the arrival of every contraction, a culmination of pain and its successive weakening), frequency (the time interval between one contraction and the next is constant). These contractions unlike the ones in the weeks before do not attenuate, rather they increase over time. The important thing is not so much the interval between contractions, but the regularity. During the contraction it is difficult to speak and walk: it is necessary to stop and lean on someone or on something;
- **small blood losses**- these are also connected with the preparation of the cervix of the uterus, caused by some capillaries breaking; indicate that labour is about to start; the losses are usually a few drops, bright red (like at the start of menstruation) and can occur several times throughout the day.
- **"losing the waters" (or amniotic fluid)** - caused by the breaking of the amniotic sac around the baby. Amniotic fluid is usually colourless and odourless; loss of the fluid is sudden, abundant and nearly always continuous. If the sac does not break completely but is only punctured in one point, the loss is scarce and discontinuous, but it will continue throughout the day usually associated with the mother's movements.
- **Nausea and/or vomiting**- does not depend on what was eaten and is due to preparation of the cervix of the uterus, therefore is an optimal sign of imminent labour!
- **Diarrhoea**- due to the hormones preparing the cervix of the uterus in the days or hours before labour, it is helpful for emptying the intestine and preparing the cervix for birth.
- The above symptoms may all be present or only in part.

The contractions generate a lot of pain but are essential for dilating the cervix of the uterus for pushing the baby in the birth canal. At the same time they massage the skin of the baby activating the immune system and helping to protect its organism. The pain more or less intense can be managed using various strategies or medications.

Active or dilating phase is the true labour: it serves to fully dilate the cervix of the uterus thanks to the contractions and the pressure of the baby's head. This phase begins when the cervix of the uterus is completely flat: contractions are regular in intensity, frequency and duration and the dilation of the cervix of the uterus is at least 4 cm.

The duration of labour is variable, on average it is between 6-8 hours for a mother giving birth for the first time and 3-5 hours for a mother who has already given birth at least once.

Sometimes the contractions are not frequent and intense enough and it may be necessary to use **oxytocin** intravenously to reinforce them.

Usually the baby approaches labour without any problem; listening for a regular baby's hearthbeat* permits identifying if the baby is having difficulty. The baby's hearth, along with other information regarding labour, are recorded in the pregnant's medical record.*

Expulsive phase is the final phase of labour that leads to the baby's birth. It starts when the diameter is able to allow passage of the baby. The progressive descent into the birth canal makes the woman feel a sensation that she should accompany the contraction by pushing, letting the baby come to light and helping the mother to handle the pain. Sometimes in this phase, there may occur some natural lacerations of the perineum more or less extended that will heal by themselves or be stitched. In other cases a surgical incision of the perineum may be necessary (episiotomy) to increase the vulva ring and facilitate the baby's exit. The birth ends with the **secondamento (afterbirth)**: that is the expulsion of the placenta and the amniotic fluid, usually shortly after birth and in any case within an hour. The expulsion of the placenta is helped by oxytocin that increases in the mother's blood circulation when the baby is latched onto the breast.

FIRST DAYS AFTER BIRTH (page 106 of the Agenda)

In the first days after birth the midwife/gynaecologist checks the uterus, vaginal discharges (called lochi, lochiations) which initially are red (like a heavy flow menstruation) and little by little become clearer until becoming yellow. The discharges, rather abundant, are characterised by a particular smell. The paediatrician checks out the baby's health. For this reason hospital births require the few days offered to the mother and baby; for home births you must schedule midwife and paediatric appointments.

Besides the clinical controls, the first days are moments for mother and baby to continue their relationship, now extra uterine, in an environment where it is possible for the mother to use the experience of the caregivers to get confirmation and help regarding her needs. Welcoming the mother and baby means **by everybody**: respect their desire/need to be together, trying to understand their requests and communicate calmly.

Having the baby nearby all day helps you to recognise his needs and attend to them in time; it allows matching your maternal rhythms to the baby's using his sleep periods to rest yourself. By so doing the hormones provided by nature will help the your maternal organism to respond to the newborn's needs.

Sometimes the thought of having to take care of the baby immediately, keeping the newborn nearby, instead of handing him over to the Nursery caregivers, can frighten a mother. It is important for you to know that nature has programmed the hormonal response in detail so that in the presence of your baby, it will tune the rhythms of your daily life with those of your child. Following these rhythms (which is really possible only at home) will allow you to recuperate quickly from the effects of delivery and gain confidence in your ability. The baby's daily rhythms are

sleep and alert, moments for cuddling, for feeds and for evacuation: they are all correlated with breastfeeding according to nature, which paces them.

In the first days the current **prevention** actions recommended for every newborn will be taken:

- eye treatment = medical drops in the eyes, in the first hours after birth for avoiding conjunctivitis caused by contact with germs in the mother's vagina
- anti-haemorrhage treatment= vitamin K indispensable for preventing haemorrhaging
- metabolic and cystic fibrosis screening= equals blood sample taken from the baby's heel to get a few drops for checking for certain diseases that if present can be cured immediately;
- assumption of colostrum= putting baby immediately to breast in order to suck the colostrum rich in antibodies and substances that build up defences.

The discharge from hospital is a time for talking with the caregivers to bring closure to the experience of pregnancy and birth with awareness and to open the next phase of the woman's (and her family) life. For the baby it is time to complete the first Health Assessment and register it on the Agenda di Salute (Health Diary). Your baby's Agenda della Salute is the way you and the paediatrician of your choice will follow the baby's health in all the phases of his growth. For the mother and father it is also an occasion to discuss choice of contraceptives with professionals. Before going home the mother should learn how to press out milk manually in case it is necessary.

POSTPARTUM PERIOD (page 93 of the Agenda)

The period that goes from birth to about 6-8 weeks afterwards is a phase of physical and psychological adaptation during which the uterus returns to the size and muscular tone of before birth, breastfeeding is consolidated, and the rhythms of mother and baby's daily life are regulated. Vaginal discharges with placenta residues called lochi are normal in this period. After birth, depending on your personal needs, yet within 30-40 days, it is helpful for you to meet a professional who has followed your pregnancy to discuss your birth experience and to evaluate your obstetric conditions, your perineum, your psychological and psychic wellbeing, any contractions, breastfeeding, opportunities for receiving group support and self help or socio-health services.

In case of discharge with odours, perineum pain, difficult healing of any sores, and other disturbances connected with the pelvic floor (uncontrollable loss of urine, pain during sexual intercourse...), it is necessary to make an appointment early on with a professional. The same with persistent pain in the breast, anxiety or significant tiredness.

After delivery, due to hormonal changes and tiredness, it is common to feel sad and melancholic. If this condition continues in time, for some women psychological and/or medical support may be helpful, and in some cases medicated.

It is helpful to know that the rhythms of the day naturally modify on the base of physiological breastfeeding and it is worth experiencing this period with awareness that the mother-baby adaptation will reach a harmonious balance with time. Adaptation to the new situation (presence of first child or a new child) with rhythms apparently very different from the normal family rhythm can create some difficulties and tensions also in the couple.

There is evidence that group encounters among women going through the same experiences allows sharing fears, anxiety, etc. and to recognise these events and emotions as "normal". Some ASL offer postnatal encounter groups for women within the Consultori.*

AT HOME WITH YOUR BABY (page 112 of the Agenda)

In order to understand your baby's behaviour in the first weeks of his life it is important to understand the changes he has undergone leaving his mother's uterus to enter in a totally different environment requiring from him a period of progressive adaptation.

Recognising the sensorial experience already matured by the baby helps to give diversified responses: touching, rocking, massaging, being visible, being heard with a tone of voice that the baby can recognise, reading stories even short ones, proposing the music listened to in pregnancy, etc.

Nearly all fetal life is lived in movement. The baby receives pushes and contra pushes from the amniotic fluid and from the uterine wall. The pleasure of being rocked reminds the baby of already known and pleasurable sensations which derive from this experience. Usually when the mother is still the baby moves and vice versa; during sleep, when the mother dreams, the baby is still, in dreamless sleep, the baby moves: these alterations are interpreted as the beginning of a dialogue where, if one speaks, the other listens waiting for her turn. The position in uterus is similar to that in a hammock: the back arched and supported with limbs free to move. That is why baby's are calmed if held this way. Crying too is an extremely efficacious communication means for asking for adult attention, sometimes it helps release tension from a day marvellously filled with stimuli.

For his entire fetal life the baby has been continuously fed through the umbilical cord and fed whenever he/she wanted by swallowing amniotic fluid. Neither hunger nor thirst were known, nor sensations of empty stomach. With birth the newborn has a fundamental new experience: feeling hunger and discomfort. Mother arrives and the discomfort ceases: little by little the baby learns and adapts to these new rhythms and intervals and trusts that the mother will respond to baby's needs. Once this trust is gained, your baby can afford to wait, knowing for certainty that within a certain time the response will arrive (with trust the baby will also learn to understand the value of time which seems so obvious for adults).

At birth, the newborn does not have elements for distinguishing night from day and undergoes a brusque insertion into an environment where there is alternation between light and dark; the baby learns to recognise day from night

and above all that nearly everyone sleeps at night and not during the day. The newborn will gradually adapt to this new rhythm, in a few weeks, if parents will teach it by diversifying day from night: for example the night feed can be done with a low light, without much ado or lots of added noise; instead during the day feeds can be preceded by a change of nappy, a massage, chatting with mother, etc.

During the neonatal period, the little one sleeps most of the time. There are two types of sleep that alternate about every thirty minutes: deep sleep and light sleep. During deep sleep the baby's face is relaxed, eyes closed and eyelids immovable, there is no body movement except for small starts and slight mouth movements. During light sleep the eyes are usually closed but sometimes open and close repeatedly, there may be slight arm, leg and body movements, breathing is irregular and the face may have different expressions (grimaces, smiles, wrinkled expressions).

Passing from light sleep to deep sleep (about every 20-30minutes) the baby comes close to waking and may whimper or move about. It is good to respect these delicate passages between one sleep state and the next without intervening immediately (for example picking up the baby at the first stirring) so as not to interfere with the baby learning the normal rhythm of sleep. The baby alternates periods of sleep with periods of wakefulness.

There is a quiet alert state when the baby does not move much and eyes are wide open: this is the time the baby studies the surrounding environment, fixes her gaze on objects and people, taking in as much information as possible. It is very important to respect these states. All the exploration allows for staying awake without being held immediately.

In other moments it is opportune to speak, read a story, sing rhymes, listen to music, hold the baby. The baby is very different in the active alert state where there is a lot of movement, looking about, making noises, usually before meals.

Most early learning comes by imitation of what is seen and heard around us. Recent discoveries have shown that some structures of the brain (called mirror neurons), reflect inside our brain what we see others do and this information is fixed in the brain.

It is remarkable to observe how attentively a 20/30 day-old newborn begins following in fascination, the voice, the facial outline and movements of those who speak gently from a distance of 20-30 cm. and respond by trying to imitate.

Knowing that from the beginning the baby expresses his-her own emotions and tries to converse with the mother is fundamental for establishing a respectful, affectionate rapport, rich for both.

BECOMING FATHER (page 111 of the Agenda)

In the pages of this Agenda information and options proposed are almost always, for sake of brevity, referred to the woman, but, as said at the beginning, are intended to include the partner who accompanies her along the pathway. **In the mind and emotions of the father, as in that of the mother during pregnancy, a space is gradually made for the idea of the baby as well as the feelings and emotions around this idea.**

On a practical basis, in the past decade, there are changes that frequently involve greater active participation of fathers in childcare, and even before during pregnancy. Being present at the Health Assessment, participation in the antenatal classes, if desired by both, can be a way to share information, emotions and to better interpret the changes that the woman is going through, and consequently know better how to help her.

In particular in the months of pregnancy attentive support from the partner in relationship to possible changes in lifestyle (balanced eating, quit smoking, exclude passive smoke, quit drinking alcohol, etc) can be of help when such changes are more difficult, besides being a stimulus for creating a healthy domestic life for the future baby.

The father's state of health can influence the child: therefore it is important to refer the health history together with the family health history for facilitating the identification of possible genetic risks. Moreover the tests foreseen serve to exclude possible sexually transmitted diseases.

In view of the Health Assessment scheduled for week 36-37 of pregnancy, there are a series of possibilities for experiencing labour, delivery and birth of the baby in a way that is closest to the expectations of both parents: speaking about them within the couple and together with the birth caregivers allows realising, as much as possible, their expressed wishes.

Being present at the birth can be a unique experience. It is important to reflect together how to experience it best to not risk facing it in some way obligated (... "because all fathers must assist at the birth"... "I have to do it"... "all my friends did it"). In fact being in the delivery room is neither "right" nor "wrong", it depends on one's own culture, own emotions, choices made as a couple, how one feels at the moment and from the context and has nothing to do with the feelings one has about his companion or towards his child. The role of the partner/father at the time of birth, like those in the weeks after, is to provide emotional support, affection, mediation and protection from the external environment. To be efficacious this support must respect the rhythms and ways each mother/baby express their emotions.

Above all with a first child the couple must reorganise its own rhythms, its spaces and also the practical needs of their everyday life and also the needs of their relationship. During the period of adaptation and settling of the changes required by the new family, it may be helpful that the father, aware of natural maternal skills of the new mother and of her choices made in pregnancy, does support and reinforce her in facing external opinions.

Awareness of the heightened sensitivity of the new mother in her first months with her baby will help not to neglect possible symptoms of the woman's discomfort that could also be resolved by specialized professional intervention (psychologist, psychiatrist, infant neuro-psychiatrist).

Knowing that the baby is able to react with the adult who takes care of her from the very beginning can help the father overcome a certain reluctance in taking care of, handling and talking with the baby. However he must recognise different attitudes in the mother figure and the father figure trying not to reverse the roles that are traditionally attributed to the mother or to the father.

ORIENTATION REGARDING FOOD HYGIENE (pag 102 of the Agenda)

In every ASL there is a Servizio per l'Igiene dell'Alimentazione e Nutrizione (SIAN) (Service for Food and Nutrition Hygiene) which has the task to:

- protect citizens from nutritional risks through controls on their quality and safety
- to contrast nutritional risk factors with information and health education of citizens as well of workers on production chains and food distribution, also with personalised dietetic-nutritional consultancy interventions. The table below shows the hygienic precautions advised during pregnancy in case of **possible contamination** of some foods.

Indications for correct preparation and storage of foods related to pregnancy

FOOD	TYPE of		ADVICES
Cereals	All types	YES	
Cakes	Without fillings	YES	
	With fillings	warning	be careful of home-made cakes using raw eggs. Salmonella may be present.
Cheese	Hard	YES	
	Soft/semi-soft with crusts or moulds (e.g. gorgonzola, brie)	NO avoid	"listeria monocytogenes" may be present
	Mozzarella-spreadable cheese (stracchino, crescenza)	YES	avoid storing too much after opening
Milk, yogurt	Fresh or UHT	YES	drink before boiling
	Raw milk from distributors raw goat milk	warning	avoid buying directly at dairy farm
Eggs	Cooked (omelettes, fried)	YES	
	Raw or slightly cooked (poached, sunny-side, zabaione, mayonnaise, cream, home-made tiramisu)	warning	wash hands after touching the shell and eat by the next day creams or mayonnaise. Salmonella may be present
Meat	Well-cooked meat of all species	YES	cook thoroughly, eat while hot
	Raw, chopped or sliced (carpaccio)	warning	avoid chopped. Carpaccio should be eaten as soon as prepared. <u>Avoid</u> for women with Toxo-test negative
	Tinned meat	warning	eat upon opening. Do not store
	Smoked meat	warning	warning eat upon opening package. <u>Avoid</u> for women with Toxo-test negative
Gastronomies	Raw ham, speck, bacon, bresaola,	YES	
	Salami	YES	
	Fresh salami (salsiccia) or little seasoned salami (cacciatori)	warning	be careful ! Salmonella may be present. <u>Avoid</u> for women with Toxo-test negative
	Cooked salted meat: cooked ham, mortadella, porchetta	YES	To be kept in fridge. Do not store
Fish	Raw fish (sushi, sashimi,.....)	NO	"listeria monocytogenes" may be present
	Cooked fish	YES	Small fish
		warning	Big fish as tuna, swordfish: only once per week to avoid concentration of metilmercurium
	Oysters, mussels, etc.	warning	Only cooked
Fruit and vegetables	Fruit	YES	Better if peeled
	Canned fruit	YES	Eat immediately after opening
	Enveloped , pre-washed vegetables	warning	Only after washing
	Frozen vegetables	YES	
	Frozen herbs (basil)	warning	Only cooked
	Ready-made salads in bars	No	Avoid may contain listeria monocytogenes and toxoplasma gondii
Cooked leftovers		warning	Keep in fridge no longer than 2 days in envelopes. Boil before eating

THE BIRTH PATHWAY AND SOCIETY (page 118 of the Agenda)

At the end of this assistance pathway it is opportune to share some considerations about the social value of adequate assistance of the Percorso Nascita and the successive Percorso Crescita (Child's Growth Pathway).

Public assistance along the Percorso Nascita is entirely free of charge, but this does not mean that it does not have a cost. For every pregnancy/birth with a physiological term and a vaginal birth in hospital, can be calculated using today's criteria (cost of tests, antenatal classes, hospital stay, antenatal and postnatal care) an average expense of 2500-3000 Euro. This expense is financed by the Regional Health Services but actually it is maintained by our community through taxes that every citizen pays to the State/Region.

Awareness of the importance of the contribution of everyone for the health of all and, specifically, to the health of the next generation of citizens, must make for greater responsibility towards an appropriate use of available resources. And in particular where the Public Health Service offers a complete and cost-free pathway of assistance based on the best evidence of efficacy.

Health is not only a right of the single individual but of the entire collective: the health of everyone is in everyone's interest.

The other social value which should be referred to is that of safeguarding the environment, in particular for new generations:

- *use of sophisticated diagnostic techniques, limited to the indications appropriate for each check, as well as for the use of products for infancy, without falling for the allure of commercial advertising, allows saving energy as well as a savings for the family economy.*
- *breastfeeding, besides the advantages for the individual baby, is ecological: fewer cows used for producing "artificial" milk, fewer farms, fewer pesticides, fewer herbicides, less paper for packaging, plastic, glass, solid refuse, less consumption of energy for production, storage and preparation for artificial milk;*
- *using ecological nappies reduces the quantity of refuse to dispose and the enormous quantities of water needed to make disposable nappies;*
- *sharing with other parents the things needed for a limited time (e.g. car seats, push chairs, clothes, etc) allows consuming less energy for the production, distribution and disposal of the products of early infancy.*

The baby's health, in the widest sense of the term (physical, psychological, rapport, environmental) will depend on a world in which he can grow, for which it is worth:

- *not wasting water, energy and food*
- *protect the environment around us indoors and outdoors*
- *promote healthy eating*
- *favour movement on foot, by bike, with public transport*
- *favour products produced respecting human rights*
- *maintain health education rights and a liveable environment for children who are excluded*
- *promote acquaintances between children and races of different nationalities*
- *educate to relationships based on communication and non-violence.*

PROCEDURES FOR NOTIFYING BIRTH AND RECOGNITION OF BABY (= legal acknowledgment of parental relationship) (page 119 of the Agenda)

When the birth occurs it is obligatory to notify birth of baby within 10 days in order to register the baby in the Birth Register of the town (Ufficio di Stato Civile del Comune). In other words, the registration of the baby at the registry informs the Italian State of the presence of the new citizen and from that moment, if the one of the parents is of Italian Nationality, he will be entitled to all the rights of an Italian citizen minor.

Recognition is the declaration of both parents that the child is their own with the consequent assumption of the legal rights of parenthood; in other words father and mother, or both, present themselves as parents assuming before the State the responsibilities this requires in respect to the child. Recognition can be made at birth, and it is usually this way for married couples, or at different times (pre-recognition during pregnancy or later for parents younger than 16 years old, or in case of disjointed parental recognition).

The notification **must be made** by presenting the **ATTESTAZIONE-di-NASCITA**⁴ (BIRTH CERTIFICATE) of the baby to one of the following offices:

- Health Direction of Hospital where the birth took place (**within 3 days** of birth)
- or to the Town Registry where the birth took place (**within 10 days** of birth).

Usually, the Attestazione-di-Nascita (Birth Certificate) will be transmitted directly by the Obstetric Unit to the Health Direction of the Hospital if the registration was made in the Hospital, while the registration at the Ufficio-Anagrafe-del- Comune (Town Council Registry Office), will be given to the parents when discharged from hospital.

⁴ Birth certificates are given exclusively by health personnel who, having assisted at the birth, attest and sign to having assisted at the delivery of the madam of whom was born a newborn of sex Birth occurred at the hour at in the town of

On this birth certificate neither name nor surname of the newborn should be indicated.

The notification of birth, instead, which declares the birth of a person, will specify all information that may identify him such as name, surname, date and hour of birth, town.

The baby can be recognised by both parents, or only by the mother or only by the father.

Possible situations are:

- Married couple: just one parent is sufficient along with the identification-cards of **both** parents.
- Unmarried couple: the presence of both parents is required, along with both their identification documents. It is also possible to make the PRE-RICONOSCIMENTO (PRE-RECOGNITION) to be done during pregnancy at the office of the town of residence. With the pre-recognition successive paperwork of recognition is faster and easier: after birth only one parent need deliver the documents, prepared in advance as do married couples.
- Single mother: the mother must be present with an identification document. Also a single mother can have the right of using the pre-recognition.

If the parent who recognises or both parents are less than 16 years old, a tutor must intervene.

- Mother younger than sixteen years old and father who has already turned 16: if the father wants to recognise the baby, the newborn must first be recognised by the father and by the mother when she turns sixteen.
- Both Mother and Father are under 16 years of age: until turning 16 the parents cannot recognize the baby; in this case it is necessary to request assistance from Social Services for starting the procedures for **temporary custody** of the newborn as defined by the law.

The law foresees that the procedure of adoptability of the baby be suspended if the mother stays with the baby and continues to help him (perhaps with the help of relatives, in particular her parents). The Court of Minors, upon mother's request or deciding on its own, can put off the procedure for adoption until she turns sixteen.

Meanwhile, the baby will be registered in custody to the parents of the mother or, if necessary, to others; however this is feasible only if the mother helps and maintains her rapport with the baby. The surname of the baby remains, in this period, the one given to him by the Registry Office. When the mother will turn sixteen, she will recognise her baby immediately or ask the Court to still hold decision (for not more than two months).

- For women who intend to use the right of not recognising the newborn: by Italian law the woman can choose whether or not to recognise her own newborn and to do so freely.

If the woman does not recognise her baby within ten days of birth and neither does the father, the Court of Minors will open procedures for adoption of the baby, whit invented surname (chosen, as is the name, by the Town Registry Office) and in a short time (maximum two months) the baby will be given in custody to a couple deemed suitable for adoption and the baby will be declared adoptable. After one year of pre-adoptive custody and if all has gone well, the couple will adopt this child, who will become their son/daughter.

The law guarantees that woman's identity will not be made known (name, surname, and address will be held secret) and the reasons for the non recognition will be known only to the caregivers and the judge of minors.

If the woman has not yet decided whether or not to recognise her child, she can ask the Court of Minors, via the caregivers and without signing or making known her name, to be still be given a bit of time before making her final decision. If the Court accepts this request, a date, not beyond two months later, will be set for the woman to decide, without the baby in the meanwhile, being declared adoptable. However only making this request is insufficient, as the woman must maintain her relationship with the baby: she has to go visit him (in the place that has been found for him) without any particular kind of authorisation, and she has to stay near the baby. Other relatives (authorised by the Court), if there are any and they want to, may intervene.

When the set period has passed, the Court will decide whether to declare the baby adoptable (in this case the woman can no longer have any contact with him). If the Court declares the woman has not abandoned the baby and she has taken care of him in this period, a different choice can be made: in particular the custody of the baby to the woman or other relatives or even temporarily to another family but, in any case, not to be adopted.

- (non EU)-mother/parent regular residents: it is possible to recognise the baby using the same procedure described above. Once recognised it is necessary to **go to one's own embassy** to register the newborn by presenting the following documents: statement of birth from the registry, passport, residence permit.
- (non EU)-mother/parent not regular resident: it is possible to recognise the newborn using the same procedure above going to the Register Office with two witnesses and the passport of both parents, in the case of a married couple or cohabitants or of the mother in the case of alone mother. Once recognised, it is necessary to go to one's own embassy to register the newborn by presenting the following documents: statement of birth from the registry, passport.
- (non EU)-mother/parents without identity documents: during pregnancy it is advisable to go to an ISI centre in order to obtain a STP document allowing to get health care in all public services. This STP doc can be used as identification document for recognition the baby at the Health Direction of the Hospital. start the bureaucratic procedures necessary for recognition of the baby also at one's own embassy. Women without a resident permit have right to ask for it during their pregnancy and during 6 months after delivery. To get the paperwork underway at one's own embassy refer to the caregiver following the pregnancy in order to get a contact with social services.

For the two points above: once the regularisation papers are in order, it is possible to make the pre-recognition, that is, recognise the baby during pregnancy before birth. For the pre-recognition it is necessary to contact the Town-Office where the woman/couple lives.

For women with a tourist visa it is necessary to contact the ISI centre as some types of visas do not permit health care in Public Services.

PROCEDURES FOR REGISTERING YOUR BABY IN THE NATIONAL HEALTH SERVICE.

For registering in the Health Services the baby's fiscal code is needed: this is given at the Agenzia delle Entrate (Tax Office). With this document go to the ASL (Ufficio Scelta e Revoca) where at the time of registering the child in the Health System a paediatrician will be chosen from those available in the district of residence. Where no paediatrician is available the newborn will be registered with a general practitioner. Once this is done, the child has access to the services provided by the Regional Health Service for child.

REGIONAL PROVISIONS FOR THE FAMILY (page 121 of the Agenda)

Besides the rights described in this document the Regione Piemonte provides:

MATERNAL AND PARENTAL SUPPORT INTERVENTIONS

To obtain information regarding the initiatives described below, you should contact social services in your own zone or directly the Centri-per-le-Famiglie activated by social services in collaboration with the health services throughout our region.

For foreign mothers the entire pathway, when necessary, provides help from cultural mediators.

> Women alone who need socio-economical support for maternity (DGR N.11-7983 of 31/07/2008)

Women alone in economic difficulty are provided a support form that can be activated immediately after **discharge** from hospital after birth; this form of support provides the possibility of:

- inserting mother and baby in a mother/baby community, in "group apartments" or in other structures adequate to specific needs
- economic support
- educational support, also at home
- home visits in collaboration with the paediatric health service
- help entering asilo nido(day nursery) or other socio-educational services for infancy
- projects for mothers getting work

> Prevalent activities in the Centri per le Famiglie are:

- information desk regarding service and interventions available to families
- couple support and family mediation
- psychological-educational consultancy for supporting parents
- activation of self-mutual-help (for example, for parents with newborns)

The Regione Piemonte also assigns specific resources in order for Social Services opportunely activate, starting from the birth of the baby, and for at least the first year of life (extendible to the third year), interventions supporting families having economic difficulties, or difficulties related to disability or pathologies or the number of newborns (for example twins).

MATERNITY LEAVE (page 123 of the Agenda)

Working mother: Maternity leave is a right: every woman, according to the law in vigour, can have work leave for two months before the baby's birth and three month afterwards or one month before and four months afterwards.

If the baby is born preterm, with respect to the date foreseen, the woman can choose to stay a home for the number of days that she did not use before the birth. To use maternity leave it is necessary to give the employer the birth certificate or a substitute declaration within thirty days of the birth. By so doing every woman will receive 80% of her wages (many contracts provide an integration up to 100%).

For the calculation of 13th month-pay and/or computation of yearly paid holidays this period counts as regular service. Moreover, the woman can request, if she deems it necessary, besides her maternity leave additional holiday permissions.

Mother on mobility: leave is not calculated during the time of permanence on the lists while she continues to be paid mobility- indemnity for the maximum period provided. The woman is not cancelled from the list if, during the maternity-leave, she does not accept work or the start of a training course. Instead if the woman is dismissed for end-of-activity of her company or, if her contract is not renewed after its deadline, she would still receive maternity indemnity.

Unemployed mother: an unemployed mother has rights to maternity indemnity if, at the beginning of the leave, she had rights to unemployment indemnity.

Women who do not work, or that, even if working, have not yet reached the minimum requirements to be entitled to a maternity leave, can get other forms of support: for example, those women who are **resident in Torino**, can obtain maternity cheques and family cheques for families with three minors. Information for getting them can be found on the site <http://www.comune.torino.it/assegni>, or directly at the Ufficio Assegni alle Famiglie- Divisione Servizi Sociali del Comune di Torino (Family Cheques Office-Social Services Division Torino) via I.Giolio, 22 Torino-Numero Verde 800732040.

Women resident in other towns can contact Uffici delle Politiche Sociali (Social Politics Office) in their own town and ask for analogous information.

Free lance mother: can use maternity leave and ask her insurance provider for a maternity indemnity. Amounts will vary depending on her type of activity (for more information contact the Insurance provider directly).

Entrepreneur mother: she is entitled to get a maternity leave by request to INPS (for more information contact the Insurance provider: INPS).

Self-employed mother: (craftswoman, shopkeeper, farmer) or para-subordinate. She can choose to stay at home for maternity leave.

For women in management roles working for a private employer the same rights apply (as to the other workers) and the same protection by INPS.

A maternity leave is provided also for housekeepers but in order to have the benefit the worker must have at least six months of weekly contributions in the preceding year or a year of contributions in the two years prior.

Mothers with a contratto-a-progetto (also called co.co.co.), participating to temporary projects or occasionally or independently enrolled, can ask for maternity leave and related benefits for up to 180 days (however for more information one should contact INPS).

Adoptive mothers and custody mothers: mothers who have adopted a child in a national or international context have the right to maternity leave for five months from when the minor is placed in the family. In the case of international adoption, maternity leave can be used also during the stay abroad or alternatively ask for an unpaid leave. In the case of custody of a minor the leave can be asked within 5 months since custody was formally decided and for a total period not less than three months. In the case of children adopted or in custody who are not yet six years old, maternity leave is available for the first three months from the effective placement in the family and if the children come from a foreign country, even if they are over six years old.

PATERNITY LEAVE (page 124 of the Agenda)

Paternity leave is available for the father once birth has taken place. The work leave benefits are the same and can be asked for the father as well, but only if the woman has not requested them. Leave without pay can be asked at the same time for both mother and father.

A Father "worker", in the condition of being sole parent or in the case where the mother is seriously ill, has the right to work leave (=paternity leave) for a period equal to the time that the mother could have benefit (up to a total of five months). To use paternity leave it is necessary to present the employer with certification of death or abandonment or a serious illness of the mother or a certificate stating the exclusive custody of the child. By so doing the father will receive 80% of his wages (many contracts provide 100% integration) and the leave will be considered as regular service, for what concerns the 13th monthly pay and paid holidays. Moreover, he may request, if he deems it necessary, additional unpaid days of paternity leave.

Fathers in mobility: leave is not calculated for the period of permanence on the mobility-lists while he continues to be paid mobility-indemnity for the maximum period provided. The man is not cancelled from the list if, during the leave, he does not accept work or the start of a training course. Instead, if the man is dismissed for end of activity of the company or the contract is not renewed after its deadline, he would still receive paternity indemnity.

For men in management roles working for a private employer, the same rights apply as to the other workers and the same protection granted by INPS.

Adoptive or custody fathers: in the case of a national or international adoption they have the right to paternity leave for five months from when the minor is placed in the family. In the case of international adoption, paternity leave can also be used during the staying abroad.

If the father is registered under gestione-separata-INPS (co-co-pro, associate in participation, etc.): he can use paternity leave and relative indemnity if:

- the mother has not requested leave
- there is no mother or she is seriously ill
- if the minor has been given in custody to the father for a stay abroad

The father can, however, request unpaid leave with rights to keep his place.

The father can ask for paternity leave for the first three months after the effective placement in the family when the child:

- is not over six years old, unless the child comes from a foreign country
- the mother has not already asked for maternity leave
- there is no mother or she is seriously ill.

PARENTAL LEAVE (page 125 of the Agenda)

If mother and father are employees, after using maternity/paternity leave, there is an elective extension available, called **parental leave**. Mother and father can use this leave even at the same time. This right can be used until the child is eight years old and for a continuous or fractioned period up to a maximum of six months. This means taking leave even for only one day. In the case of alone parents (either mother alone or father alone) a continuous or fractioned period lasting up to a maximum of ten months can be used. In any case, if three consecutive months are requested, the maximum is eleven months. It is important to let the employer know at least fifteen days in advance before starting the leave of absence.

As for indemnity, INPS will contribute 30% of his pay, up to three years age of the child. Afterwards no contribution will be made unless the income of the mother or father is less than 2.5 times the minimum amount of pension (for information contact the Insurance provider).

The period of leave is calculated on the basis of working seniority in the company.

Free lance mothers and mothers with children born after January 1st 2000 have right to parental leave including economic benefits up to 3 months within the first year of life of their son.

Mothers who are workers "a-progetto" or belonging to similar categories, registered at "gestione separata INPS", have right to indemnity for parental leave for a period up to 3 months and within the first year after birth.

Are excluded from parental leave-rights the workers in domestic services, as housekeepers, and those registered with Gestione separata INPS, so called parasubordinates (e.g. co co co pro)

Adoptive mothers and fathers can use parental leave, whatever age the child, within eight months of placement in the family, but they can only receive the indemnity only for the leave period used in the first three years of the minor's placement in the family.

If there are more than two children it is possible to use the months of leave provided for each child.

DAILY REST : during the first year of baby's life both mother and father can have daily rests.

The mother: if she works more than 6 hours she can have two rests accumulated in each day. One hour per rest. If the work schedule is less than 6 hours she can have only one rest.

In the case where the mother sends her baby to an Asilo-nido (day nursery) or other nursery of the company, the rest period is ½ hour.

In case of multiple births the rest doubles and the additional hours can be used by the father. In the case of adoption or custody the same rules apply to the first year of the child's placement in the family. If two or more children are adopted or taken in custody, the rest time doubles.

It should be known that from the point of view of retribution, the rests correspond completely to the time and pay of work. Thus INPS will take care of the total sum payed. As for the social security contribution aspects, the rest breaks are covered by a contribution stamp.

The father: can have daily rests if:

- the child or children are in his sole custody
- the employee mother does not use them
- the mother is not an employee
- the mother is a free lancer or self-employed
- the mother is dead or severely ill.

Only in these cases can the father be given:

- two rests (cumulative in a single day), if his work schedule is over 6 hours (one hour each rest)
- only one rest if his work schedule is less than 6 hours
- a ½ hour rest period if his son is using an Asilo-nido or other suitable structure, available in the working place or in the vicinity.

LEAVE AND PERMISSION FOR SICK CHILDREN (page 126 of the Agenda)

Every parent has the right to leave if their children are sick.

Mothers and fathers can use it, alternatively, until 8 years of child's age.

The leave is available to the requesting parent even if the other parent is not entitled to get the benefit.

Up to 3 years the mother or the father can have work leave at any time, with no limit of time until the child is completely well, for the period of illness of each child. In the case of adoption and custody the age limit is raised to 6 years.

From 3 to 8 years mother or father can have work leave for a maximum of 5 work days per year for each child (adoption and custody cases included).

If on the date of adoption (or custody) the child age is between 6 to 12 years, then a sick leave (for child illness) may be used in the first three years from the child's placement in the nuclear family. A medical certificate is required from a specialized doctor of the National Health Services. Controls on the mother or fathers' illness do not apply to this type of leave. If the child is recovered in hospital during one of the parent's holiday periods it is possible to suspend the holidays for the entire period of the recovery.

From the viewpoint of pay, there is no indemnity. The leave periods are used for calculating seniority, but not for computing holidays or additional monthly bonuses.

As for the social security contribution, the period of leave within the child's three years of age provide a state substitute contribution stamp, while between 3 to 8 year state substitute contribution stamp is reduced.

For adoptive fathers or custody fathers the same prohibition of dismissal applies until a year from the child's placement in the family.

Dismissal can be given in case of grave fault on the father's part that constitutes just cause (but he does not lose rights to indemnity), if the business closes, if the job that the father was hired for ends or expires and even if the father has not completed the trial period. In this last case it may be necessary to verify that there has not been discrimination due to the request for paternity leave.

The father can not be suspended from work unless the activity or his sector goes out of business and he can not be put into mobility. The father can in no case be dismissed for requesting parental leave or for assisting a child's illness.

SERIOUS HANDICAPPED CHILD (page 126 of the Agenda)

If a child has a handicap, according to the criteria established by the law 104/92 permissions and rests for the mother and for the father, provided by the same law, can be accumulated with the parental leave or the sick leave.

Up to 3 years: extension of parental leave up to a maximum of three years, unless the child is recovered in a specialized institute.

From 3 up to 18 years of age: up to 3 days per month are available, even continuously if necessary.

Over 18 years of age: up to 3 days per month (continuously if needed) if the child lives with the parents making the request or does not live with them, but is assisted continuously and exclusively by them.

From the viewpoint of pay, in the case of prolonged parental leaves, indemnity is 30% of the salary. Instead for daily rests and monthly permits, the pay is 100 %. Social security contribution is made in both circumstances.

YOUR RIGHTS on the place of work (page 27 of the Agenda)

Keeping your place of work: tasks, location and roles

Returning from maternity/paternity leave, the parent has the right to keep her/his place of work, in the same location or in the same town and has the right to stay there until the child is one year old. The mother or father should be given the same tasks as before going on leave or other tasks that the collective contract considers equivalent. The same rights apply to both parents after parental leave, a permission, or a rest.

Prohibition of Dismissal: Fathers who use paternity leave, being the sole parent or the mother being seriously ill, cannot be dismissed until the child is one year old.

Mothers cannot be dismissed since the start of pregnancy (even if the employer was not yet informed) until the child is one year old. For adoptive mothers or custody cases the same prohibition holds for one year from the child's placement in the family.

Dismissal may be communicated: if the woman has committed a grave fault that constitutes just cause (but she does not lose the maternity indemnity), if the company she works for ceases activity, if the job the woman was hired for or the contract runs out and also if she has not completed her trial period. For this last situation it may however be necessary to verify that there has not been discrimination because the woman was pregnant.

Even if the woman is a domestic worker and her pregnancy began while working she cannot be dismissed until the third month after delivery. She cannot be suspended from work unless the activity or the section where she works is suspended and she cannot be put into mobility. She cannot be dismissed if she asks for parental leave or if she is absent for a child's illness.

DISMISSALS (page 127 of the Agenda)

If the mother gives her dismissal voluntarily by the end of the baby's first year, as foreseen by contract, she does not need to pre-advise her employer and has the right to ask the same indemnity provided in case of dismissal.

If it is the father who uses paternity leave and asks for dismissal voluntarily by the baby's first year, he has the right to the same indemnity provided in case of dismissal and does not need to pre-advise as foreseen by contract. The dismissal is not valid if it has not been approved by the Department of Labour.

PROHIBITION OF NIGHT WORK (page 127 of the Agenda)

Until the child's first year, the mother can not work from 12:00 a.m. to 6 o'clock a.m. It is not obligatory to do night work until the child is three years old. If the mother is sole parent of a child living with her, it is not obligatory for her to do night work until her child is 12 years old. If she has to take care of another child or another disabled person, she never has to do night work.

The father does not have to do night work until the child is three years old if the mother is already doing night work. If the father is sole parent of a child living with him, night work is not obligatory until the child is twelve years old and, same as for the mother, if there is another child or a disabled person to care for, night work is never obligatory.

POSSIBILITY OF REQUESTING AN ANTICIPATION OF LIQUIDATION (page 128 of the Agenda)

To support the expenses during periods of parental leave when pay gets reduced, either the father or the mother have the right to ask their employer an anticipation of their liquidation, as well as for medical expenses or for buying a house.

SOME OTHER INFORMATION.....

Moreover, it is important to remember that it is possible to ask for a part-time according to Law 53/2000 as a measure to conciliate work and home time. There is no law obliging the company to allow part-time, but in case it is not conceded, the father and the mother can contact the Equal Opportunity Advisor in order to try mediating with the company they are working for. So far there have been good results thanks to the funding provided for companies that introduce forms or means of conciliation of home time with work.

It is possible to ask the company where you work if means of conciliation of home time with work have been introduced together with/or flexible forms of timetables that could be of interest to you.

By now there are many experiences regarding this, also because a number of incentives for the companies are provided for promoting this type of initiative, starting from art.9 of law 53/2000, of the European Social Fund. If the company has not yet introduced this, the parents can promote the introduction by putting the company in contact with the Equal Opportunity Advisor to receive all the necessary information.

If the mother does not work or has a low income, she can ask for Assegno-maternità (maternity cheques) by contacting the offices of her Comune of residence for assegno-comunale (Town cheques) or INPS for the state-cheques (both in presence of determined needs). Even for the father, this request must be made within six months of the birth or from the child's placement in an adoptive or custody family.

For non-EU mothers or fathers, a residence permit is needed for obtaining the cheques.

To find out more about maternity/paternity laws and parental leave contact INPS site (<http://www.inps.it>) or telephone number 803164 giving information in eight languages. This service is free of charge.